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First-Person Perspectives on Dual Diagnosis Anonymous (DDA): A Qualitative Study

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Description

Objective: People dually diagnosed with substance abuse and mental illnesses often feel alienated at traditional 12-step meetings, yet they need the peer support provided by such groups. Dual Diagnosis Anonymous (DDA) is a peer-support program specifically for people with co-occurring disorders, which addresses many of the factors that members find alienating about traditional 12-step groups. This study aimed to elicit first-person perspectives on DDA. **Methods:** Occupational therapy students conducted 13 focus groups with 106 DDA members in three settings: the community (6 groups, $n = 36$), correctional facilities (5 groups, $n = 53$), and the state psychiatric hospital (2 groups, $n = 17$). Researchers inductively analyzed focus group transcripts to identify prominent themes. **Results:** The vast majority of participants were between the ages of 18 and 49 ($n = 87$, 82.1%) and were non-Hispanic/White ($n = 82$, 77.4%). Most participants had been using substances for more than 10 years and had been diagnosed with a mental illness for more than 10 years. The most common substance of choice among those in the community and corrections setting was multiple substances, while those in the state hospital identified alcohol most often. Bipolar disorder was the most common mental illness diagnosis among participants in the state hospital, but depression and anxiety were the two most common diagnoses in the community and corrections participants. Four primary themes emerged from the qualitative analysis: (1) feeling accepted by others in the group, (2) acceptance within the group of mental illness and substance abuse together, (3) the structure of DDA meetings compared to other 12-step meetings, and (4) a focus on hope and recovery from both illnesses. **Conclusions:** DDA provides a helpful alternative for individuals who do not feel comfortable at traditional 12-step groups due to their mental illness. Members value the acceptance, understanding, discussion, and hope in DDA meetings.

Disciplines

Occupational Therapy

Comments

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ABSTRACT

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Methods: Occupational therapy students conducted 13 focus groups with 106 DDA members in three settings: the community (6 groups, $n = 36$), correctional facilities (5 groups, $n = 53$), and the state psychiatric hospital (2 groups, $n = 17$). Researchers inductively analyzed focus group transcripts to identify prominent themes. **Results:** The vast majority of participants were between the ages of 18 and 49 ($n = 87$, 82.1%) and were non-Hispanic/White ($n = 82$, 77.4%). Most participants had been using substances for more than 10 years and had been diagnosed with a mental illness for more than 10 years. The most common substance of choice among those in the community and corrections setting was multiple substances, while those in the state hospital identified alcohol most often. Bipolar disorder was the most common mental illness diagnosis among participants in the state hospital, but depression and anxiety were the two most common diagnoses in the community and corrections participants. Four primary themes emerged from the qualitative analysis: (1) feeling accepted by others in the group, (2) acceptance within the group of mental illness and substance abuse together, (3) the structure of DDA meetings compared to other 12-step meetings, and (4) a focus on hope and recovery from both illnesses. **Conclusions:** DDA provides a helpful alternative for individuals who do not feel comfortable at traditional 12-

step groups due to their mental illness. Members value the acceptance, understanding, discussion, and hope in DDA meetings.

Keywords *Dual Diagnosis Anonymous, dual diagnosis, co-occurring disorders, 12-steps, substance abuse, mental illness, addiction*

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Dual Diagnosis Anonymous (DDA), a specialized 12-step program modeled after Alcoholics Anonymous (AA), has conducted peer-run groups in corrections facilities, hospitals, and communities in Oregon since 2005 (Monica, Nikkel, & Drake, 2010). Although some literature has described the effectiveness of specialized 12-step groups similar to DDA (Rosenblum et al., 2014; Timko, Sutkowi, & Moos, 2010; Aase, Jason, & Robinson, 2008; Magura et al., 2008; Magura, 2008), minimal information exists regarding first-person experiences in 12-step programs due to the required anonymity of traditional 12-step fellowships. Tradition 11 of AA states, "Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films" (Alcoholic Anonymous World Services, 2013, p. 562). This tradition has been interpreted as not allowing research on first-person accounts of participation in AA. By contrast, DDA has permitted research as long as anonymity is respected. DDA's five rules of respect include the following, "As our first rule states, there can be no recovery in DDA without confidentiality and anonymity. It is what's first and it is what's most important. This rule applies to DDAers and friends of DDA. Nothing, absolutely nothing, should be taken out of a meeting of dual diagnosis anonymous. There are exceptions to this rule. An example of an exception is if a member of DDA gives her/his permission to allow their story, or what they share in a meeting, to be repeated outside of the meeting" (Dual Diagnosis Anonymous of Oregon, 2008, paragraph 3). This exception provided the opportunity to conduct research with consent from each participant.

This study aimed to elicit first-person perspectives, via focus groups, on DDA. The Pacific University and Dartmouth Institutional Review Boards, the Oregon State Hospital

Research Review Committee, and the Oregon Department of Corrections Research Committee approved the study.

METHODS

Participants

Eligibility requirements included: at least 18 years of age, self-identify as having substance abuse and a mental illness, able to communicate in English, and willingness to consent to audio-recording or notes. Recruitment included flyers distributed at DDA meetings, posted on the DDA of Oregon website and Facebook page, and sent out via the DDA of Oregon mailing list. Leaders also invited participation at the beginning of DDA meetings. Participation was voluntary and no compensation was provided to participants. All participants gave written informed consent after discussion of the study and prior to focus groups. The Pacific University Institutional Review Board provided primary oversight and monitoring.

Focus Group Procedures

Between November 2012 and June 2013, occupational therapy students and DDA members conducted 13 focus groups: six in the community, four in a women's correctional facility, one in a men's correctional facility, and two in the state hospital. Focus groups were conducted in lieu of regularly scheduled meetings; members who did not want to participate attended a regular DDA meeting. Community focus groups were conducted at a non-locked peer-run residential facility and the DDA Central Office. Focus groups in the corrections facilities and state hospital were limited by the facilities. The men's correctional facility allowed

one visit while the women's correctional facility allowed two visits with two focus groups conducted simultaneously at each visit. DDA groups were only provided one time per week in the men's correctional facility and two times per month in the women's correctional facility, both with institutional limitations on the number of individuals who could participate in a given meeting. Two visits to the state hospital were allowed with one for informed consent and the other to conduct two concurrent focus groups. Each focus group lasted approximately one hour and included up to 10 participants. All focus group facilitators completed specialized training on conducting focus groups. Focus group questions covered members' perspectives on DDA, the pathways that led them to DDA, their own personal experiences in DDA, the impact of DDA on their lives, and how DDA helped them to recover from substance abuse and mental illness. All focus groups were audio-recorded and transcribed verbatim by research assistants. Focus groups were selected over other qualitative methods to provide insight into a range of DDA groups and settings that would not have been feasible using, for example, individual interviews. In addition, focus groups capitalized on the naturalistic structure of the DDA groups. Focus groups are useful during the exploratory phase of research to generate initial understandings of phenomena that can be studied in more detail and greater depth through subsequent research.

Analysis

Researchers, not group leaders, independently analyzed data from the focus groups and developed themes through an inductive, iterative process (Boyatzsis, 1998). Our initial review of the transcripts identified 23 provisional themes that were directly grounded in the data (Charmaz, 2006). We then constructed a qualitative matrix (Miles & Huberman, 1994) to examine the

presence of the provisional themes across the different study sites. Matrices provided "an organized, compressed assembly of information" to draw conclusions (Miles & Huberman, 1994, p. 12). This approach facilitated the identification of patterns and relationships. Through ongoing review, we refined provisional themes into the main themes reported herein.

RESULTS

Participants

Participants ranged in age from 18 to over 60 years, with most between the ages of 18 and 49 (n = 87, 82.1%). A variety of ethnicities were represented, but the majority of participants were non-Hispanic/White (n = 82, 77.4%). The highest level of education achieved by participants began with grade school and extended to obtaining graduate degrees. The largest group educationally was those with high school diplomas/some community college (n = 49, 46.2%; see Table 1). As shown in Table 2, participants in the community and in corrections facilities identified "multiple substances" as the most common drug of choice (n = 26, 63.9% and n = 25, 47.2%, respectively), while those in the state hospital reported alcohol as the most common (n = 5, 29.4%). Length of use was overwhelmingly more than 10 years in the community (n = 31, 86.1%) and corrections (n = 38, 71.7%), and evenly distributed from two to more than 10 years in the state hospital. Time sober varied greatly from less than three months to more than five years across all three settings. Diagnosis also varied with the majority of participants identifying multiple psychiatric diagnoses with a wide range of time since first diagnosis. Depression and anxiety were the two most common mental illness diagnoses in the

community and corrections participants, while bipolar disorder was the most common among those in the state hospital.

Participation in DDA varied depending on setting. In the community almost 70% (n = 25) of participants attended once per week, in the state hospital only 47% (n = 8) attended weekly, and in corrections facilities (with limited DDA meetings), the majority attended DDA once (n = 35, 66%) or twice (n = 13, 24.5%) per month. Many individuals had been attending DDA for less than three months (n = 41, 38.7%) or 3-6 months (n = 20, 18.9%), and only 5 (4.7%) had been attending for more than five years. See Table 3 for additional details. The majority of participants had been in at least two of the settings since the onset of their dual diagnosis and believed that having support systems, such as DDA, that were consistent and predictable across environments was of great benefit.

Themes

Four primary themes emerged from the focus groups and were consistent across settings: (1) acceptance by others, (2) acceptance of mental illness and substance abuse together, (3) the structure of DDA meetings, and (4) hope and recovery. Within the four primary themes, many subthemes were evident.

Acceptance by others. Many participants identified that they felt connected to others at DDA. The following quotes demonstrate this connection:

> "I have bipolar disorder and I can come to DDA and talk to other people that have bipolar disorder, which is not like a lot of venues… there is huge stigma about mental illness and so

at times I'm embarrassed to say I have bipolar disorder. …But at DDA you can say 'I have bipolar disorder` and there's like five other people that are like 'I have bipolar disorder too` and then you can talk about your experiences of when your symptoms have out of control, and you really feel not alone anymore."

"I could actually relate to the people in DDA meetings, I mean these people have done the same things I have done."

"It's nice to know that you're not alone in recovery, that there's other people struggling too."

"It's had a positive influence on my relationships because it's made me being more open towards other people than I normally would because I understand that we are coming from the same kind of background and it's easy to compare pasts together."

Participants also identified that they can open up and feel safe without fear of judgment while in DDA meetings:

"The thing I like about DDA so far is that I can be me. I can totally be me. …I feel like I have weird idiosyncrasies, and certain things matter to me, and they're acknowledged and honored in DDA. … No one says you're a weirdo or you did something wrong."

"When I came here I totally felt validated, umm, that I wasn't different from anyone else here. I could share my story, I could talk about things that are bothering me without being judged, and that was huge."

"You walk into a meeting and everybody's greeting and nobody cares what your crime is."

"… I don't talk in NA and AA and CA. I just sit there. But I found that I can talk in DDA… I found a group that I can communicate with, that I can be honest with, that I can be opened with. That I can expect them to be that with me."

"Before coming to DDA I wouldn't tell anybody what I was going through, what I've been through. … Now I communicate with people one day in a support group, people who've been through things kind of similar to what you've been through…"

"It's the only place I feel actually comfortable speaking at, and actually like opening up and sharing, and I feel like I have a strong support system here…"

"The guys, they open up and just for no reason will start crying. Just knowing he's in a safe place…"

"I don't feel like I'm the only person in the world who goes through what I go through anymore, cause then I don't feel so crazy."

Acceptance of mental illness and substance abuse together. Participants acknowledged that their mental health challenges came paired with their substance use but identified that outside of DDA they were often asked to separate them.

"Since I have bipolar disorder and heroin addiction, I wanted to get treated for both things because in my experience my drug usage mirrors my mental disorder."

"Before I found out about DDA I felt very secluded in that going to other 12-step programs because, um, talking about any kind of medications, or any kind of other symptoms like my depression and social anxiety, um, was almost, it was almost shunned or almost viewed as something very separate, and what I realized is that, umm, I need to focus on both…"

"It's OK that I have these two different issues, and it's ok that I can address them… don't have to look at them as two separate entities… That's a huge, huge revelation that's lifted."

Many group members also stated that DDA helps them to deal with their medications.

"When I first came into AA and I had sobriety for about three years, but in that time I was on Paxil, and uh I felt guilty, because I felt like I didn't have true sobriety, because the people around me were pretty against um having medication."

"I go to AA here but you know it's almost like 'psst he takes medication`. When I'm in DDA I don't get that because we understand that the medication helps me."

"It picks up where other programs have left off. …There is so much judgment about medication in other programs. When I take certain medications I can hold my life together. DDA is the only meeting I come to now."

Structure of DDA meetings. Focus group members reported feeling that the structure of the DDA meetings allows them to share when they want to but also to feel comfortable not sharing when they don't. There was a theme of support for the ability to engage in cross talk (e.g., giving feedback), something that's not allowed at other types of 12-step meetings.

"We weren't forced to talk, or you know, I didn't feel like I was…"

"You know if you don't wanna share you can pass and when somebody shares there's time taken… [the meeting chair] will ask them if they want feedback and somebody who has some feedback will say… do you wanna hear something I have to say about that same issue or whatever. And people can say yes or no."

"Most of the meetings [other than DDA] I go to it's a very specific format 'no cross talk, no feedback'. I mean that cool but here being able to offer some feedback to encourage, I know I've been offered the encouragement and it helped me at that time, instead of waiting 45 minutes later."

"The AA/NA way of doing meetings were that crosstalk stuff is like really strictly monitored."

"One of the things I like about DDA is that we share with each other… there is feedback if you want it, if you don't want it people don't, but if you do we're able to share ideas with each other on how to get through things."

Some individuals did express concern that the crosstalk can get out of hand if not monitored by the meeting chair.

"I was kind of concerned about, but it didn't really seem to get out of control was that, when um, when feedback was starting to happen, um some people got into more of a um discussion, rather than just feedback, you know. It got a little out of hand. And I feel like it was reigned in… I don't think it was a big deal…"

"So maybe just a description at the beginning of the meeting like how that works…"

Participants also identified feeling that the structure promotes more personal commitment at DDA.

"I don't know what it is but there is some automatic respect in the group that I have not seen in other groups."

"So it just seems like people umm, are a little more into it, or a little more receptive, and there isn't that on the spot feeling either."

The most evident concerns about meetings centered around wanting more printed literature, more organized contact lists, and more meetings in general.

Hope and recovery. A strong theme was that DDA gives each individual hope for a better future as well as education about what recovery is and how to recover.

"It's given me a new sense of hope. I don't have to look at myself as a sick person or feel sorry for myself. I just know I have challenges to overcome. A great deal of hope. That is life changing."

"You're like 'I'm all messed up. I'm destined to relapse and screw everything up in my life and just keep trippin up everywhere I go' and there's hope here that you know, you're not alone."

"There is an educational piece about DDA because you learn more about other people's experiences and diagnosis."

"There's a definite awareness that it's given. You know what I mean? And that's an, that's another big thing is being able to be aware and deal with it."

"Also, I learn from different people, because we're all in different places and different people come up with their issues so we're able to give experience."

Participants clearly defined what recovery from substance abuse and mental illness means to them.

"I think recovery means have respect for yourself. Not needing addictions to hide from yourself."

"Recovery is when you don't need to escape from reality. When you can accept things day to day."

"Recovery is my responsibility. I'm responsible for my actions and reactions. I can look in the mirror and know I'm OK. I'm aware of my choices and what they mean. Recovery means looking at the big picture. Mental illness is selfish. I'm able to step back and see consequences. I lose that in addiction. I'm a person. I'm not a junkie."

"Recovery means for me being able to function and be happy. Because I really know how to be depressed and I really know how not to function. So recovery means I can function and have some resemblance of happiness."

"It's waking up in the morning and brushing your teeth or hopping in the shower, that can be recovery, just taking care of what you gotta take care of for yourself… That's kind of what recovery means to me, what can you do to better yourself."

"Trying to get over the obstacles and not just getting over the obstacles but taking them with you and learning from them and trying to overcome them."

DISCUSSION

Participants in DDA feel connected to others within the meeting, much more so than in other support groups. DDA members accept, understand, and talk openly about having both mental illness and substance abuse. They feel that they benefit from talking with others who share dual diagnosis because it encourages hope and facilitates recovery from both illnesses.

The four themes identified were similar across the three different settings (community, corrections facilities, and psychiatric hospitals), indicating that content transferred easily to another setting when participants transitioned. DDA's unique structure provides a peer-support option where people can discuss the interrelated issues of mental illness and substance abuse and be open about their treatments, including the use of medication. Sharing experiences in DDA helps participants to understand that they are not alone in their struggles. DDA provides an opportunity for members to learn about the relationship of their mental illness to their substance use in order to promote recovery. Members learn from one another's experience and apply this information in order to support their own recovery from both illnesses in a way that doesn't occur in traditional 12-step meetings.

This study adds to knowledge regarding specialized 12-step groups for people with dual diagnosis. Few research studies have described the effectiveness of specialized 12-step groups similar to DDA, and we found none describing first-person perspectives. Gaining the perspective of service users helps to understand the components and mechanisms that underlie engagement, participation, and change.

Several limitations warrant mentioning. The study included participants in diverse settings, but the number of participants in the corrections setting greatly outnumbered the participants in either the community or the state hospital. This could potentially create a bias

towards over-representation of the corrections population. In addition, the participants were largely non-Hispanic/White and therefore it is difficult to generalize findings to diverse cultural backgrounds. Future research should attempt to reach a broader range of ethnicity and greater numbers of participants in the community and state hospital system. Focus groups have well known limitations, including limited depth and a potential to conform to group-level perspectives (Morgan, 1996). We did not collect formal documentation to verify diagnoses and relied on participant self-report. In addition, participant responses could have been biased by engaging in the focus groups during the regularly scheduled DDA meeting time and in the regular meeting location.

Conclusions

DDA effectively fills a gap in the traditional 12-step services for individuals dually diagnosed with mental illness and substance abuse. Although many who attend DDA also attend other 12-step meetings, participants clearly value the special features of DDA meetings.

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DISCLOSURES

Mr. Roush, Dr. Carpenter-Song, and Dr. Drake report no conflicts of interest related to this manuscript and no additional compensation for professional services. Mr. Monica received compensation as the executive director of DDA during this study.

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Table 1. General Demographic Characteristics of Participants (N = 106)

Characteristic	Community n=36	Corrections n=53	State Hospital n=17
Gender			
Male	23 (63.9%)	12 (22.6%)	13 (76.5%)
Female	13 (36.1%)	41 (77.4%)	4 (23.5%)
Age (years)			
18-29	6 (16.7%)	13 (24.5%)	10 (58.8%)
30-39	8 (22.2%)	18 (34.0%)	3 (17.6%)
40-49	14 (38.9%)	13 (24.5%)	2 (11.8%)
50-59	6 (16.7%)	8 (15.1%)	2 (11.8%)
60+	2 (5.5%)	1 (1.9%)	0 (0.0%)
Ethnicity			
Non-Hispanic/White	31 (86.1%)	43 (81.1%)	8 (47.0%)
Hispanic	1 (2.8%)	0 (0.0%)	2 (11.8%)
African-American	0 (0.0%)	1 (1.9%)	2 (11.8%)
Native American	3 (8.3%)	4 (7.5%)	2 (11.8%)
Multi-Ethnic	0 (0.0%)	3 (5.7%)	2 (11.8%)
Other	1 (2.8%)	1 (1.9%)	1 (5.9%)
Not identified	0 (0.0%)	1 (1.9%)	0 (0.0%)
Highest Education			
Grade school	0 (0.0%)	3 (5.6%)	1 (5.9%)
Some HS	7 (19.4%)	15 (28.3%)	5 (29.4%)
HS degree/some CC	17 (47.2%)	24 (45.3%)	8 (47.0%)
CC degree/some UG	6 (16.7%)	9 (17.0%)	2 (11.8%)
UG/some GS school	5 (13.9%)	0 (0.0%)	0 (0.0%)
Graduate degree	1 (2.8%)	2 (3.8%)	1 (5.9%)

Note. HS = high school, CC = community college, UG = undergraduate, GS = graduate school.

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Table 2. Dual Diagnosis Characteristics of Participants (N = 106)

Dual Diagnosis Characteristic	Community n=36	Corrections n=53	State Hospital n=17
Drug of choice			
Alcohol	7 (19.4%)	4 (7.5%)	5 (29.4%)
Methamphetamine/Cocaine	2 (5.5%)	20 (37.7%)	1 (5.9%)
Narcotics	0 (0.0%)	1 (1.9%)	3 (17.6%)
Hallucinogens	1 (2.8%)	0 (0.0%)	1 (5.9%)
Prescriptions	0 (0.0%)	1 (1.9%)	0 (0.0%)
Marijuana	1 (2.8%)	0 (0.0%)	2 (11.8%)
Heroin	1 (2.8%)	1 (1.9%)	0 (0.0%)
Multiple Substances	23 (63.9%)	25 (47.2%)	4 (23.5%)
No Answer	1 (2.8%)	1 (1.9%)	1 (5.9%)
Length of use			
<1 year	0 (0.0%)	2 (3.8%)	0 (0.0%)
1-2 years	0 (0.0%)	0 (0.0%)	3 (17.6%)
2-5 years	1 (2.8%)	4 (7.5%)	4 (23.5%)
5-10 years	3 (8.3%)	9 (17.0%)	4 (23.5%)
>10 years	31 (86.1%)	38 (71.7%)	5 (29.4%)
No Answer	1 (2.8%)	0 (0.0%)	1 (5.9%)
Time sober			
<3 months	7 (19.4%)	2 (3.8%)	0 (0.0%)
3-6 months	11 (30.6%)	6 (11.3%)	1 (5.9%)
6-12 months	6 (16.7%)	14 (26.4%)	1 (5.9%)
1-2 years	2 (5.5%)	14 (26.4%)	4 (23.5%)
2-5 years	5 (13.9%)	14 (26.4%	3 (17.6%)
>5 years	4 (11.1%)	3 (5.7%)	4 (23.5%)
No Answer	1 (2.8%)	0 (0.0%)	4 (23.5%)
Diagnosis*			
Schizophrenia	7 (19.4%)	4 (7.5%)	3 (17.6%)
Bipolar disorder	9 (25.0%)	18 (34.0%)	9 (52.9%)
Depression	20 (55.5%)	34 (64.2%)	2 (11.8%)
Anxiety disorder	16 (44.4%)	31 (58.5%)	2 (11.8%)
ADHD/ADD	2 (5.5%)	10 (18.9%)	2 (11.8%)
PTSD	12 (33.3%)	16 (30.2%)	1 (5.9%)
Other	5 (13.9%)	2 (3.8%)	4 (23.5%)
No Answer	5 (13.9%)	2 (3.8%)	3 (17.6%)
Time since first diagnosis			
<1 year	3 (8.3%)	5 (9.4%)	1 (5.9%)
1-2 years	2 (5.5%)	2 (3.8%)	0 (0.0%)
2-5 years	5 (13.9%)	7 (13.2%)	4 (23.5%)
5-10 years	9 (25.0%)	12 (22.6%)	2 (11.8%)
>10 years	10 (27.8%)	25 (47.2%)	6 (35.3%)
No Answer	7 (19.4%)	2 (3.8%)	4 (23.5%)

Note. ADHD/ADD = attention deficit hyperactivity disorder/ attention deficit disorder; PTSD = posttraumatic stress disorder.
*Total more than 100% due to many clients having multiple diagnoses

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Table 3. Participation in Dual Diagnosis Anonymous (DDA) (*N* = 106)

DDA Participation	Community *n*=36	Corrections *n*=53	State Hospital *n*=17
Time in DDA			
<3 months	15 (41.7%)	25 (47.2%)	1 (5.9%)
3-6 months	7 (19.4%)	10 (18.9%)	3 (17.6%)
6-12 months	0 (0.0%)	7 (13.2%)	1 (5.9%)
1-2 years	5 (13.9%)	7 (13.2%)	4 (23.5%)
2-5 years	6 (16.7%)	4 (7.5%)	2 (11.8%)
>5 years	2 (5.5%)	0 (0.0%)	3 (17.6%)
No Answer	1 (2.8%)	0 (0.0%)	3 (17.6%)
Frequency of Attendance			
1x per month	2 (5.5%)	35 (66.0%)	3 (17.6%)
2x per month	4 (11.1%)	13 (24.5%)	2 (11.8%)
1x per week	25 (69.4%)	1 (1.9%)	8 (47.1%)
2-3x per week	3 (8.3%)	1 (1.9%)	0 (0.0%)
4-5x per week	1 (2.8%)	0 (0.0%)	1 (5.9%)
>5x per week	0 (0.0%)	0 (0.0%)	0 (0.0%)
No Answer	1 (2.8%)	3 (5.7%)	3 (17.6%)