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Newcomers to Al-Anon family groups: Who stays and who drops out?☆

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HIGHLIGHTS

- Al-Anon is the most-used form of help for people concerned about another's drinking.
- We assessed the prevalence and predictors of dropout among Al-Anon newcomers.
- Drop-outs had fewer referrals by providers and less severe problems than attendees.
- Drop-outs were more concerned about their drinker's psychological health.
- Drop-outs had high rates of problems and would benefit from ongoing help and support.

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ABSTRACT

Al-Anon Family Groups (Al-Anon), a 12-step mutual-help program for people concerned about another's drinking, is the most widely used form of help for concerned others (COs) in the US. This study assessed the prevalence of dropout, and predictors of dropout, in the six months following newcomers' initial attendance at Al-Anon meetings. Al-Anon's World Service Office mailed a random sample of groups, which subsequently yielded a sample of 251 newcomers who completed surveys at baseline and 6 months later. At the 6-month follow-up, 57% of newcomers at baseline had dropped out (had not attended any Al-Anon meetings during the past month). At baseline, individuals who later dropped out of Al-Anon were less likely to have been referred to Al-Anon by their drinker's health care provider, and reported less severe problems than individuals who continued to attend, but dropouts were more often concerned about their drinker's psychological health; newcomers with these concerns may have found them incompatible with Al-Anon's philosophy. Dropouts reported high rates of problems, suggesting that COs who drop out of Al-Anon would benefit from ongoing help and support.

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1. Introduction

Al-Anon Family Groups (Al-Anon) is a 12-step mutual-help program for people concerned about another's drinking. Al-Anon is the most widely used form of help for concerned others (COs) in the US (Miller, Meyers, & Tonigan, 1999; O'Farrell & Clements, 2012; O'Farrell & Fals-Stewart, 2001). This study assessed the prevalence of dropout, and predictors of dropout, in the six months following newcomers' initial attendance at Al-Anon meetings. Greater knowledge of factors associated with early dropout may increase provider awareness about COs and lead to more effective and efficient targeting of Al-Anon facilitation efforts.

1.1. Prevalence of dropout from 12-step groups

Participation in 12-step groups is associated with positive outcomes (Magura, Cleland, & Tonigan, 2013; Moos & Moos, 2007), but dropout rates are high. Dropout from Alcoholics Anonymous (AA) attendance has been studied among individuals treated for substance use disorders (SUDs). For example, dropout from 12-step groups was 40% at 1 year following SUD treatment (Kelly & Moos, 2003). Similarly, in Project MATCH's Twelve Step Facilitation outpatient condition, 41% of clients who initiated AA attendance during treatment dropped out during the following nine months (Tonigan, Connors, & Miller, 2003). Dropout from consistent 12-step group attendance over 2 years among treated

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cocaine users was 60% (Fiorentine, 1999). We have been unable to locate any estimates of dropout rates from Al-Anon, with the exception of an article from *Good Housekeeping* in 1960, stating that about 10% of attendees dropout after two or three meetings. However, the article did not provide the source of this statement.

1.2. Predictors of dropout from 12-step groups

Factors associated with dropout from 12-step groups include the demographic characteristics of being white, younger, less educated, and less likely to attend religious services (Kelly & Moos, 2003; Laudet, Magura, Cleland, Vogel, & Knight, 2003; McCrady, Epstein, & Hirsch, 1996). The main reason for initiating Al-Anon participation is accumulated life stressors and lack of resources, such as the drinker's or family's financial, relationship, legal, health, and work problems (Roth, 2004; Roth & Tan, 2007, 2008), but the extent to which these factors are associated with subsequent dropout by Al-Anon newcomers is unknown. Dropouts from conjoint treatment for alcoholism were less committed to their relationship with their spouse or partner (Epstein, McCrady, Miller, & Steinberg, 1994), and dropouts from 12-step groups reported being unable to relate to the severe life stressors and lack of resources experienced by other members (Klaw & Humphreys, 2000). Such findings suggest that problems due to life stressors and lack of social resources may be less common among Al-Anon dropouts than among stable members.

Resistance to 12-steps groups stems partly from a perceived lack of meeting convenience (e.g., distance from the nearest meeting, bad timing of meetings) (Kelly, Kahler, & Humphreys, 2010; Laudet, 2003). In addition, individuals with beliefs that are discordant with 12-step philosophy are less inclined to actively engage with mutual-help groups (Ouimette et al., 2001). For example, not believing in the disease model of addiction, not having an abstinence goal, not perceiving a need for lifelong 12-step group attendance or support from a higher power, and conflicts with the concepts of surrender, powerlessness, and spirituality were associated with subsequent reduced participation or dropout (Fiorentine & Hillhouse, 2000; Kelly & Moos, 2003; Klaw & Humphreys, 2000; Mankowski, Humphreys, & Moos, 2001). Additional reasons for dropout from 12-step attendance identified by Kelly et al. (2010) were discomfort with self-disclosure and with the group format. Similarly, McCrady et al. (1996) noted that individuals who decreased their involvement with AA over the course of SUD treatment felt uncomfortable with certain aspects of the program, and also may have had goals that AA was unable to meet.

Limited evidence suggests that dropout from 12-step groups is also associated with better functioning at the time of initial attendance in terms of self-reported health (Kelly et al., 2010; Laudet et al., 2003; McCrady, 1998). Although more participation in 12-step groups has been associated with more reliance on approach coping, and less on avoidance coping, to deal with health and other personal crises (Forys, McKellar, & Moos, 2007; Humphreys, Mankowski, Moos, & Finney, 1999; Majer, Droege, & Jason, 2012), research has not examined the extent to which newcomers' coping styles are associated with their subsequent engagement with mutual-help groups such as Al-Anon.

1.3. Present study

The purpose of this study of Al-Anon newcomers was to examine the prevalence and baseline predictors of dropout six months later. Although attendees' demographic characteristics, life stressors and resources, views of 12-step programs, goals of attendance, functioning, and coping have been examined in relation to participation in and dropout from other mutual-help groups, these factors have not been examined to understand dropout from Al-Anon. It is not known whether similar factors are associated with dropout from Al-Anon or whether other factors are responsible. In particular, unique to Al-Anon, is that newcomers' views of the drinkers in their lives may be related to subsequent drop-out and retention. That is, drinkers' characteristics, including their life stressors and functioning, may help to explain why some Al-Anon newcomers drop out and others do not. Identifying predictors of dropout, especially those that are amenable to intervention, should suggest strategies to enhance the utilization of Al-Anon by COs.

2. Method

2.1. Sample

The sample was 228 of 251 individuals who completed surveys at baseline and 6 months later, and whose status as dropped out or retained at follow-up could be determined (see Results section). All participants were Al-Anon newcomers at baseline; in accordance with Al-Anon convention, “newcomer” was defined as having attended 6 Al-Anon meetings or fewer (lifetime).

2.2. Procedure

2.2.1. Baseline

To acquire the sample, Al-Anon's World Service Office (WSO) mailed (but did not pay for) a random sample of 4500 Al-Anon groups. The WSO is a combined business office and service center that registers and supports Al-Anon groups, coordinates Al-Anon conferences, and creates and distributes Al-Anon literature and outreach materials throughout the world. The mailing introduced the study, asked permission for research staff to contact the group, and stated that the group was free to accept or refuse. Representatives were asked to return their group's permission to be contacted, their contact information, and an estimate of the number of newcomers attending their group per month directly to the researchers in prepaid envelopes; “newcomer” was defined. Of the 979 groups (22%) responding, 853 (87%) gave permission, and 126 (13%) refused (Timko et al., 2013).

Research staff mailed responding Representatives a cover letter explaining procedures to hand out surveys to newcomers and the purpose and potential benefits of the survey, and inviting them to call and discuss questions or concerns. The mailing included the number of survey packets corresponding to the estimated number of newcomers per month. Representatives were given a standard script to follow and asked to give the survey to the next newcomer at their meetings, without regard to demographic or other characteristics. If newcomers declined the survey, Representatives offered it to the next newcomer. Representatives were asked to send a notice to research staff (envelope provided), indicating how many newcomers who were approached declined. Of the 853 groups contacted, 784 (91.9%) returned notices; of these, 672 (85.7%) participated, and, on average, had obtained a refusal from less than one newcomer ($M = .48$, $SD = 1.2$).

A cover letter with the newcomer questionnaire and consent form provided a study summary (aims; methods; the survey's voluntary and confidential nature, basic content, and time requirements; how to contact project staff; request to complete the survey within two weeks). Surveys were received from 54% ($N = 360$) of groups that agreed to participate. Respondents ($N = 631$; mean number per group = 1.9; $SD = 1.2$) were offered a \$25 gift card. They returned their consent form and questionnaire in separate envelopes to protect confidentiality.

2.2.2. Follow-up

Of the 631 respondents, 365 were newcomers. Of the 365 newcomers, 305 (83.6%) agreed, at the time of the baseline survey, to be contacted about the 6-month follow-up survey. After 6 months, participants were mailed a copy of the follow-up survey and contacted by email to let them know the follow-up survey had been mailed to them. Participants again returned their survey and payment

Table 1
Demographic characteristics of Al-Anon newcomer dropouts (n = 130) and attendees (n = 98).

	Dropouts	Attendees	χ^2 or t	Total
	% (N) or M (SD)	% (N) or M (SD)		% (N) or M (SD)
Female	88.3 (113)	85.3 (81)	.44	87.0 (194)
White	96.9 (124)	91.7 (88)	8.40	95.1 (212)
Age	44.7 (13.3)	47.5 (12.6)	−1.60	46.7 (13.4)
Married or living with intimate partner	61.7 (79)	63.2 (60)	.05	62.3 (139)
Years of education	15.2 (2.2)	15.1 (1.9)	.27	15.2 (2.1)
Employed	66.9 (85)	76.3 (71)	2.34*	70.9 (156)
Personal income ($)	53,200 (62,200)	55,000 (66,500)	−.19	53,991 (63,868)
You and your family have health insurance	86.5 (109)	86.3 (82)	.00	86.4 (191)
Any children under 18	40.9 (52)	31.6 (30)	2.05	36.9 (82)
Any children 18 years or older	41.7 (53)	53.7 (51)	3.12*	46.8 (104)
Number years living where you are now	7.9 (9.3)	9.4 (10.2)	3.80*	8.6 (9.7)
Lives with family	72.7 (93)	71.3 (67)	.96	72.1 (160)
Religious practices			.59	
Spiritual	50.4 (64)	46.8 (44)		49.8 (110)
Religious	43.3 (55)	48.6 (44)		44.8 (99)
Other (atheist, agnostic, or unsure)	6.3 (8)	4.3 (4)		5.6 (12)

* $p < .05$.

information separately to protect their confidentiality, and received $25 as compensation for participating. Of the 305 agreeing to the follow-up survey at baseline, 251 (82.3%) returned it. Of those who did not return the follow-up survey, 4 (12%) could not be located, and 50 (63%) were located but did not return the questionnaire.

2.2.3. Surveys

Although the 6-month survey asked about current well-being, only one question from the survey was used in this study: How many Al-Anon meetings have you attended in the past month? Otherwise, all analyses are based on the baseline survey. Baseline survey items were drawn mainly from the Health and Daily Living Form (HDL; Moos, Cronkite, & Finney, 1992), which has demonstrated strong psychometric characteristics in family studies of alcohol use and other mental health disorders (Brennan, Schutte, & Moos, 2010; Timko et al., 2009). The survey was pretested with four individuals (Al-Anon group secretary, long-term member, newcomer, dropout).

The survey ascertained newcomers' demographic characteristics (Table 1). It asked about influences on the individual's decision to initially come to an Al-Anon meeting (Table 2). Specifically, respondents noted whether they initially came to Al-Anon because of (a) each of 10 problems, (b) each of 7 people or groups who may have advised or

Table 2
Al-Anon newcomer drop-outs (n = 130) and attendees (n = 98): Influences on the decision to come to an Al-Anon meeting.

	Dropouts	Attendees	χ^2	Total
	% (N)	% (N)		% (N)
Problems with your:				
Overall quality of life and well-being	93.7 (118)	92.6 (88)	.09	93.2 (206)
Relationship with your: drinker	89.0 (113)	94.7 (90)	2.42*	91.4 (203)
Spouse/partner	67.7 (86)	76.8 (73)	2.26*	71.6 (159)
Relatives	62.5 (80)	53.1 (51)	1.98*	58.5 (131)
Children	47.7 (61)	44.8 (43)	.18	46.4 (104)
Friends	33.9 (43)	33.3 (32)	.01	33.6 (75)
Finances	35.9 (46)	35.8 (34)	.00	35.9 (80)
Home or neighborhood	29.7 (38)	25.0 (24)	.61	27.7 (62)
Work or school	25.8 (33)	24.0 (23)	.10	25.0 (56)
Police, law, criminal justice system	12.6 (16)	11.5 (11)	.07	12.1 (27)
People who advised or encouraged you to try Al-Anon:				
Friends or coworkers	44.5 (57)	41.7 (40)	.18	43.4 (97)
People you know in Al-Anon	38.6 (49)	29.2 (28)	2.16*	34.5 (77)
Family members	34.4 (44)	31.3 (30)	.24	33.0 (74)
People you know in AA	30.7 (39)	31.3 (30)	.01	30.9 (69)
Your drinker's health provider(s)	25.0 (32)	34.7 (33)	2.49*	29.1 (65)
Your main drinker	22.0 (28)	28.1 (27)	1.08	24.7 (55)
Your own doctor or other provider	27.3 (35)	24.0 (23)	.33	28.9 (58)
Reason you came to Al-Anon:				
Agree that alcoholism is a disease	88.7 (110)	88.2 (82)	.02	88.5 (192)
Like Al-Anon's anonymity	80.8 (101)	76.6 (72)	.57	79.0 (173)
Want a circle of friends you can relate to	84.8 (105)	77.7 (73)	1.41	81.3 (178)
Meetings are at convenient times and places	85.6 (107)	70.2 (66)	7.60**	79.0 (173)
Meetings are free of charge	83.2 (104)	68.4 (65)	6.58**	76.8 (169)
Want to meet people who may be role models	76.0 (95)	70.7 (65)	.78	73.7 (160)
Like Al-Anon's spiritual orientation	64.8 (81)	68.1 (64)	.26	66.2 (145)
People you know benefited from Al-Anon	64.8 (81)	58.5 (55)	.90	62.1 (136)
Like Al-Anon's group format	66.4 (83)	56.4 (53)	2.28*	62.1 (136)
Want drinker to go to AA	54.8 (68)	54.8 (51)	.00	54.8 (119)
Want drinker to get professional treatment	53.6 (67)	52.1 (49)	.05	53.0 (116)

* $p < .05$.
** $p < .01$.

Table 3
Health status of Al-Anon newcomer drop-outs (n = 130) and attendees (n = 98).

	Drop-outs	Attendees	χ^2 or t	Total
	% (N) or M (SD)	% (N) or M (SD)		% (N) or M (SD)
How would you describe your health?				
Good or excellent	88.1 (111)	81.9 (77)	1.65	85.5 (188)
In the past 6 months, had:				
Diagnosed medical condition	33.3 (42)	43.0 (40)	2.13*	37.4 (82)
Diagnosed psychological condition	38.3 (49)	43.2 (41)	.54	40.4 (90)
Physical abuse	8.6 (11)	16.8 (16)	3.44*	12.1 (27)
Sexual abuse	5.0 (6)	2.2 (2)	1.15	3.8 (8)
In the past 6 months, often experienced feeling:				
Anxious (tense)	88.9 (112)	84.9 (79)	.74	87.2 (191)
Depressed (sad or blue)	73.8 (93)	74.2 (69)	.00	74.0 (162)
Guilty	66.9 (85)	69.2 (63)	.13	67.9 (148)
Happy	65.6 (82)	72.5 (66)	1.18	68.5 (148)
Hopeless	62.2 (79)	63.0 (58)	.02	62.6 (137)
A positive attitude toward yourself	60.8 (76)	59.8 (55)	.02	60.4 (131)
A lot of control over what happens to you	44.4 (56)	34.1 (31)	2.39*	40.1 (87)
In the past month:				
Had a drink containing alcohol	58.4 (73)	62.8 (59)	.51	60.3 (132)
Drank 5 or more drinks on one occasion	23.0 (17)	20.3 (12)	.13	21.8 (29)
Used prescription drugs	55.1 (70)	60.6 (57)	.67	57.5 (127)
Used non-prescription drugs	3.2 (4)	4.3 (4)	.67	3.6 (8)

* p < 05.

encouraged them to try Al-Anon, and (c) each of 11 aspects of Al-Anon. Also, respondents reported on their goals of initial Al-Anon attendance (not tabled), health status (Table 3), and personal functioning and coping (Table 4). Further, survey respondents described their main drinker in terms of his or her demographic and relationship characteristics; substance use, its consequences, and help obtained; and concerns that prompted initial Al-Anon attendance (Table 5).

2.3. Data analysis

We compared baseline characteristics of newcomers who dropped out with those who were retained in Al-Anon as of the 6-month follow-up using t-tests for continuous variables, and chi-square tests for categorical variables.

3. Results

3.1. Dropout rate

At the 6-month follow-up, dropout was defined as not having attended any Al-Anon meetings during the past month; retention was defined as having attended at least one meeting during the past month. As reviewed by Laudet (2003), declines in 12-step group participation typically begin about 3 months after attendance initiation. A total of 23 respondents did not report how many meetings they had attended in the past month, leaving 228 respondents for analyses. Using the definitions, 130 (57.0%) newcomers at baseline had dropped out at 6 months, and 98 (43.0%) were retained in Al-Anon. The 98 still attending at 6 months had attended a mean of 22.8 meetings (SD =

Table 4
Functioning and coping of Al-Anon newcomer drop-outs (n = 130) and attendees (n = 98).

	Drop-outs	Attendees	χ^2	Total
	% (N)	% (N)		% (N)
Satisfied with your:				
Relationship with friends	73.4 (91)	70.3 (64)	.24	72.1 (155)
Relationship with children	63.3 (57)	67.2 (43)	.24	64.9 (100)
School or work	63.2 (60)	65.3 (49)	.09	64.1 (109)
Home and neighborhood	63.1 (77)	64.3 (54)	.03	63.6 (131)
Relationship with relatives	61.8 (76)	67.1 (57)	.61	63.9 (133)
Finances	49.2 (61)	37.6 (35)	2.89*	44.2 (96)
Overall quality of life and well-being	44.1 (56)	33.7 (32)	2.48*	39.6 (88)
Relationship spouse or partner	32.0 (32)	24.7 (20)	1.18	28.7 (52)
Relationship with drinker	19.5 (24)	12.2 (11)	2.07*	16.4 (35)
When you have an important problem or crisis to deal with, you:				
Talk with family, friends	92.2 (118)	92.6 (88)	.02	92.4 (206)
Step back and be more objective	75.0 (96)	58.9 (56)	6.44**	68.2 (152)
Try to see the good side	70.3 (90)	62.4 (58)	1.53	67.0 (148)
Seek help from people, groups with same problem	65.6 (84)	60.0 (57)	.74	63.2 (141)
Make a plan of action and follow it	60.3 (76)	46.8 (44)	3.97*	54.5 (120)
Try not to think about the problem	59.5 (75)	49.5 (47)	2.21*	55.2 (122)
Talk with a professional (such as a doctor)	50.8 (65)	62.1 (59)	2.85*	55.6 (124)
Take upset feelings out on other people	50.0 (64)	49.5 (47)	.01	49.8 (111)
Spend more time in work, leisure, social activities	44.9 (57)	42.1 (40)	.17	43.7 (97)
Try to help others with a similar problem	44.9 (57)	29.5 (28)	5.53**	38.3 (85)
Accept it: Nothing can be done	33.1 (42)	33.0 (31)	.00	33.0 (73)

* p < .05.
** p < .01.

Table 5
Drinkers of Al-Anon newcomer drop-outs (n = 130) and attendees (n = 98).

	Drop-outs	Attendees	t or χ^2	Total
	M (SD) or % (N)	M (SD) or % (N)		M (SD) or % (N)
Demographics				
Age	44.4 (15.9)	46.0 (15.4)	−.72	45.1 (15.7)
Male	73.2 (90)	74.7 (68)	.07	73.8 (158)
Relationship				
Years known drinker	20.8 (15.0)	20.9 (14.9)	−.05	20.9 (14.9)
Years troubled by drinker's drinking	9.4 (10.4)	9.0 (9.8)	.30	9.3 (10.1)
Years drinker's drinking has been a problem	13.1 (13.3)	12.1 (12.3)	.51	12.7 (12.8)
In-person, daily contact with drinker	50.4 (64)	52.8 (47)	.89	51.4 (111)
Other daily contact with drinker (email, phone)	45.8 (55)	54.5 (48)	4.52*	49.5 (103)
A lot of concern about drinker's: Drinking alcohol	55.9 (71)	66.7 (71)	3.40*	60.5 (133)
Prescription drug use	26.6 (33)	34.8 (32)	1.97	30.1 (65)
Use of non-prescribed drugs	26.6 (34)	31.5 (29)	.71	28.6 (63)
Drinker's problems due to drinking or drug use:				
Psychological health	71.2 (89)	61.5 (56)	2.22*	67.1 (145)
Family arguments	65.6 (82)	69.2 (63)	.32	67.1 (145)
Physical health	64.8 (81)	56.0 (51)	1.69	61.1 (132)
Money	64.0 (80)	58.2 (53)	.74	61.6 (133)
Job or school	54.4 (68)	52.7 (48)	.06	53.7 (116)
Driving under the influence (DUI)	53.6 (67)	51.6 (47)	.08	52.8 (114)
Friend or neighbor arguments	39.5 (49)	46.2 (41)	.95	42.3 (91)
Broke or damaged property	26.6 (33)	24.2 (22)	.16	25.6 (55)
Arrested	16.8 (21)	15.4 (14)	.08	16.2 (35)
Drinker's drinking and drug use in past month:				
Drank at all	59.8 (61)	63.8 (51)	.30	61.5 (112)
If drank at all: number days drank	18.0 (10.8)	20.0 (9.9)	−1.06	19.8 (10.4)
Number drinks, typical drinking day	9.3 (11.5)	8.2 (5.6)	.57	8.8 (8.6)
Number of times had 5 or more drinks	12.0 (10.5)	14.7 (10.2)	−1.12	13.1 (10.4)
Used prescription drugs at all	50.5 (55)	54.7 (41)	.32	52.2 (96)
Used non-prescription drugs at all	20.8 (22)	18.9 (14)	.09	20.0 (36)
Concerns about drinker that influenced initial participation in Al-Anon:				
Confused about how to cope with life problems	86.4 (108)	82.8 (77)	.54	84.9 (185)
Depressed or moody	85.7 (108)	84.0 (79)	.12	85.0 (187)
Stressed, tense, anxious, unable to relax	83.3 (105)	73.1 (68)	3.33*	79.0 (173)
Missing what's important in life	83.2 (104)	83.9 (78)	.02	83.5 (182)
Low self-esteem	77.8 (98)	69.1 (65)	2.07*	74.1 (163)
Angry	75.4 (95)	81.7 (76)	1.27	78.1 (171)
Neglecting responsibilities	70.6 (89)	71.0 (66)	.00	70.8 (155)
Unsatisfying spiritual life	69.6 (87)	59.8 (55)	2.25*	65.4 (142)
Lonely and isolated	68.8 (86)	66.7 (62)	.11	67.9 (148)
Feels hopeless	65.6 (82)	59.1 (55)	.95	62.8 (137)
Drinks too much, too often	65.1 (82)	68.8 (64)	.34	66.7 (146)
Drinking causes problems for loved ones	64.3 (81)	72.0 (67)	1.48	67.6 (148)
Drinking causes serious harm to him/her	63.5 (80)	61.3 (57)	.11	62.6 (137)
Physical health problems	62.4 (78)	55.9 (52)	.93	59.6 (130)
Drinking causes serious harm to others	49.6 (62)	43.3 (39)	.83	47.0 (101)
Drinks around other people	41.3 (52)	39.6 (36)	.06	40.6 (88)
Uses drugs	39.8 (49)	39.4 (37)	.01	39.6 (86)
Receives verbal/physical abuse	22.5 (27)	17.2 (16)	.92	20.2 (43)
Drinker's help-seeking for alcohol and drugs in past 6 months:				
Detoxification	25.0 (31)	31.9 (29)	1.22	27.9 (60)
Inpatient or residential program	29.3 (36)	31.9 (29)	.17	30.4 (65)
Outpatient care	25.8 (32)	28.6 (26)	.20	27.0 (58)
12-step mutual-help groups	45.2 (57)	50.0 (45)	.48	47.2 (102)
Number of meetings, if attended	32.4 (40.9)	58.3 (91.9)	−1.72*	43.9 (69.2)
Had 12-step sponsor	30.4 (38)	28.7 (25)	.07	29.7 (63)

* $p < .05$.

18.0) in the past 6 months and 3.9 (SD = 3.0) in the past month, compared to drop-outs' mean of 5.8 (SD = 6.6) in the past 6 months and 0 in the past month ($t = -8.69$ and -12.63, respectively, $p < .001$).

3.2. Predictors of dropout

3.2.1. Demographics

At baseline, dropouts were less likely to be employed ($X^2 = 2.34$, $p < .05$) and to have adult children ($X^2 = 3.12$, $p < .05$), and had lived a fewer number of years in their present residence ($X^2 = 3.80$, $p < .05$) (Table 1). Otherwise, dropouts and attendees did not differ on demographic characteristics.

3.2.2. Influences on the initial decision to attend Al-Anon

At baseline, dropouts were less likely than attendees to report that problems in their relationships with their main drinker ($X^2 = 2.42$, $p < .05$), and with their spouse or partner ($X^2 = 2.26$, $p < .05$), influenced their initial decision to attend Al-Anon (Table 2). However, dropouts were more likely to report that problems with their relatives influenced this decision ($X^2 = 1.98$, $p < .05$). Dropouts were more likely to have been advised or encouraged to attend Al-Anon by people they

know in Al-Anon ($X^2 = 2.16$, $p < .05$), but less likely to have been encouraged by their drinker's health provider ($X^2 = 2.49$, $p < .05$). Further, dropouts were more likely to endorse meetings' convenience ($X^2 = 7.60$, $p < .01$), no-cost ($X^2 = 6.58$, $p < .01$), and group format ($X^2 = 2.28$, $p < .05$) as reasons for initial attendance.

In addition to influences on the decision to come to an Al-Anon meeting, the survey assessed goals of Al-Anon attendance. These goals, which are not tabled, focused on improving the problems that may have influenced the initial decision to attend a meeting. Dropouts and attendees did not differ on what they hoped to gain from Al-Anon.

3.2.3. Health status

As shown in Table 3, dropouts were less likely than attendees to report a diagnosed medical condition ($X^2 = 2.13$, $p < .05$) and to be the recipient of recent physical abuse ($X^2 = 3.44$, $p < .05$). They were also more likely to state that they felt they had a lot of control ($X^2 = 2.39$, $p < .05$). Dropouts and attendees did not differ on recent use of alcohol or drugs.

3.2.4. Functioning and coping

Compared to attendees, dropouts were more likely to be satisfied with their finances ($X^2 = 2.89$, $p < .05$), overall quality of life and well-being ($X^2 = 2.48$, $p < .05$), and relationship with the drinker ($X^2 = 2.07$, $p < .05$) (Table 4). However, even among dropouts, less than one-half were satisfied with these aspects of their lives.

Dropouts were more likely to endorse aspects of approach coping as methods they used (step back and be more objective [$X^2 = 6.44$, $p < .01$], make a plan of action and follow it [$X^2 = 3.97$, $p < .05$], try to help others with similar problems [$X^2 = 5.53$, $p < .01$]), but were also more likely to endorse one aspect of avoidance coping (try not to think about the problem; $X^2 = 2.21$, $p < .05$). Dropouts were less likely to say they talk with professionals to cope with crises ($X^2 = 2.85$, $p < .05$).

3.2.5. Drinker

Dropouts did not differ from attendees on the drinker's demographic characteristics or their relationship history with the drinker (Table 5). Dropouts were less likely to have daily contact with the drinker other than in-person ($X^2 = 4.52$, $p < .05$), and to have a lot of concern about the drinker's alcohol use ($X^2 = 3.40$, $p < .05$). Drinkers of dropouts were more likely to be seen as having psychological problems ($X^2 = 2.22$, $p < .05$), but otherwise dropouts and attendees did not differ on drinker's substance use or its consequences.

With respect to concerns about the drinker that prompted initial Al-Anon attendance, compared to attendees, dropouts were more likely to be concerned about their drinker's stress ($X^2 = 2.33$, $p < .05$), low-self-esteem ($X^2 = 2.07$, $p < .05$), and unsatisfying spiritual life ($X^2 = 2.25$, $p < .05$). Drinkers of dropouts who attended 12-step groups had attended fewer meetings in the past 6 months than drinkers of Al-Anon attendees who attended 12-step groups ($t = -1.72$, $p < .05$).

4. Discussion

In this study, 57% of newcomers to Al-Anon discontinued meeting attendance within six months. This percentage is somewhat higher than the approximately 40% of individuals treated for SUDs who drop out of AA within 1 year (Kelly & Moos, 2003; Tonigan et al., 2003). The gap is not surprising in that Al-Anon newcomers may believe that their problems are not serious enough to require ongoing help, whereas treated patients are more likely to have recognized the severity of their disorder. In addition, because many treated patients have prior experience with AA (Fiorentine & Hillhouse, 2000; Timko, DeBenedetti, & Billow, 2006), they are already familiar with the AA culture, which may be associated with continued meeting attendance (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009).

During the 6-month study period, dropouts attended a mean of about one meeting per month, compared to attendees' mean of about one meeting per week. Individuals who were retained at follow-up may have attended Al-Anon from the start at the weekly frequency found beneficial to participants of AA (Fiorentine, 1999), whereas those who dropped out may not have tried at least weekly engagement with the fellowship. Studies documenting trajectories of 12-step affiliation have identified similar subgroups that either affiliate upon initiation and sustain consistent attendance, or attend at a low frequency early on and then disengage (Kaskutas, Bond, & Avalos, 2009; Morgenstern, Kahler, Frey, & Labouvie, 1996; Witbrodt et al., 2012).

4.1. Predictors of attrition

At baseline, individuals who later dropped out of Al-Anon reported less severe problems than individuals who continued to attend. More specifically, dropouts were less likely to have a diagnosed medical condition and to report being victimized by physical abuse than those who were retained in Al-Anon. Dropouts also were more likely to be satisfied with their finances and their quality of life and well-being. These findings are consistent with Andersen and Newman's (2005) framework examining determinants of medical care utilization, in which a lower level of perceived need is associated with less use of help resources. It is also consistent with prior findings that severe substance use and related life problems are associated with sustained participation in AA (Timko, Billow, & DeBenedetti, 2006; Witbrodt et al., 2012).

Dropouts were also more likely to use aspects of approach coping, which is associated with better adjustment than is avoidance coping (Taylor & Stanton, 2007). Avoidance, one aspect of which dropouts endorsed more frequently (try not to think about problems or crises), may have a positive effect when applied in the first phase of coping because it reduces anxiety and the lack of perceived control. In this vein, dropouts were more likely to report having a lot of control. However, a negative effect of avoidance coping is that it interferes with obtaining needed help (Groarke, Curtis, Coughlan, & Gsel, 2004; Kreitler, 1999).

Newcomers who later dropped out of Al-Anon were less likely to report problems in their relationship with their drinker and with their spouse or partner. They also had less phone and email contact with their drinker. Moreover, dropouts were less likely to have a lot of concern about their drinker's use of alcohol. This was true despite the lack of group differences in the frequency and quantity of the drinker's alcohol use. These findings support the idea that, compared to attendees, dropouts are more likely play down their problems and thus perceive less need for help. However, dropouts were more likely than those retained in Al-Anon to note that problems in their relationships with relatives outside their immediate family influenced their initial decision to attend meetings. Possibly, individuals who come to Al-Anon concerned about relationships that are less central to their everyday lives are more likely to discontinue attendance.

We also found that drinkers of dropouts who attended AA had attended fewer meetings; specifically, drinkers of dropouts attended a mean of 1.3 meetings per week whereas drinkers of individuals retained in Al-Anon went to a mean of 2.4 meetings per week. This finding supports the possible reciprocity between a CO's Al-Anon participation and the drinker's 12-step group participation (Roth & Tan, 2007; White & Kurtz, 2005). It also suggests that, like dropouts, drinkers of dropouts may downplay their problems and need for help.

Dropouts were less likely to have been referred to Al-Anon by their drinker's health care provider and to talk with a professional as a way to cope with problems or crises, but more likely to have been referred by Al-Anon members. The lack of referral by health care professionals may contribute to long delays between the beginning of COs' difficulties and their seeking help through Al-Anon (Timko et al., in press). Patients with SUDs who receive enhanced referrals to 12-step groups by health care providers participate more in meetings and have better outcomes (Timko, DeBenedetti, et al., 2006; Timko, Sutkowi, Cronkite,

Makin-Byrd, & Moos, 2011), and individuals referred by health care providers to behavioral health services follow through with referrals at high rates (over 80%) (Auxier et al., 2012; Healey et al., 2013). Overall, individuals are more likely to become engaged in Al-Anon when attendance is recommended by health care professionals.

Providers can assist COs by providing information about meetings, such as who attends them, their purpose, how they are conducted, and where to find them, and emphasizing that meetings are anonymous. By encouraging COs to attend at least 3 meetings before deciding whether to continue, the provider may increase the probability that COs have a positive experience and continue to attend (CSAT, 2006). Members of Al-Anon can be invited to talk with family members of drinkers in treatment programs, and providers can encourage COs connected to the same treatment program to attend meetings together so that they can reinforce and reassure one another (CSAT, 2006). Even with these recommendations, research is needed to identify how providers can play a larger role in referring COs to mutual-help (Laudet, Savage, & Mahmood, 2002).

Although our findings suggest that the problems of newcomers who drop out of Al-Anon are less severe, dropouts were more often concerned about their drinker's psychological health, specifically, his or her high stress and anxiety, low self-esteem, and unsatisfying spiritual life. Newcomers with these concerns about their drinkers may have found them to be unsuited to Al-Anon's philosophy. Al-Anon discourages trying to change the drinker and advises COs to detach from the drinker, focus on themselves, and obtain help for their own distress and related psychological difficulties.

Dropouts may have been attracted to try Al-Anon for reasons other than its core philosophy. They were more likely than attendees to report that they came to Al-Anon because meetings are at convenient times and places and are free of charge. These findings suggest that dropouts may have been looking for a “quick fix” for their problems (Klingmann, 2000; Moyers, 2011). We also speculate that dropouts, who more often endorsed Al-Anon's group format as a reason for trying the program, may have been looking for social connections that were relatively less available to them. That is, compared to ongoing attendees, dropouts less frequently reported being employed and having adult children to interact with, and had lived a fewer number of years in their present residence.

4.2. Limitations

A limitation of this study is that participants' reports about the drinkers in their lives reflect the reporter's perceptions. These perceptions may be inaccurate, especially among participants who had less contact with their drinker. In addition, the extent of self-selection bias due to Al-Anon groups and newcomers' deciding whether or not to participate in the study is unknown. Finally, we conducted multiple comparisons without adjustment, such that our findings require replication.

5. Conclusions

Although dropouts initially had less severe problems than individuals who continued to attend Al-Anon, dropouts did report high rates of problems; for example, 89% reported problems with their drinker, 56% had a lot of concern about the drinker's alcohol use, and only 44% were satisfied with their quality of life and well-being. Thus, individuals who drop out of Al-Anon may continue to have problems and needs that would benefit from ongoing help and support, particularly in light of the chronic and relapsing nature of SUDs.

Al-Anon has experienced internal and societal changes that present challenges to long-term membership. In contrast to our finding that less than one-half of drinkers of Al-Anon newcomers may be attending AA, initial Al-Anon groups consisted mainly of wives of AA members, which likely facilitated ongoing participation. Today, as results of this study suggest, newcomers to Al-Anon may be increasingly concerned about someone with multiple addictions and/or mental health problems, while Al-Anon's focus remains to “help friends and families of alcoholics” (http://www.al-anon.org/pdf/afamagazine.pdf). In addition, the increased accessibility of Al-Anon resources online and via social media, together with competing demands of work and caring for both children and older parents, may decrease the likelihood of face-to-face meeting attendance. Still unknown is whether newcomers whose initial Al-Anon attendance is short-lived may return to the fellowship later for sustained participation. Clearly, long-term, prospective studies are needed to examine patterns of help-seeking and outcomes over time among people concerned about another's drinking and other substance misuse and mental health problems.

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Contributors

Authors CT, AL, and RM designed the study and wrote the protocol. CT and AL conducted literature searches and provided summaries of research studies. CT oversaw the statistical analyses. CT wrote the first draft of the manuscript and all authors contributed to and have approved the final manuscript.

Conflict of interest

All authors declare that they have no conflicts of interest.

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