

OUTPATIENT SELF HELP FOR DRUG DEPENDENT INDIVIDUALS IN GERMANY—APPROACHES, CLIENTELE, AND EFFECTS

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ABSTRACT

Between November 1999 and April 2001 the German Department of Health (Bundesministerium für Gesundheit) supported a study analyzing the situation of outpatient self-help for drug dependent individuals in Germany. The term outpatient self-help for drug dependent individuals (SHG) refers to those self-help groups existing independently, outside of therapeutic or institutional settings, whose members are either former users and/or are still using drugs. The presented study is the first one to analyze all self-help approaches for drug dependent individuals existing in Germany. It describes their philosophy, structural frame, and characteristics of their members. First statements about the effects of SHGs are generated—employing a cross-section analysis—using the examined population as an example. This article presents central results of the study. They lead to the conclusion that SHGs are relevant to the social, psychic, and substance-specific reintegration of their members.

INTRODUCTION

Five major characteristics classify groups or initiatives assembled in the term “Outpatient Self Help for Drug Dependent Individuals (SHG)”:

1. All members are either former users and/or are still using drugs.

2. The majority of the members lead an independent social life outside of therapeutic facilities or governmental institutions.
3. Meetings take place outside of therapeutic settings and without the presence of professional help.
4. Members organize their activities autonomously. The maximum function professional helpers have is advisory.
5. Non-Profit-Organizations sometimes offer the structural frame of meetings or networking, however, they have no financial or legal influence, nor do they have any influence on contents of meetings.

Applying this definition, the study presented excludes self-help for alcoholics, inpatient self-help for drug addicts (compare Fredersdorf, 2000), and self-help groups in professional facilities and/or closed institutions.

Four approaches of outpatient self-help for drug dependent individuals exist in Germany at the time of the study deadline:

1. Narcotics Anonymous (NA): Here we are dealing with 179 groups following the international 12-Step philosophy of the “anonymous-movement.” NA Germany are interconnected to international NA-initiatives and the “World Service Office” in California. They represent an abstinence-oriented self-help approach in which the members make an effort to become or remain abstinent from the use of psychoactive substances.
2. JES (Junkies, Ex-User, Substituted): Here we are dealing with 46 groups under the roof of the German Aids Aid (Aidshilfe). JES Germany represents the acceptance-oriented approach of SHGs, in which the members tolerate the use of psychoactive substances and/or substitution-drugs. It emphasizes that the spreading of safer-use information is the goal of self-help, and not abstinence. JES Germany is interconnected to similar national initiatives.
3. Young Drug Addicted related to Caritas (Caritas): Here we are dealing with 24 groups that were initiated by the Catholic, non-profit-organization “Caritas,” with the help of professional advisors who guided the groups into independence. Young drug-users often cannot relate to the views and experiences of old users over-represented in NA and JES. This initiative’s goal is to motivate the drug-user under the age of 25, who feels uncomfortable with NA and JES, to become engaged with self-help. Young Drug Addicted related to Caritas consider lifelong abstinence their goal.
4. Other Independent Initiatives: Here we are dealing with 17 associations, offering local groups and activities for drug-addicted individuals. These initiatives are only related to non-profit-organizations in special cases. In comparison to the three programs mentioned above, these associations are not interconnected with each other. They also consider lifelong abstinence their goal.

By January 2001, 266 SHGs were identified in Germany and questioned in a complete survey in writing. The following section will first describe the methodic basis of the study, philosophy, clientele, and activities of abstinence- and acceptance-oriented self-help-groups and then the group-dynamic and substance-specific effects. Due to the lack of space, two further central parts of the study will not be presented here. One is a synopsis of current self-help approaches for drug-addicted individuals derived from empirical studies and qualitative scientific discourses published in either Anglo-American or German journals. The second is a pre-test in inpatient therapeutic facilities for drug-addicted individuals in Germany, examining the cooperation between professional-help and self-help. A brief English summary of these two parts is to be found in the German published book (Fredersdorf, 2002).

METHODIC BASIS OF THE STUDY

To this day, German addiction research does not sufficiently appreciate abstinence- and acceptance-oriented approaches of SHGs, although they have an effect on the reintegration of their members. According to Humphreys (1997), this statement can also be transferred to the situation of international research on self-help for addicted. There are neither empirical studies analyzing the effects of 12-Step approaches, the integration of self-help in inpatient therapy, or regarding self-help effects of the large abstinence-associations in Germany, nor have innovative self-help models been evaluated sufficiently. Two exceptions are the Synanon-Catamnesis (Fredersdorf, 1997) supported by the German Department of Health and the fixing of location of the German Aids Aid referring to the JES-initiative (DAH, 1998).

Reservations of the affected are probably just as causal for the minimum scientific interest in SHGs, as the profession-oriented focus of addiction-research in Germany is. To gain background information in this social field, an extensive communication-process was initiated. Two workshops, one with representatives of JES groups the other with representatives of NA, were performed and the approach's specific self-help philosophy was discussed. Seven representatives of each acceptance and abstinence-oriented group were questioned in qualitative interviews to gain deeper information. An e-mail hotline ensured the direct communication throughout the entire study.

These three communicative proceedings served to approach each other, come closer, establish trust, exchange information, and to create an acceptance for the cross-section survey in writing.

The communicative-approach produced the wished success with three of the four self-help initiatives. Except for NA, acceptable to good response rates were achieved: 41% Caritas, more than 54% Other, and 60% JES. Plus, of all partaking groups 42% to 67% of all actually attending members participated in the study.

Within NA groups, a response-rate of only 14% was attained, and only one-fourth of the attending members actually took part in the survey. After a controversial discussion lasting six months within NA, NA Germany had decided not to actively support or impede this study. As a methodological consequence of the biased sample—and to do justice to both self-help approaches—acceptance- and abstinence-oriented groups were analyzed separately. Subsequently, statements regarding *abstinence-oriented* groups refer to all outpatient self-help groups for addicted in which the members make an effort to become or stay permanently abstinent from the use of psychoactive substances. Statements regarding *acceptance-oriented* groups refer only to JES.

A total of 308 self-help attendees took part in the survey (JES = 175; all other groups = 133). Making use of a question regarding the actual presence of members, the size of the population can be estimated. According to a cautious estimate, 2,400 affected are engaged in SHGs in Germany. Consequently, the sample consists of approximately 13% of the population.

The standardized questionnaire employed consists of validated questions regarding demographic, psychosocial, and substance-specific aspects of the clientele (Deutsche Gesellschaft für Suchtforschung und Suchttherapie, 1992). The questions cover the time period six months before attending a SHG as well as the time period six months prior to questioning. On the basis of retrospective questions, we were able to describe the re-integration effects of these two periods. Furthermore, the questionnaire contains questions concerning meetings, activities, and structural frames of SHGs. These questions were partially taken over from literature and partially resulted from recognition-interests of the affected and the authors.

The reliability of the results was validated utilizing split-half-method, employing three interval scaled variables, with a total of 42 items. Since it makes sense to choose items with a higher power, questions were included, which would one assumes lead to fundamental differences between acceptance- and abstinence-oriented groups. These questions related to psychosocial achievements of the SHG, the spiritual attitude of the questioned, and the satisfaction with features of the SHG. The three reliability tests showed good to very good correspondence rates of the separated sample halves (correlation of both halves: 0.64-0.89; Spearman-Brown-Coefficient: 0.78-0.94; Guttman-Split-Half-Coefficient: 0.78-0.94; Alpha for the first half: 0.39-0.91; for the second half: 0.22-0.88).

ABSTINENCE— ACCEPTANCE-ORIENTED PHILOSOPHY

Narcotics Anonymous (NA) follows the international 12-Step philosophy of the “anonymous-movement.” They cope with the disease addiction by working on the 12-Steps and 12-Traditions of Alcoholics Anonymous, which were transferred to the problematic nature of drug-addiction (see Humphreys, 1993; Narcotics

Anonymous, 1993; Ronel, 2000). NA generally utilizes group therapy. This means that at a meeting, axioms derived from the 12-Step philosophy are treated, in order to achieve or keep up an abstinent life. All you need to do to establish an NA group is to arrange a regular meeting at a location where the 12-Step philosophy is discussed and lived. Living the 12-Step philosophy involves a fundamental spirituality and the open dealing with one's own substance-abuse history, working on improving one's own personality, and carrying the message of self-help to others affected. NA does not operate in public. Although they cooperate with professional substance-rehabilitation services, they do not make any drug-political or other statements, nor do they accept external financial help or lend their name to other professional substance-rehabilitation services. Primary principles of their self-help approach are: anonymity of the members, autonomy of the group, and fundamental democratic approaches to making decisions. Of all SHGs, 12-Step groups are the ones best empirically studied. The majority of available data suggest that 12-Step programs help the alcohol- or drug-addicted to "stay clean" in the long run (Chappel, 1992; Chappel & DuPont, 1999).

JES-initiatives interpret their approach as a change of paradigm in the abstinence-oriented substance-rehabilitation services (see Deutsche AIDS-Hilfe, 1996). They explicitly support a "life worthy of human beings with drugs." Their approach spreads through low-level help and drug-political public relations activities. Rarely do they offer group therapy. Contacting substance-services, safer-use information, organization of contact centers for members of the drug scene, telephonic advice, needle exchange, attending affected in hospitals and in prison, integration of substituted individuals in jobs, and the implementation of seminars for the affected are examples of low-level help. Up to now, effects of JES-groups have not been studied empirically.

Abstinence-oriented groups not belonging to 12-Step self-help are closely associated with professional substance-rehabilitation services. They often developed out of a therapy and/or an aftercare initiative related to a welfare program. This is especially true for the groups of Young Drug Addicted related to Caritas. In these facilities, self-help groups can utilize locations and needed office equipment, which they partially finance on their own. Here they also find reliable and responsive contacts. Professional advisors fulfill the job of moderator. They guide the group to self-help. Goals and structures of the group remain largely self-determined.

Abstinence-oriented SHGs not belonging to NA pursue a variety of interests that vary from leisure activities, to mutual social- and psychic-assistance, and public relation activities. Sometimes they are even paid for their self-help accomplishments in the field of "occupation" and "prevention." Behavior-oriented self-help approaches like, for instance, "Rational Recovery" (Galanter, Egelko, & Edwards, 1993) or "Recovery Training and Self-Help" (McAuliffe, 1990) do not exist in Germany. So far, in Germany, existing abstinence-oriented approaches outside the 12-Step philosophy have not been studied empirically.

THE CLIENTELE

The study presented was able to support two central assumptions. Acceptance- and abstinence-oriented SHGs serve different clientele (all following differences are at least significant at $p < 0.05$ level). Next to the different philosophies, the demographic structure of the members shows that both self-help approaches pursue different sides of the drug-phenomenon (see Table 1). The differences found show that abstinence-oriented groups orientate themselves toward a middle-class clientele and operate distant from the drug scene, while acceptance-oriented groups orientate themselves toward a lower-class clientele and operate close to the drug scene.

Members of acceptance-oriented groups have a lower level of education and vocational training than members in the comparison group. The proportion of women and substituted individuals is higher within acceptance-oriented groups. While the majority of members of abstinence-oriented groups seek peer contact to ex-users and are abstinent from drugs and alcohol, members of acceptance-oriented groups seek peer contact to people who have addiction problems and show very low rates of abstinence.

This study is the first to generate general index figures for German SHGs. The following significant differences indicate that acceptance-orientated groups are more homogenous and constant than abstinence-oriented groups; acceptance-oriented groups continue to exist approximately one year longer than do abstinence-oriented groups. On the average, they are two members larger, present a smaller fluctuation of members, but also experienced a smaller growth of members within the past six months prior to questioning. Nearly three-fifths of the acceptance-oriented and four-fifths of the abstinence-oriented groups meet one to three times a week.

THE GROUP ACTIVITIES

The philosophical differences of the two self-help approaches described above are reflected in the specific activities performed by the SHGs.

Abstinence-oriented groups are mostly directed inward and conceptualized as group therapy or leisure-time meeting place. Acceptance-oriented groups, in contrast, are mainly directed outward and action-oriented. Two-thirds of acceptance-oriented SHGs, in contrast to nearly three-fourths of the comparative sample, are related to group therapy. Acceptance-oriented SHGs, however, very often—and highly significant more often than the comparative sample—offer a variety of services for their members and other users: mediation, counseling, information, and supplemental services. Additionally, acceptance-oriented self-help puts activities related to public relations into practice seven times as often and makes arrangements for their clients to visit other drug-rehabilitation services (especially practicing doctors, inpatient and outpatient treatment programs)

Table 1. Characteristics of Acceptance- and Abstinence-Oriented Outpatient Self-Help Groups for Drug Dependent Individuals in Germany

Outpatient Self-Help for Drug Dependent Individuals in Germany		
Characteristics of members and groups at the time of questioning	Self-help approach	
	Acceptance-oriented	Abstinence-oriented
Members		
Average age	30.6-33.8	32.7-36.2
Sex: "female"	40.0%	34.0%
Nationality: "German"	92.7%	96.9%
Marital status: "married"	56.2%	66.9%
Educational status: "low"	40.6%	27.7%
Educational status: "high"	8.8%	24.4%
Vocational training: "none"	31.1%	13.7%
Vocational training: "completed"	48.8%	66.4%
Working in a job within the six month prior to questioning	38.2%	53.3%
Most peer contacts to individuals with an addiction problem	51.0%	13.9%
Most peer contacts to individuals who are abstinent living ex-users	24.0%	61.4%
Living in an own apartment	67.7%	80.2%
Substituted more than 12 days a month	54.3%	2.7%
Living abstinent from 10 psychoactive substances (incl. alcohol and methadone, excl. tobacco)	4.2%	65.3%
Groups		
Average existence in years	6.1-7.3	5.1-6.8
Average number of members	11.8	9.6
Average growth in the number of members within the six months prior to questioning	6.5	8.2
Average "fluctuation of members"* within the six months prior to questioning	0.75-1.1	1.4-1.9
1 to 3 meetings per week	57.6%	80.2%
Organization of regular group-conversations	68.8%	72.2%
Organization of leisure time activities	72.1%	54.1%
Organization of consulting services	68.3%	30.1%
Organization of public relations activities	70.0%	25.4%
Organization of mediating services	70.1%	13.8%

*Joining plus leaving members in relation to the actual size of the group.

7.2 times as often, as abstinence-oriented self-help groups do. Approximately three-fourths of all acceptance-oriented in comparison to one-half of all abstinence-oriented undertakings are directed toward leisure activities.

THE GROUP DYNAMIC EFFECTS

Outpatient self-help for addicts has various constructive psychological and social effects on its members. Over four-fifths of members of all groups equally learned to empathize with others and to cope with negative feelings. Members of all groups are very satisfied with their self-help group. On a scale of satisfaction with a maximum of 66 points—which was the sum of 11 items dealing with the satisfaction with a variety of group services—members of all approaches reached an average of 51.7 points. JES members, however, are significantly more satisfied with the job of mediation, with representatives or facilities of professional addiction-rehabilitation services that their group performs. JES members would recommend their group to others more often than for members of acceptance-oriented groups would (JES: 97.6%; all other groups: 84.5%).

The individual social status of attendees is enhanced by outpatient self-help for drug dependent individuals. Measured by the condition described in the base periods previously noted, the friendship situation was improved in 83.9% of all group members, as well as the physical condition in 71.4%, and the spiritual condition in 86.5%. However, members of acceptance- and abstinence-oriented groups differ significantly in the improvement of their legal situation (JES: 63.9%; all other groups: 28%), living arrangements (JES: 60.8%; all other groups: 40.2%), and their financial situation (JES: 57.5%; all other groups: 41.1%). The higher optimized standard of living of members of acceptance-oriented groups can be explained by their worse social status during the six months before attending an SHG. In all four central criteria of the objective social situation (partnership, friends, vocational situation, and living arrangements), members of acceptance-oriented groups achieved significantly worse results than members of abstinence-oriented groups.

The scientific literature published in German presumes that self-help contains extensively forming influences (i.e., Moeller, 1992, 1996; Wohlfahrt & Breitkopf, 1995). Particular interactive effects that go beyond mechanisms of forming groups, function in an autonomous operating community of individuals with similar convictions. In the opinion of the humanistic psychology and pedagogy, these are the primary mechanisms for the educational and individual growth of the subject and therefore the central effects of self-help.

In the study presented these effects are represented by an index consisting of 32 items. These statements are derived from: qualitative statements of the

self-help members, empirical studies on self-help for drug addicts, and theoretical contributions concerning self-help in general. Here are three examples:

- “In our self-help group, it is possible to talk about ones’ own problems.”
- “In our self-help group, members have peer function.”
- “In our self-help group, one is encouraged to try new things.”

A factor analysis of the 32 items shows, that SHGs have four major effects. These four effects characterize the primary educational mechanisms of SHGs and most likely even the central pedagogic impact of any engagement in self-help:

1. An increase of the self-awareness (explains 21.9% of the variance): The group influences the view of ones’ self and the social empathy of its members. Members view themselves more realistically because of the meetings. They also become more sensitive to the situation of the other members.
2. Extrinsic social affirmation (explains 19.9% of the variance): The group reaffirms its members in the process of gaining individual competence. Members feel strengthened on their individual course.
3. Psychosocial and substance-specific integration (explains 17% of the variance): The group helps its members to become socially more stable and motivates them, to reduce their use of psychoactive substances. Members (re)integrate themselves into society and use fewer substances—in smaller doses.
4. Offering social services (explains 8.3% of the variance): The group offers its members specific services supporting daily life. Members make use of consulting and advisory services, which may lead to further progress.

Acceptance- and abstinence-oriented SHGs differ significantly regarding the following four group dynamic factors:

1. Factor: Abstinence-oriented groups influence characteristics of self-awareness twice as often as acceptance-oriented groups do.
2. Factor: Acceptance-oriented groups reaffirm their members twice as intensively as abstinence-oriented groups do.
3. Factor: Abstinence-oriented groups integrate their clientele psychosocial and substance-specific one-and-a-half times more often than acceptance-oriented groups do.
4. Factor: Acceptance-oriented groups offer social services twice as often, as abstinence-oriented groups do.

THE SUBSTANCE-RELATED EFFECTS

Last but not least, it was expected that the attendance of SHGs would correlate with a reduced use of psychoactive substances. Corresponding hypotheses relate to:

- Eleven psychoactive substances (alcohol, heroin, methadone, other opiates, psychopharmacoon, cocaine, amphetamines, cannabis products, hallucinogens, inhalant substances, tobacco).
- Four intake frequencies (not used, used up to 3 days per month, used between 4 and 12 days a month, used more often than 12 days a month).
- Two base periods (during the six months prior to the first self-help group attendance, during the six months prior to questioning).

Implementing a quasi-pre-post comparison (Wilcoxon MPSR-Test), we were able to assess significant substance-reducing effects within the scope of this cross-section study:

During the six months prior to questioning, members of acceptance-oriented SHGs used the following substances less than during the six months prior to their first self-help group attendance: alcohol (47.6%); heroin (59.9%); psychopharmacoon (36.3%); cocaine (53.8%); amphetamines (51.9%); cannabis products (32.8%); hallucinogens (25.6%); inhalant substances (12.8%); tobacco (11.7%). All listed percentages are significantly higher than the proportion of acceptance-oriented group members who have increased their use of substances during the base periods.

The attendance of abstinence-oriented groups also reduces the use of nine substances, however to a different degree: alcohol (59.9%); heroin (34.0%); psychopharmacoon (31.1%); cocaine (43.3%); amphetamines (29.5%); cannabis products (48.6%); hallucinogens (22.1%); inhalant substances (6.7%); and tobacco (30.3%).

Here too, all listed percentages are significantly higher than the proportion of abstinence-oriented group members who have increased their use of substances during the base periods.

According to this analysis, members of *acceptance-oriented* groups primarily reduce their use of heavy, illegal drugs more than members of abstinence-oriented groups do. The reason for this effect is found by comparing the intake frequencies during the six months prior to the first self-help group attendance. Members of *abstinence-oriented* groups live significantly more often abstinent and use several illegal substances less than members of acceptance-oriented groups. This effect is to be explained by the closeness of abstinence-oriented groups to professional therapeutic facilities. In this context, abstinence-oriented self-help often functions as an aftercare program. As such, it carries on the therapeutic process with its own means.

The results above are still surprising regarding one further aspect: although the acceptance-oriented self-help approach commits itself to tolerance regarding the use of “soft” and “hard” illegal drugs, and it does not motivate its members toward abstinence, it has an intermediate effect upon the use-behavior of its members. Cautiously considering the methodological limits of this study (cross-section analysis, subjective description of the intake behavior), this result seems to indicate that social control mechanisms of peers and “sympathy” effect do exist. This study cannot detect if the impact of acceptance-oriented activities on these mechanisms is conscious or unconscious.

DISCUSSION

The complete survey presented generated first findings about SHGs in Germany. Within the scope of a quantitative-qualitative design, the different approaches of acceptance- and abstinence-oriented initiatives were described. The quantitative survey indicates that the outpatient self-help for drug-addicted in Germany has psychosocial and substance-specific effects. Acceptance- and abstinence-oriented approaches attract a different clientele—and therefore pursue different social sides of the drug phenomenon. Although both approaches vary in their drug-specific norms and therefore sketch a diametrically opposite version of society, they both contribute, in their own specific way, to the (re)integration of their attendees. Self-help groups and initiatives seem to have a lasting educational effect on their members. Therefore, they can be viewed as a place for catching up on individual development and socialization.

Notwithstanding the extensive layout of this study, the following epistemological limitations still exist:

- Since only Anglo-American and German literature was analyzed during the theoretical preparation, it remains unclear if studies examining SHGs in other language-zones—for example in the Mediterranean, Scandinavian, or Asian—exist. Due to the dominance of the empirical Anglo-American discourse in addiction-research, this seems rather unlikely. However, it is imaginable that self-help groups for addicted from other language-zones—like the Russian initiative “New Pilgrims” (compare Medwedjew & Streljannaja, 1997) or the groups Humphreys (1997) mentioned—are not evaluated.
- As a cross-section analysis, this study only delivers retrospective statements regarding the effects of SHGs. How far the affected picture themselves exaggerated in retrospect—in the negative and in the positive sense—remains undefined.
- It is not possible to make any specific statements regarding 12-Step self-help, because of the below-average response rate NA had.

- How far the observed effects, index figures, or mechanisms of SHGs are valid within outpatient self-help for alcoholics in Germany, also remains unclear.
- It also remains unclear how far affected, those who did not respond, have an influence on the relative favorable social, group-specific, and substance-specific success of SHGs. According to a conservative interpretation, one would assume a positive bias of this study, because chances are higher that relapsed or socially less integrated affected will refuse to take part in a study. Refusal, independent from the individual state of the member, can also be caused—as the example NA shows—by group-norms, the non-acceptance of people from outside, or the rejection of scientific work. Which argument is truest cannot be proven in this study. The acceptable to good response-rate of attendees outside the 12-Step approach indicates a certain validity of answers.

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