

## Chapter 8 Self-help programs

This chapter discusses self-help approaches for patients, including Alcoholics Anonymous and Smart Recovery®, and their families.

Recommendation	Strength of recommendation	Level of evidence
8.1 Long-term participation in Alcoholics Anonymous can be an effective strategy to maintain abstinence from alcohol for some patients.	B	II
8.2 Assertive referral practices to Alcoholics Anonymous increase participation and improve outcome.	A	I
8.3 SMART Recovery® may be an effective self-help alternative to Alcoholics Anonymous for reducing alcohol consumption.	D	IV
8.4 Self-help groups for families may provide support for those affected by people with alcohol dependence.	D	IV

### Alcoholic Anonymous (AA)

#### *What is AA?*

Established in the US in 1935, over 100,000 groups exist worldwide with a total membership of approximately two million (Alcoholics Anonymous 2001). AA is founded on the assumption that shared experience and mutual support are necessary for recovery from addiction (Alcoholics Anonymous 2001). In particular, AA proposes that sobriety is only possible by first acknowledging one's inability to control the drinking habit, committing to a comprehensive overhaul of one's identity and lifestyle, and assisting new members in their recovery process (Alcoholics Anonymous 2001). AA is the prototype for many self-help groups, with its core program based around 12 steps (see Table 8.1) that promote increased self-awareness and heighten a sense of meaning in life. It is important to note that the concept of God or a 'higher power' includes anything of a transpersonal nature that can be drawn on for strength, including the AA group (Browne 1991; 1994).

#### *How it works*

AA is founded on the assumption that shared experience and mutual support are necessary for recovery from addiction. In particular, AA proposes that sobriety is only possible by first acknowledging one's inability to control the drinking habit, committing to a comprehensive overhaul of one's identity and lifestyle, and assisting new members in their recovery process. Several studies have also suggested that AA-facilitated abstinence is partly due to an increase in self-efficacy that arises from its recovery.

**Table 8.1: The 12 steps of Alcoholics Anonymous**

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Affiliation with Alcoholics Anonymous in addition to a structured aftercare program may benefit patients, as the AA program strengthens the individual's sense of self-efficacy (see Tonigan and Connors 2008) and provides a social network supportive of abstinence (Bond et al. 2003; Litt et al. 2007; Vaillant, 2005).

Research also suggests that patients who attend AA as part of a structured aftercare program in addition to individual outpatient sessions, and begin attendance early in the treatment process, demonstrate better outcomes than individuals attending either AA or treatment alone (Ito and Donovan 1990; Moos and Moos 2005; Moos Moos, 2006a; Moos and Moos 2006b; Ouimette et al.1998).

In Australia, about 1,700 groups are currently in operation in all states and territories on a daily basis; for those unable to access physical groups, a number of groups are available online (<http://www.alcoholicsanonymous.org.au/>). Based on the 12 traditions adopted by AA's organisational body (Alcoholics Anonymous 1978), the only requirement for membership is a desire to stop drinking, with meeting attendance incurring no cost.

### ***Evidence for AA effectiveness***

Whilst literally hundreds of studies that examine the effectiveness of AA have been conducted, it should be noted that the literature base is subject to several serious limitations. Very few randomised controlled trials exist, most participants have had exposure to other treatment programs in addition to AA, and naturalistic studies only include participants who have elected to attend treatment (suggesting a higher degree of motivation to change).

Further, the majority of studies have limited the examination of AA participation to the frequency and duration of meeting attendance, which fails to capture the breadth of involvement in the program. Several recent studies have suggested that the level of engagement with various aspects of AA are more important determinants of its effectiveness than meeting attendance alone (Timko et al. 2006; Timko and DeBenedetti 2007; Weiss et al. 2005). These studies have prompted a move away from attendance-only measurement of AA involvement, with a growing literature base adopting more refined measures of affiliation.

Despite these limitations, a substantial body of methodologically sound naturalistic research suggests that AA is beneficial in promoting abstinence and facilitates the maintenance of long-term sobriety (see Moos and Timko, 2008, for a review). In a 16 year longitudinal study, Moos and Moos (2006a; see also Moos and Moos, 2005 and 2006b) examined how the duration of various treatment approaches in the first year of help-seeking behaviour influenced drinking outcomes. Whilst both professional treatment and AA affiliation for a period of 27 weeks or more in the first year of recovery were associated with better 16 year abstinence rates, the improvements gained by professional treatment were mediated by AA attendance; only participants who concurrently participated in AA showed better long-term outcomes. Further, continued involvement in AA (yrs 2-8) was associated with a higher likelihood of remission at each follow up point.

Due to the difficult nature of running randomised controlled trials into AA's efficacy, most RCTs have compared Twelve Step Facilitation Therapy (TSF) – a program designed to foster increased commitment to AA as part of an extended care strategy – to traditional treatment approaches (Nowinski et al. 1995). To date, several studies have demonstrated that TSF is as effective as CBT and Motivational Interviewing in facilitating sobriety and is actually more effective than these modalities when abstinence is the goal (Ouimette et al. 1997; Project MATCH Research Group 1997; see Ries et al. 2008 for a review).

One Cochrane review undertook to compare AA and other 12-step programs to other psychosocial interventions, looking for any evidence in reducing alcohol intake, achieving abstinence, maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol associated accidents and health problems (Ferri et al 2006). Their main findings were that no experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches to reduce alcohol dependence or problems. However this does not detract from the social benefits of either of these approaches.

Additionally, Timko et al. (2006; see also Timko and DeBenedetti, 2007) have demonstrated that therapists' referral practices influence the depth of the client's participation in AA. Intensive referral (IR) practices include providing meeting schedule and public transport timetables, finding a temporary sponsor and organising for AA volunteers to accompany the client to meetings, and asking the client to use a 'meeting journal' (signed off by the AA meeting convener) to record attendance and reactions to the meeting. Compared to the standard referral condition where only minimal information about local AA meeting schedules was provided, participants randomly allocated to the IR group were more fully involved in the AA program (e.g., service, sponsorship, 'spiritual awakening') and demonstrated significantly better substance use outcomes over the ensuing 12 months.

Several studies have also suggested that AA-facilitated abstinence is partly due to an increase in self-efficacy which arises from its recovery program (Project MATCH

Research Group, 1997; Tonigan and Connors 2008). AA provides a new social network supportive of abstinence; for the patient who lacks such support in their home environment, this aspect of AA involvement plays an important role in relapse prevention (Bond et al. 2003; Litt et al. 2007; Vaillant, 2005).

Clinicians using Twelve-Step Facilitation therapy to encourage AA involvement deepen their patients' commitment to the use of AA as part of an extended care plan, resulting in improved abstinence rates and greater treatment retention (Ouimette et al. 1997; Nowinski et al. 1995; Project MATCH Research Group, 1997; Timko et al. 2006; Timko and DeBenedetti 2007).

A recent study by Walitzer et al. (2009) illustrates one method that was effective in increasing AA involvement and abstinence from alcohol. A total of 169 alcoholic outpatients (57 women) were assigned randomly to one of three conditions: a directive approach to facilitating AA, a motivational enhancement approach to facilitating AA or treatment as usual, with no special emphasis on AA. The results showed that participants in the directive condition for facilitating AA involvement reported more AA meeting attendance, more evidence of active involvement in AA and a higher percentage of days abstinent than people in the treatment-as-usual group. The effect of the directive strategy on abstinent days was also somewhat influenced through the involvement in AA. The motivational enhancement approach to facilitating AA had no effect on the percentage of abstinent days or the percentage of heavy drinking days.

### ***For whom is AA appropriate?***

A common misconception concerning 12 step groups is that members need to be religious to benefit from the program. In a study of 3,018 male substance abusers, individuals involved with AA demonstrated improved outcomes whether or not they identified with a particular religious or spiritual belief system (Winzelberg and Humphreys 1999). AA may also be appropriate for dually diagnosed clients, although the efficacy of AA depends on the nature of the additional diagnosis (see Moos and Timko 2008). In particular, depressed clients require more intensive outpatient support, particularly in the early stages of aftercare treatment, to facilitate the social elements of AA involvement (including finding an appropriate sponsor) and to reduce the likelihood of dropping out of the program (Curran et al. 2002; Kelly et al. 2003; Moos and Timko, 2008).

Clients who demonstrate a higher level of symptom severity are more likely to affiliate with AA (Tonigan et al. 2006) and appear to benefit more as the amount of involvement increases (Morgenstern et al, 2003).

Further, AA provides a new social network supportive of abstinence that assists in promoting recovery. Litt et al. (2007) randomly assigned 210 participants to either a network support (NS), NS and contingency management, or case management experimental condition. In the NS conditions TSF was employed to promote AA attendance, thereby increasing the number of social contacts supportive of abstinence. As hypothesised, participants in the NS groups demonstrated heightened attitudinal and behavioural support for abstinence at post-treatment and a 15 month follow-up, with AA involvement correlated to improved drinking outcomes. Participation in AA would thus also be appropriate for clients with limited social support or a social network comprised of other substance users.

## **Referring to AA**

A growing body of research is demonstrating that the use of TSF and 'intensive AA referral' as part of outpatient treatment improves AA meeting attendance and involvement, and is associated with better long-term outcomes (Nowinski et al. 1995; Project MATCH Research Group 1997; Connors et al. 2001; Timko et al. 2006; Timko and DeBenedetti 2007; see Ries et al. 2008 for a review).

TSF is designed to increase the client's commitment to and involvement with AA; the clinician works through the core features of the AA ideology (e.g., acceptance of the inability to control the addiction) with the client over 12 sessions in 3 months. If adopted as part of an extended care plan following inpatient treatment, TSF and AA attendance can assist in helping the client through the initial 3 month 'danger period'.

Intensive referral practices can also be used as a means of removing barriers to aftercare participation, reducing the likelihood of treatment dropout, and increasing the level of AA involvement. These include providing meeting schedule and public transport timetables, organising for AA volunteers to accompany the client to meetings, using a 'meeting journal' (signed off by the AA meeting convener) to record attendance and reactions to the meeting, and organise for a temporary sponsor (Timko et al. 2006; Timko and DeBenedetti 2007). As each AA group is different in terms of its overall atmosphere, it is also recommended that clinicians attend several meetings across different groups to assist in matching the client to a suitable situation (Passetti and Godley 2008; Ries et al. 2008).

A longer duration of AA attendance in the first year of treatment and sustained involvement across years 2-8 of a longitudinal follow-up study has been linked to better long-term outcomes (Moos and Moos 2006a),

## **SMART Recovery®**

An alternative to the AA self-help approach is Self Management and Recovery Training (SMART), a not-for-profit mutual-aid group aimed at facilitating recovery from any addictive behaviour. SMART Recovery® (originally the non-profit Rational Recovery Self-Help Network) officially began in the US in 1994 and is a spin-off from the original. At present approximately 16 online and 300 face-to-face meetings are sponsored worldwide by SMART (<http://www.smartrecovery.org/>). Although relatively new to Australia, over 50 groups are currently operating across most states on a weekly basis (<http://www.smartrecoveryaustralia.com.au/>).

Founded on scientifically validated addiction treatment principles (at present, the organisation adopts a Cognitive Behavioural Therapy (CBT) framework), SMART Recovery® differs from AA in that it eliminates the focus on spirituality inherent to the 12-step approach (Li et al. 2000). Instead, it aims to tackle addiction through using a four-point recovery program designed to enhance members' motivation and teach techniques that help to manage lifestyle and behavioural difficulties (Horvath and Velten 2000) (see also <http://www.smartrecovery.org/intro/index.htm>). Skills training involves exposure to (among other things) cost-benefit analyses, identifying and rectifying irrational thoughts, and role-playing.

Although based on an empirically supported theoretical framework, SMART Recovery® is a relatively young organisation, and very little research has assessed

its efficacy in comparison to other self-help groups. The only two studies that have investigated SMART Recovery® and AA have done so with dual-diagnosis patients, rather than alcohol-specific patients in aftercare (Penn and Brooks 2000; Brooks and Penn 2003). The SMART (CBT) program was compared to 12-step program, with 112 patients alternately assigned to the two treatment conditions; 50 completed the 6-month treatment program. Assessments occurred at baseline, 3 months, and 6 months during treatment, and at 3- and 12-month follow-ups. Analyses were conducted at the 3 month follow-up. The 12-step intervention was found to be more effective in decreasing alcohol use and increasing social interactions; however, it was associated with a worsening of medical problems, health status, employment status, and psychiatric hospitalisation. Positive changes in health and employment were associated with the SMART intervention, and alcohol use also decreased, although not as much as in the 12-step group.

Whilst the 12-step intervention in these studies appeared to impact more positively on alcohol-related outcomes than SMART, the findings indicate that SMART patients exhibited greater improvements to overall health and employment. It is necessary, however, to exercise caution in interpreting such findings, given that both AA and SMART Recovery® groups operate as self-help rather than as specialised inpatient treatment programs.

### **Self-Help for Families**

Family therapy is a viable treatment for the patient and major changes often have to be made in the family to support the patient's recovery (Higgins 1998). According to Higgins, the interpersonal dynamics of the family may support and maintain the addictive behaviour; this is why addressing the family unit as a whole is more productive than changing the addict's behaviour in isolation. This change has the potential to be perceived as a threat, destabilising the family unit.

Again, there is little empirical evidence in the form of randomised controlled trials to demonstrate the benefit of family involvement on treatment for alcohol use disorders. However, Barnett (2003) conducted an extensive review of current research, literature, and internet-based resources. The conclusion of her article was that alcohol dependency flourishes within the social context of the family system and is one of the leading causes of family dysfunction. She stresses that, therefore, understanding the impact of alcoholism on the family and being familiar with resources and referrals is critical to the management of treatment for the patient and family. It is imperative that the family be recognised as the unit of treatment and be included in the treatment plan. Barnett also states that involving the patient and the family in the treatment for alcohol problems is validated and supported by the principles of family systems theory (Lipps 1999).

## References

- Alcoholics Anonymous 1978, *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services.
- Alcoholics Anonymous 2001, *Alcoholics Anonymous*. New York: Alcoholics Anonymous World Services.
- Barnett, MA 2003, All in the family: resources and referrals for alcoholism. *J Am Acad Nurse Pract* 1510: 467-472.
- Bond, J, Kaskutas LA and C Weisner 2003, The persistent influence of social networks and Alcoholics Anonymous on abstinence. *J Stud Alcohol* 644: 579-588.
- Brooks, AJ and PE Penn 2003, Comparing treatments for dual diagnosis: Twelve-step and Self-Management And Recovery Training. *Am J Drug Alc Abuse* 292: 359-383.
- Browne, BR 1991, The selective adaptation of the Alcoholics Anonymous program by Gamblers Anonymous. *J Gambler Stud* 73: 187-206.
- Browne, BR 1994, Really not God: Secularization and pragmatism in Gamblers Anonymous. *J Gambler Stud* 103: 247-260.
- Connors, GJ, JS Tonigan and WR Miller 2001, A longitudinal model of intake symptomatology, AA participation and outcome: retrospective study of the project MATCH outpatient and aftercare samples. *J Stud Alcohol* 626: 817-825.
- Curran, GM, Kirchner JE, Worley M et al. 2002, Depressive symptomatology and early attrition from intensive outpatient substance use treatment. *J Behav Health Serv Res* 292: 138-43.
- Ferri, M, L Amato and M Davoli 2006, Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database Syst Rev* 3: CD005032.
- Higgins, MP 1998, Alcoholic families, the crisis of early recovery. *Fam Ther* 253: 203-219.
- Horvath, AT and E Velten 2000 SMART Recovery®: Addiction recovery support from a Cognitive-Behavioral perspective. *J Rational-Emotive and Cognitive-Behavioral Ther* 183: 181-191.
- Ito, JR and DM Donovan 1990, Predicting drinking outcome: Demography, chronicity, coping, and aftercare. *Addict Behav* 156: 553-559.
- Kelly, JF, JD McKellar and R Moos 2003, Major depression in patients with substance use disorders: Relationship to 12-Step self-help involvement and substance use outcomes. *Addiction* 984: 499-508.

- Li, EC, C Feifer and M Strohm 2000, A pilot study: Locus of control and spiritual beliefs in Alcoholics Anonymous and SMART Recovery members. *Addict Behav* 254: 633-640.
- Litt, MD, Kadden RM, Kabela-Cormier E et al. 2007, Changing network support for drinking: Initial findings from the Network Support Project. *J Consult Clin Psychol* 754: 542-555.
- Lipps, AJ 1999. Family therapy in the treatment of alcohol-related problems: A review of behavioral family therapy, family systems therapy and treatment matching research. *Alcohol Treat Q*, 173: 13-23.
- Moos, RH and BS Moos 2005, Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcohol Clin Exper Res* 2910: 1858-1868.
- Moos, RH and BS Moos 2006a. Participation in Treatment and Alcoholics Anonymous: A 16-Year Follow-Up of Initially Untreated Individuals. *J Clin Psychol*, 626: 735-750.
- Moos, RH and BS Moos 2006b, Treated and untreated individuals with alcohol use disorders: Rates and predictors of remission and relapse. *Int J Clin Health Psychol* 63: 513-526.
- Moos, RH and C Timko 2008, Outcome research on 12-step and other self-help programs. In: Galanter, M and HD Kleber (eds) *The American Psychiatric Publishing Textbook of Substance Abuse Treatment 4th ed.*, American Psychiatric Publishing.
- Morgenstern, J, Bux DA, Labouvie E et al. 2003, Examining mechanisms of action in 12-Step community outpatient treatment. *Drug Alcohol Depend* 723: 237-247.
- Nowinski, J, S Baker and K Carroll 1995, *Twelve Step Facilitation Therapy Manual*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Ouimette, PC, JW Finney and RH Moos 1997, Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *J Consult Clin Psychol* 652: 230-240.
- Ouimette, PC, RH Moos and JW Finney 1998, Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *J Stud Alcohol* 595: 513-522.
- Passetti, LL and SH Godley 2008, Adolescent substance abuse treatment: clinicians self-help meeting referral practices and adolescent attendance rates. *J Psychoactive Drugs* 401: 29-40.
- Penn, PE and AJ Brooks 2000, Five years, twelve steps, and REBT in the treatment of dual diagnosis. *J Rational-Emotive and Cognitive-Behavioral Ther* 184: 97-208.

- Project MATCH Research Group 1997, Matching alcoholism treatments to client heterogeneity: Project MATCH Post-treatment drinking outcomes. *J Stud Alcohol* 581, 7-29.
- Ries, RK, M Galanter and JS Tonigan 2008, Twelve-step facilitation: An adaptation for psychiatric practitioners and patients. In: Galanter M and HD Kleber (eds). *The American Psychiatric Publishing Textbook of Substance Abuse treatment 4th ed.*, American Psychiatric Publishing.
- Timko, C and A DeBenedetti 2007, A randomized controlled trial of intensive referral to 12-step self-help groups: One-year outcomes. *Drug Alcohol Depend* 902-3: 270-279.
- Timko, C, A DeBenedetti and R Billow 2006, Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction* 1015: 678-688.
- Tonigan, JS, MP Bogenschutz and WR Miller 2006, Is alcoholism typology a predictor of both Alcoholics Anonymous affiliation and disaffiliation after treatment? *J Subst Abuse Treat* 304: 323-330.
- Tonigan, JS and GJ Connors 2008, Psychological mechanisms in Alcoholics Anonymous. In: Galanter, M and HD Kleber (eds). *The American Psychiatric Publishing Textbook of Substance Abuse Treatment 4th ed.* American Psychiatric Publishing.
- Vaillant, GE 2005, Alcoholics Anonymous: Cult or cure? *Aust N Z J Psychiatry* 396: 431-436.
- Walitzer, KS, KH Dermen and C Barrick 2009, Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *Addiction* 1043: 391-401.
- Weiss, RD, Griffin ML, Gallop RJ et al. 2005, The effect of 12-step self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug Alcohol Depend* 772: 177-184.
- Winzelberg, A and K Humphreys 1999, Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *J Consult Clin Psychol* 675: 790-794.