Questions Asked During Live Webinar Broadcast on 3/29/2023

**Current Scientific Evidence About Mutual Help Groups**

**Presenter:** A. Tom Horvath, PhD

**How do you feel about using terms like "misuse" and "abusing substance(s)"?**

A: Misuse is a suitable term. I think “abuse” is stigmatizing.

**What about Dharma Recovery?**

A: I am not aware of any studies about this Buddhism based mutual help group, but I have heard positive client comments about it.

**Any interesting data regarding an individual's attendance of more than one type of support group, e.g., Attending both SMART and CHADD (ADHD peer support)? Is there a notion of any kind of multiplier effect for success?**

A: I think we do not know yet. However, there is at least one study in progress that looks at individuals that attended SMART, AA, both, or neither. It may provide evidence about this issue. Personally I doubt that there is a multiplier effect (I think we are already at a ceiling).

**Does the fact of the Dodobird verdict not call into question the validity of specific theories that are given that purport to explain both the causes of any mental illness category, as well as the reasons given by the supporters of a given therapy for its effects?**

A: Exactly. That was the argument made when this term was used in 1936.

**So, are these studies concluding that they various groups have the same efficacy? That’s not been my anecdotal experience, but I’m curious what the data says.**

A: My reading of the studies is that therapists who are strong on common factors are equally effective, regardless of the specific treatment they use. However, anxiety disorders may be an exception. Furthermore, other professionals view this issue differently, and believe specific treatments are better.

**Given the lack of standardization of self-help groups (every group seems to be different in attitudes about therapy/maintenance medication/etc.), does this make it more difficult to use research for generalization to the substance abuse population?**

A: There is significant lack of standardization both within mutual help groups, and across them. However, one study I mentioned found five common factors among mutual health groups. Suggest that this lack of standardization may not be a major issue. Those five factors were learning coping skills, learning a new lifestyle, bonding and support, the opportunity to give back, and building self-confidence.
Could you provide the definition reference you mentioned about recovery from alcohol?
A:
https://www.niaaa.nih.gov/research/niaaa-recovery-from-alcohol-use-disorder/definitions

Thoughts on the new "preaddiction" term being considered?
A:

The opening paragraphs of that blog:

Addiction is an undesirable term because it is used by many in an all-or-none fashion, or to denote a state of disease (leaving out those who view these disorders as primarily behavioral). Consequently, preaddiction is also undesirable. I believe that eliminating the terms addiction and preaddiction will greatly reduce stigma, because these terms are used to divide people into two groups (addicted, non-addicted). That division is a foundation of stigma.

The addictive behavior spectrum has 6 levels: 1) abstinence, 2) moderation, 3) misuse (subclinical use), 4) mild SUD (or a comparable level if there is no disorder for that behavior or substance), 5) moderate SUD, and 6) severe SUD. Every individual has a standing on this spectrum for each addictive behavior or class of behaviors.

The term "addictive problems" can be applied to levels 3-6. This term is consistent with Broadening the Base of Treatment for Alcohol Problems, published by the National Academy of Sciences in 1990. The term is also consistent with your opening statement:

"Background: Substance misuse and substance use disorders (SUD) continue to have a devastating impact on people in the United States"

Do you think courts are getting any closer (especially drug court) to allowing their requirements to reflect the different choices in mutual support?
A:
They should be. It is illegal in the US to require AA specifically

https://www.smartrecovery.org/court-mandated-attendance/

What role does in-person vs online meeting play in attendance? Many of my clients want in-person and in my area AA/12 Step meetings returned to in person whereas SMART meetings remain mostly online.
A:
I think we don’t know. In my experience there are people who will simply not attend online. Also, there are no conversations in the parking lot after a Zoom meeting, which is a big disadvantage. However, the groups I conduct for SMART and in my practice seem very similar to face to face, so I appreciate the convenience, and it seems a worthwhile tradeoff.

How do you feel about sober support being mandatory in treatment?
A:
I encourage only necessary requirements in treatment. Being in a mutual help group is desirable for many, but I don’t view it as necessary.
Any data on individuals who started in a 12 Step program that sustained long term recovery who switch to another type of program for example: from AA to Recovery Dharma? Or who stopped attending but maintained recovery
A: I don’t know of any data. I anecdotally know many individuals in SMART who have done so, and they seem to do about as well as everyone else.

Most of our (very limited) treatment programs (residential, IOP, and OP) only offer and acknowledge 12 Step programs. Are there successes in helping expand options within the treatment communities, similar to the slow albeit court-ordered acceptance of Medication for Addiction Treatment while in treatment?
A: I expect that the opioid overdose/drug poisoning crisis will continue to drive change. In San Diego, where we actually have enough SMART meetings to make SMART a viable mutual help option, we have regular attendance from several treatment facilities, and we see many of the patients in the liver transplant program.

How many people here have been a part of a 12-step group for at least a year?
A: Is this a question to the attendees?

What experiences are usually present in mutual self-help groups that may correlate to experiences in psychotherapy?
A: As I mentioned above: one study I mentioned found five common factors among mutual health groups. Suggest that this lack of standardization may not be a major issue. Those five factors were learning coping skills, learning a new lifestyle, bonding and support, the opportunity to give back, and building self-confidence.

These factors look similar to the common factors of psychotherapy.

https://en.wikipedia.org/wiki/Common_factors_theory

Is SMART recovery geared more towards hard/moderate drinkers vs alcoholics?
A: I’m sure some people would say that. It is time to retire the term alcoholic unless (as the Big Book says) a person has chosen it themselves. SMART addresses any level of addictive problems, for those who wish to attend.

Is SMART recovery inmate-led in prisons, or are there always staff involved in the groups?
A: I don’t know.

How is success/effectiveness being defined? The measure I’d seen in the past was making it to one year of uninterrupted recovery.
A: Most studies on alcohol problems look at outcomes like DDD (drinks per drinking day) and PDA (percentage days abstinent), which are completely flexible. The groups are then compared on how much these numbers change.

Does the Craft program work?
A:
Compared to the Johnson Institute Intervention, and Al-Anon, CRAFT is substantially more effective at getting the identified patient into treatment.

Is there evidence of bias among SUD treatment professionals who have personal recovery experience and what is the impact?
A: I cannot cite scientific evidence on this subject, but I vaguely recall that it exists.

How do you feel about Faith Based Groups, doing support Groups?
A: I support any group that does not harm people and that people want to attend.