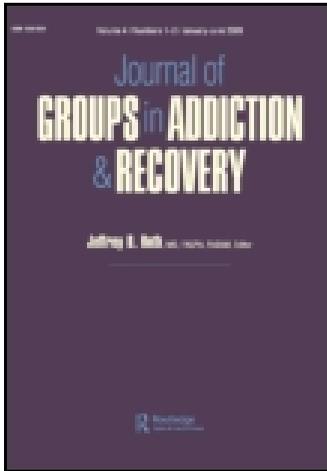


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### Broadening the Base of Addiction Mutual-Help Organizations

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## Broadening the Base of Addiction Mutual-Help Organizations

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*Peer-led mutual-help organizations addressing substance use disorder (SUD) and related problems have had a long history in the United States. The modern epoch of addiction mutual help began in the postprohibition era of the 1930s with the birth of Alcoholics Anonymous (AA). Growing from 2 members to 2 million members, AA's reach and influence has drawn much public health attention as well as increasingly rigorous scientific investigation into its benefits and mechanisms. In turn, AA's growth and success have spurred the development of myriad additional mutual-help organizations. These alternatives may confer similar benefits to those found in studies of AA but have received only peripheral attention. Due to the prodigious economic, social, and medical burden attributable to substance-related problems and the diverse experiences and preferences of those attempting to recover from SUD, there is potentially immense value in societies maintaining and supporting the growth of a diverse array of mutual-help options. This article presents a concise overview of the origins, size, and state of the science on several of the largest of these alternative additional mutual-help organizations in an attempt to raise further awareness and help broaden the base of addiction mutual help.*

**KEYWORDS** *mutual help, mutual aid, self-help, Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, Secular Organization for Sobriety, Women for Sobriety, Moderation Management*

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## INTRODUCTION

At first glance, the notion of individuals with serious, objectively verifiable, cognitive and social impairments being able to facilitate life-saving changes in similarly impaired individuals may seem a little incongruous—from a derisory standpoint, a clear case of “the blind leading the blind.” It is therefore striking to observe that peer-led mutual-help organizations composed of such individuals have been shown to facilitate the same kinds of salutary behavior changes as trained professionals (Humphreys & Moos, 2001, 2007; Moos & Moos, 2006; Timko, Moos, Finney, & Lesar, 2000; Timko, Sempel, & Moos, 2003). A potential reason for at least some of these mutual-help group benefits may lie in the humorous quip frequently expressed within recovery circles: “We may be sick, but we’re not all sick on the same day.”

In the addiction field, examples of mutual-help organizations have been well known, even synonymous with addiction recovery for more than 200 years (White, 1998). Alcoholics Anonymous (AA) is by far the largest and most recognized, and its size and impact have garnered much public health and research attention (Emrick, Tonigan, Montgomery, & Little, 1993; Kelly & Yeterian, 2012; Tonigan, Toscova, & Miller, 1996). However, many other mutual-help organizations have emerged since AA began, either inspired by, or in opposition to, it. These AA alternatives have received only limited attention, but due to their similar social orientation and group format, they may confer benefits comparable to those of AA. Given the diverse experiences and preferences of individuals seeking recovery from substance use disorder (SUD) and the valuable role that mutual-help organizations have been shown to play, raising the profile of a broader array of available mutual-help options may enhance the chances of recovery for more people. To this end, the purpose of this article is to describe six of the largest addiction recovery mutual-help AA alternatives: Self-Management and Recovery Training (SMART Recovery), Secular Organization for Sobriety (SOS), Moderation Management (MM), LifeRing, Women for Sobriety (WFS), and Celebrate Recovery (CR). We begin by providing a brief review of the growth and impact of AA followed by a summary of the origins, growth, size and reach, and state of the science on these alternative recovery mutual-help organizations.

## ALCOHOLICS ANONYMOUS

AA experienced an inconspicuous beginning in Akron, OH, amid the post-prohibition era of the 1930s. AA has since grown from 2 members to more than 2 million members in 2011 and has been adapted and successfully

assimilated into a variety of cultures globally (AA, 2001; Mäkela, 1996). Despite originating under the auspices of a quasireligious organization known as the Oxford Group (AA, 1957; Oxford Group, 1933) and operating at a grassroots community level, AA's language and concepts also have profoundly influenced our *professional* clinical approaches to addressing alcohol and other drug problems (McElrath, 1997; Roman & Blum, 1999; White, 1998), and its philosophy and concepts have imbued our broader language and culture (Travis, 2009).

AA's growing influence and purported success at facilitating long-term addiction recovery has garnered increasing public health and scientific scrutiny (Ferri, Amato, & Davoli, 2006; Institute of Medicine, 1990; McCrady & Miller, 1993). In terms of its verifiable impact, hundreds of published studies, many in top scientific journals, have supported the beneficial effects of AA in helping alleviate alcohol and other drug problems. This body of scientific literature has been summarized in narrative reviews as well as quantitatively, through rigorous meta-analyses (Emrick et al., 1993; Ferri et al.; Humphreys et al., 2004; Kaskutas, 2009; Kelly, 2003; Kownacki & Shadish, 1999; Tonigan et al., 1996; White, 2009). AA participation is associated with producing and maintaining salutary changes in alcohol and other drug use that are on par with professional interventions while simultaneously reducing reliance on professional services and thus lowering related health care costs (Humphreys & Moos, 2001; Humphreys & Moos, 2007; Humphreys et al.; Kelly & Yeterian, 2012). Despite some earlier concerns regarding AA's ability to cater effectively to women, young people, people of color, those with comorbid psychiatric illnesses, and non-religious/spiritual persons, research has found that AA confers similar benefits to women as men (Del Boca & Mattson, 2001; Kelly, Stout, Zywiak, & Schneider, 2006); to young people (Alford, Koehler, & Leonard, 1991; Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Brown, Abrantes, Kahler, & Myers, 2008; Kelly, Dow, Yeterian, & Kahler, 2010; Kelly, Myers, & Brown, 2000; Kennedy & Minami, 1993); to many (e.g., Ouimette et al., 2001; Timko, Sutkowski, Cronkite, Makin-Byrd, & Moos, 2011), but not all, persons with psychiatric conditions (e.g., those with severe social impairments and/or psychotic spectrum illness; Bogenschutz & Akin, 2000; Kelly, McKellar, & Moos, 2003; Noordsy, Schwab, Fox, & Drake, 1996; Tomasson & Vaglum, 1998); and to those individuals who are non-religious/spiritual or less religious/spiritual (Kelly et al., 2006; Winzelberg & Humphreys, 1999).

Additional anecdotal concerns have centered around AA's position on potentially helpful medications. In general, surveyed AA members have been found to be supportive of the use of psychotropic (e.g., antidepressants, antipsychotics) and relapse prevention medications (e.g., naltrexone, acamprosate, disulfiram), although there may be a vocal minority who oppose it (Meissen, Powell, Wituk, Girrens, & Arteaga, 1999; Rychtarik, Connors, Dermen, & Stasiewicz, 2000; Tonigan & Kelly, 2004). However, it is unclear

whether this oppositional minority is specific to AA membership or is a more general facet of individuals attempting to recover; at least one study of alcohol-dependent individuals found that AA participation was unrelated to opposition to the use of medications (Tonigan & Kelly, 2004). Given the importance of this issue, however, AA itself has published a pamphlet on this matter in which it states that it is plainly wrong to deny any member the right to psychiatric medications (AA, 2001).

More rigorous evidence in support of AA emerging in the past 20 years, in particular, has moved AA from a peripheral status as a “nuisance variable” and potential obstacle to progress in the field, to playing a more central role in a recovery-oriented system of care (Kelly & White, 2011; Kelly & Yeterian, 2012; White, 2008). Stemming from these findings on AA’s broad reach, effectiveness, and cost-effectiveness, professional interventions have been developed and tested, designed specifically to engage patients with these community mutual-help resources during and after treatment. These “Twelve-Step Facilitation” (TSF) interventions have been found to enhance patient outcomes in randomized controlled investigations (Kahler, Read, Stuart, Ramsey, McCrady & Brown, 2004; Kaskutas, 2009; Litt, Kadden, Kabela-Cormier, & Petry, 2009; Project MATCH Research Group, 1997; Sisson & Mallams, 1981; Timko & DeBenedetti, 2007; Timko, DeBenedetti, & Billow, 2006; Walitzer, Dermen, & Barrick, 2009), and consequently, TSF is now an “empirically supported treatment” as defined by the American Psychological Association and U.S. federal agencies.

With the emergence and increasing availability of illicit substances, addiction to drugs other than alcohol has become more prevalent. This led to adaptations of AA’s formula to address the needs of individuals addicted to drugs other than alcohol. The largest among these is Narcotics Anonymous (NA) founded in 1953, which addresses all substances, but other 12-step based organizations soon emerged focusing on specific substances, such as Pot Smokers Anonymous (1968), Pills Anonymous (1975), Marijuana Anonymous (1989), Cocaine Anonymous (1982), Nicotine Anonymous (1985), and Crystal Meth Anonymous (1994). With the increased acknowledgement of the overlap between comorbid psychiatric disorders and SUD (e.g., Regier, Narrow, & Rae, 1990), “dual-focused” mutual-help organizations have emerged providing support for both sets of problems simultaneously (e.g., Dual Disorders Anonymous [1982], Dual Recovery Anonymous [1989], and Double Trouble in Recovery [1993]). Family members, themselves gravely affected by addiction among loved ones, developed their own mutual-help groups based on the same 12-step and 12-tradition template as AA. The most notable among these were Al-Anon (1951), Alateen (1957), and Nar-Anon (1968).

All of the above organizations are based on AA’s organizational template of the 12 steps and 12 traditions (AA, 1953). However, several other recovery organizations have emerged specifically to serve as secular and religious alternatives to AA and other 12-step programs. In the next section, we

describe the origins, size and reach, and state of the science of several of the largest and earliest of these alternatives. Specifically, we describe: SMART Recovery, SOS, MM, LifeRing, WFS, and CR.

### Self-Management and Recovery Training (SMART Recovery)

SMART Recovery began in 1994 as an offshoot of Rational Recovery (Horvath & Yeterian, this issue). The stated goals of SMART Recovery are to “support individuals who have chosen to abstain, or are considering abstinence from any type of addictive behavior (substances or activities), by teaching how to change self-defeating thinking, emotions, and actions; and to work towards long-term satisfactions and quality of life” ([www.smartrecovery.org/intro/index.htm](http://www.smartrecovery.org/intro/index.htm)). It teaches self-empowerment and self-reliance and views addictions/compulsions as complex maladaptive behaviors with possible physiological factors. It teaches tools and techniques for self-directed change and encourages individuals to recover and live satisfying lives.

The SMART Recovery meetings have a contemporary cognitive-behavioral orientation, are educational, and include open discussions. It also explicitly advocates the appropriate use of prescribed medications and psychological treatments. It draws on evidence-based practices and “evolves as scientific knowledge of addiction recovery evolves” ([www.smartrecovery.org/intro/index.htm](http://www.smartrecovery.org/intro/index.htm)). The main processes of recovery stated by SMART Recovery are enhancing and maintaining motivation to abstain, coping with urges, problem solving (e.g., managing thoughts, feelings, and behaviors), and lifestyle balance achieved and reinforced through meeting participation. Professionals and peers serve as volunteer facilitators of SMART Recovery meetings.

As of December 2011, SMART Recovery was reported to have more than 650 groups throughout the world, with most of them in the United States. The SMART Recovery Web site maintains a current listing of face-to-face meetings (which are available in most U.S. states) and daily online meetings (which offer either voice and/or text connection). In the most recent SMART Recovery participant survey ( $N = 513$ ; [http://www.surveymonkey.com/sr.aspx?sm=mYZaRq3wln9vAaQhcXBxp4Aj82eJeDLX\\_2ftPftMvLLbI\\_3d](http://www.surveymonkey.com/sr.aspx?sm=mYZaRq3wln9vAaQhcXBxp4Aj82eJeDLX_2ftPftMvLLbI_3d)), most SMART Recovery participants were Caucasian (93.2%), 42.7% were female, and the median age was approximately 50 years old. Slightly more than half (53.5%) of those surveyed reported being SMART Recovery members for less than 1 year. Despite SMART Recovery having a secular orientation and providing an alternative to 12-step organizations, 60.7% of members reported believing in some kind of god or higher power, and 85.2% reported attending AA or other 12-step organizations in addition to SMART Recovery. Thus, although there is a large overlap in 12-step participation among SMART members, it seems that SMART offers something potentially unique and appealing that is not offered in 12-step organizations.

Research on the effectiveness of SMART Recovery is limited. Two cross-sectional survey studies examined characteristics of SMART Recovery members (e.g., religiosity, locus of control) relative to members of other mutual-help organizations, such as AA (Atkins & Hawdon, 2007; Li, Feifer, & Strohm, 2000). One of these studies (Atkins & Hawdon) found a significant relationship between the duration of continuous abstinence and the extent of participation in mutual-help groups, which included SMART Recovery. This relationship did not differ by type of mutual-help organization. This suggests that the benefits from SMART Recovery participation may be similar to that of other mutual-help organizations (Horvath & Yeterian, this issue).

Although not a test of SMART Recovery as a mutual-help organization, a related study compared professionally led 12-step- and SMART Recovery-based intensive outpatient treatment programs for dually diagnosed patients (Brooks & Penn, 2003). Findings revealed SMART Recovery-based treatment was less effective at reducing alcohol use compared with the 12-step-based treatment, but it was more effective at improving participants' employment status and medical concerns. Several limitations were apparent in this study, however, including a high dropout rate and unequal treatment exposure across conditions. Also, as alluded to earlier, intensive outpatient treatment is not comparable to the context in which real-world SMART Recovery groups are run, and this study sample was composed of dually diagnosed individuals who may not be representative of most SMART Recovery members (Horvath & Yeterian, this issue).

SMART Recovery is beginning to make successful forays into other countries besides the United States. A small pilot study in Great Britain about participant ( $N = 65$ ) perceptions of SMART Recovery (MacGregor & Herring, 2010) found that the majority of SMART Recovery attendees (79%) found groups to be very helpful and intended to continue attending within the next 3 months. Most had attended other mutual-help groups, such as AA, but reported SMART Recovery was more useful to them.

SMART Recovery is an interesting hybrid mutual-help organization in that it takes evidence-based motivational and cognitive-behavioral strategies evaluated in professional clinical settings and populations and implements these in a community mutual-help group context. It is growing nationally and internationally, and future research evaluation will reveal whether this translation of evidence-based clinical practice to a mutual-help context results in stronger engagement, retention, and recovery outcomes. Given the limited empirical literature on SMART Recovery, there are myriad research opportunities available to expand knowledge of its effectiveness, health care cost-offset potential, and potential for benefitting particular types of individuals, such as atheists and agnostics.

## SECULAR ORGANIZATION FOR SOBRIETY

SOS was started in 1986 by James Christopher, a disaffected AA member looking to eradicate the spiritual/religious elements from the recovery mutual aid offered through 12-step fellowships. The organization refers to itself as “a self-empowerment approach to recovery” without any spiritual or religious involvement. Its therapeutic processes and general organizational principles are quite similar to AA however, and much of the organizational language is very similar to AA’s 12 traditions. Meetings are typically 90 minutes in duration and each group is autonomous and self-supporting through its own voluntary contributions.

SOS does not possess a clear, sequential program of action, like AA, but does advocate honest sharing, association with others including other alcoholics, and a focused “Sobriety Priority” of abstaining from alcohol “no matter what.” The organization’s group meetings typically encourage self-admission of alcohol addiction, a daily reminder of this fact, the goal of enhanced quality of life (“the good life”), honest and confidential sharing with other affected individuals, and personal responsibility for recovery (Christopher, 1988). The course of action needed to achieve sobriety is largely left up to the individual to decide for himself or herself, but it is encouraged to be sought using the experience of those SOS members who have found it.

Despite its size and longevity, there has been very little research conducted on SOS to date. The largest survey of 158 members was published in 1996 by Connors and Dermen. The response rate was very low, however, ranging from somewhere between 15% and 29% (Connors & Dermen). Most of the members who responded were White (99%), male (73%), well educated (79.5% reported at least some college or more education), and about 40 years old on average. The majority (70%) reported no current religious affiliation, and 70% described themselves as atheist or agnostic and another 22% as spiritual but not religious. Respondents liked the lack of religious emphasis the best and found the interpersonal aspects of the organization the most helpful. The average number of years of sobriety was 6.3. About 30% were also attending AA meetings in addition to SOS. Average attendance frequency during the past year was about two to three times per month, and the total number of SOS meetings attended was 45.4 (Connors & Dermen).

With the limitation of the low response rate noted, it appears that in keeping with its goals and orientation, SOS tends to attract atheist/agnostic and nonreligious individuals, and the average meeting attendance figures suggest it is able to engage individuals for the long term. Although about one third of members also attended AA, the majority benefited from SOS, and much like in AA, which has 50% of its members with more than 5 years of sobriety, they appeared to find continued benefits despite an average of more

than 6 years of sobriety. SOS's growth and staying power warrant further research on its member composition, effectiveness in helping individuals stay sober and improve quality of life, dropout rates, and mechanisms of change.

### Moderation Management

MM, founded in 1994, is the only substance-focused mutual-help organization that explicitly advocates moderate, nonharmful use of alcohol and not complete abstinence. Given that the largest portion of the burden of disease, disability, and negative social and economic impact is attributable to this segment of hazardous/harmful drinking individuals, MM has immense public health potential.

MM embodies four major principles: self-management, balance, moderation, and personal responsibility. MM's main aim is to share strategies for successful moderation and the "restoration of balance," which include both changes in behavior and the management of emotions. Its main therapeutic process is through self-monitoring of drinking to keep within healthful limits. This is supported by MM group participation. A primary tool used in MM is "awareness." Daily drink charting is intended to bring an unconscious habit back to consciousness and within control. The very act of counting the number of drinks consumed each week is one of the key processes of therapeutic change. MM advocates nine steps (<http://www.moderation.org/readings.shtml#9steps>) that include an initial 30-day period of abstinence during which the member can assess how alcohol has affected them, set drinking limits, and begin to make lifestyle changes. MM members are asked to limit drinking to no more than 9 drinks per week, no more than 3 per day, for women; and to no more than 14 per week, no more than 4 per day for men. These limits are the same as those recommended by the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Even after moderate drinking is begun within the context of MM, MM still recommends not drinking every day, but rather to abstain from alcohol completely on at least 3 to 4 days per week.

In terms of evidence for its beneficial effects, there have been no longitudinal studies or experimental efficacy studies. Two independent surveys have been conducted and show that MM appears to attract problem drinkers who are less severely dependent than those who seek to join AA and who possess greater social resources (Humphreys & Klaw, 2001; Kosok, 2006). These surveys have supported the notion that nondependent "problem drinkers" utilize MM and are mostly drinking in the harmful/hazardous range as opposed to the dependent range (Humphreys & Klaw; Kosok).

MM fills an important gap in the range of options for the large number of individuals who are nondependent drinkers but nevertheless are suffering from a range of alcohol-related problems. MM can therefore provide support

and reduce harms attributable to alcohol without requiring abstinence. This is often an attractive option for many who do not see themselves needing to abstain completely. It can also provide an opportunity to gain support and structure while assessing, experientially, whether individuals can successfully moderate drinking behavior. The goal of a 30-day initial period of complete abstinence followed by a prescribed noncontinuous weekly drinking pattern and limiting quantity to within NIAAA guidelines is likely to quickly separate those individuals who will continue to benefit from MM from those for whom abstinence may be the easier and optimal goal. Typically in the course of alcohol dependence, sufferers possess a strong desire to be able to successfully regulate alcohol consumption. Although, MM's explicit focus is to cater to those wishing to continue to moderate over time, it may therefore also play an intermediate role by providing an opportunity for those dependent on alcohol to realize they are unable to stop or control their alcohol use in a supportive environment without criticism.

## LIFERING

LifeRing for Secular Sobriety is a cognitive-behaviorally oriented support group that emphasizes a tradition of positive psychology rather than spirituality or religious ideas. Founded in 2001, it has grown to about 140 face-to-face meetings as well as online meetings with about 1,000 participants. It has already begun surveys of its membership (sample responded = 401) indicating 58% were male, the average age was 47.8 years old, more than 80% had attended some college, and 44% had a bachelors degree. The average length of sobriety was 2.74 years. In the past year, 40% reported attending a religious service of some kind. In keeping with LifeRing's goal of targeting any kind of substance dependence, survey respondents' primary substances covered a full range of substances of misuse including tobacco.

The LifeRing approach centers on empowerment of the "sober self" characterized by three major components: recognition, activation, and mastery. Recognition emphasizes insight and empowerment by realizing that the "sober self" is a part of who individuals are and has helped them access help and get to this point in their lives. Activation is about living in sobriety and facing the challenges of recovery, which is discussed in group meetings. Mastery is supported through empowering individual members to develop their own "Personal Recovery Program" (PRP). Individuals' PRPs can be allowed to occur naturally as things progress, or more strategically by working through the organization's *Recovery by Choice* workbook. This facilitates the formation of the PRP across nine different recovery-related domains.

The LifeRing approach is essentially a grassroots experientially based mutual-help group but is informed by the latest treatment and recovery

research. Consequently, it incorporates ideas from cognitive-behavioral, motivational, humanistic, existential, and positive psychology areas. No studies have been conducted on LifeRing, but its continued expansion is evidence of its value to many individuals suffering a variety of substance addiction problems. Future research should focus on which individuals may be likely to engage with the organization and on its effectiveness in helping individuals maintain recovery.

## WOMEN FOR SOBRIETY

WFS was established in 1975 by Jean Kirkpatrick, a woman in recovery, who found that AA did not meet all her needs. She believed that women needed their own groups, free from men and role expectations, in which to share their experiences and grow stronger. WFS has between 1,000 and 2,000 members in Canada and the United States and approximately 300 face-to-face meetings (Humphreys, 2004). Almost all these members are Caucasian, well educated, and middle class (Kaskutas, 1992). The WFS program "is an affirmation of the value and worth of each woman," as exemplified in its 13 Statements of Acceptance (Kirkpatrick, 1978). Kirkpatrick maintains that these statements can lead women to see themselves more positively, to increase their self-confidence, and to learn to see themselves as able to overcome their drinking and other problems. The changes they experience are reinforced by the group. WFS groups provide acceptance, nurturing, and a sense of belonging and are a place to release anxiety, share fears, and learn to trust.

A comprehensive survey of WFS membership (response rate = 73%,  $n = 600$ ) was conducted by Kaskutas (1994). Respondents reported their reasons for attending WFS as well as AA and also reported their reasons for not attending AA. Study participants reported that they attended WFS for support and nurturance (54%), for a safe environment (26%), for sharing about women's specific issues (42%), and because of its positive emphasis (38%) and focus on self-esteem (39%). They reported attending AA primarily as insurance against relapse (28%), for its wide availability (25%), and for sharing (31%) and support (27%). Women who did not attend AA reported feeling as though they never fitted in to AA (20%), found AA too negative (18%), disliked the "drunkalogs" (14%) and the focus on the past (14%), and felt that AA was geared too much to men's needs (15%).

WFS is the only major organization specifically for women seeking recovery from alcohol addiction. It takes a positive and affirming stance through its focus on enhancing self-esteem, self-empowerment and self-acceptance, emotional growth, and spirituality: "Emotional growth is happiness; spiritual growth is peace. Together these create a competent, loving woman" (Kirkpatrick, 1978). Like SOS, AA, and others, WFS encourages continued involvement over the long haul, and similar to AA, WFS advocates

a day-at-a-time approach. WFS has not grown rapidly in the United States or other countries since its beginning in the 1970s. Yet, its evident staying power and sizeable membership indicate that it plays an important role for alcohol-addicted women. Research is needed on its overall effectiveness and unique potential to engage women reluctant to attend AA.

## CELEBRATE RECOVERY

In contrast to the other organizations mentioned previously, CR is an explicitly Christian-based religious recovery support organization functioning under the auspices of formal church organizations. CR was founded in 1991 at Saddleback Church in Lake Forest, CA. It was started by John Baker, an alcoholic who found recovery in AA, but who felt constricted in his ability to openly discuss his Christian beliefs within the AA context. He became inspired to begin a separate group where celebration of his addiction recovery along with his Christian values and beliefs could be expressed candidly. After obtaining the blessing and encouragement from his pastor (Rick Warren) from the Saddleback Church, he began the first CR meeting. This was initially based on AA's 12 steps but as things developed into the more formally known CR organization, 8 principles were derived based on the Beatitudes found in Christian Scripture (Matthew 5:1–12, King James Version). These principles describe a very similar sequential process and content as the 12 steps of AA (Baker, 2005; Headley, Olges, & Sickinger, n.d.). The organization does not focus exclusively on recovery from substance-related problems and instead allows anyone to attend who is having difficulty changing problematic and troubling patterns of behavior (i.e., it is open to those "healing from hurts, habits, and hang ups"; [www.celebraterecovery.com](http://www.celebraterecovery.com)). It is somewhat similar in this regard to SMART Recovery, which encourages membership for those suffering from substance or behavioral addiction problems.

CR meetings possess a similar format to 12-step meetings. However, the curriculum of CR is strictly monitored by the national organization (Headley et al., n.d.). To use the CR name and materials, a leader must agree to abide by the expectations listed in "The DNA of an Authentic Celebrate Recovery Meeting." Typical CR meetings begin in a single, large group then break into smaller groups separated by gender and organized by content. Unlike AA but similar to other secular mutual-help organizations, members are discouraged from identifying themselves as their particular problem (e.g., "I'm Susan and I am an alcoholic"), and preference is given to self-identifying as "a Christian who is struggling with. . ." Similar to the AA model, CR encourages individual mentoring (like an AA sponsor), but in addition, has a small support network referred to as "accountability partners." In CR, sponsors fulfill largely the same role as an AA sponsor but more explicitly support spiritual growth through prayer and discussion of members' concerns and questions. The

accountability partners are exclusive to CR and are described as a group of at least three to four people who are at a stage of recovery and who share the same challenge as the focal member. Such homogeneity in content and the recovery stage may enhance therapeutic cohesion and universality (Yalom & Leszcz, 2005). Accountability partners pray for each other and give and seek support through phone calls between face-to-face meetings (Headley, et al.).

CR has grown considerably since its beginning in 1991. According to the CR Web site ([www.celebraterecovery.com](http://www.celebraterecovery.com)), more than 170,000 individuals have completed the CR program, and there are approximately 17,000 CR group ministries operating around the world in approximately 50 countries. The structure of CR is noteworthy. Specifically, its broader focus on behavioral problems and concerns beyond substance use is likely to attract a larger number of potential members than would be the case if its sole focus was on substance-related problems alone. A potential downside of a broader focus, however, could be less group cohesion, universality, and mutual identification. That said, the meeting format of breaking into smaller subgroups with similar concerns and issues may help maintain and strengthen these therapeutic group elements. CR's rapid growth and popularity presents some evidence of its potential benefit. However, little is known about its ability to engage and retain members over time or whether it helps reduce relapse rates and enhances the odds of long-term recovery.

## DISCUSSION AND CONCLUSIONS

Stemming from the rapid growth and influence of AA, a variety of secular, spiritual, and religious alternative mutual-help organizations have emerged during the past 40 years. This multitude of new groups reflects a reality of the diverse needs and preferences of individuals suffering from SUD. However, these alternatives, the largest of which are described herein, have experienced relatively slow growth and acceptance as the mutual-help landscape in the United States has been dominated largely by 12-step organizations such as AA and NA. There are several possible reasons for this slow growth and acceptance of these non-12-step alternatives in the United States. Some of these reasons may relate to differences in operational structure among the various organizations themselves; some may also relate to the degree of fit within the broader cultural context in which they have emerged; while others may pertain to a clinically driven "catch 22" scenario, whereby clinicians are reluctant to refer to smaller organizations or to organizations without a local presence, which in turn, continues to limit their growth. This, in turn, makes it difficult to conduct the kinds of research studies that have been conducted on larger organizations, such as AA, which have increased confidence in AA's effectiveness and thus led to more referrals. We discuss each of these reasons in the following paragraphs.

In terms of operational differences, one reason for the rapid growth of AA and other 12-step mutual-help organizations may be in part due to these organizations' decentralized and "horizontal" authority structure: There is no CEO, president, or leaders in the usual sense issuing top-down instructions—rather, there are only "trusted servants" who are elected by the group and encouraged to rotate regularly. Also, each group itself is completely autonomous and financially self-supporting and able to make its own decisions based on the democratically expressed collective "group conscience." It is merely suggested that 12-step groups adhere to the guidelines (the "12 traditions") outlined in the book, *Twelve Steps and Twelve Traditions* (AA, 1953). Consequently, anyone can start an AA meeting of any kind at any time provided the new group tries to adhere to these traditions. AA's co-founder, Bill W., himself described AA as a kind of "benign anarchy" because of this laissez-faire approach (AA, 1957). This policy of individual and group autonomy may be a major reason why AA and other similar organizations have grown so large. A possible downside of this approach, however, is that this "hands-off" policy affords no oversight, or "quality control," increasing potential variability in group dynamics, content, and any potential therapeutic benefit (Kelly, Stout, Magill, Tonigan, & Pagano, 2011; Tonigan, Miller, & Connors, 2001). AA membership growth may also be linked to its strong service ethic and its implicit expectation for prolonged, if not lifelong, participation (many of the alternatives profiled here expect participation only as long as needed and then encourage members to leave and get on with their lives). Indeed, almost half of the AA membership has 5 or more years of sobriety (AA, 2008).

In contrast, other organizations, such as SMART Recovery, possess a more typical centralized organizational structure, with a president, and require trained facilitators to run group meetings. Some other mutual-help organizations require certification for group leaders or otherwise possess a more "vertical" organizational structure that exerts elements of control of its groups. The consequence of these different policies may mean that the freedom inherent in 12-step organizations facilitates rapid growth, whereas growth may be constricted more by the barriers of consultation, training, and oversight that is often required in other mutual-help organizations.

The ultimate question, of course, may be one of "reach" versus "effectiveness" (Glasgow, Lichtenstein, & Marcus, 2003) or more commonly, "quantity versus quality." That is to say, does the greater oversight and centralized structure, designed to enhance model adherence and provide "quality control," actually result in sufficiently superior effectiveness and member benefit to justify the more tightly controlled approach, despite placing potential limitations on growth? Currently, there are no comparative effectiveness studies of mutual-help organizations to test this. In general, however, it may be that most recovery-focused mutual-help organizations confer broadly similar benefits. Generalizing from the results of comparative trials of professional

treatments, this could well be the case (Morgenstern & Longabaugh, 2000), especially because all of the mutual-help organizations share common therapeutic elements, such as their social structure and group format (Humphreys, 2004; Yalom & Leszcz, 2005). These social components have been shown to be the major pathway through which AA confers its beneficial recovery effects (Kelly, Hoepfner, Stout, & Pagano, 2012). Renowned psychoanalyst, Carl Jung, asserted also that “the protective wall of human community” was one of the major general pathways to addiction recovery (AA Grapevine, 1968).

Another reason why AA and other 12-step organizations have grown so rapidly, particularly in the United States, may have to do with cultural fit and context. AA’s emphasis on spirituality and its use of religious language may be particularly appealing in a country like the United States, where the majority of the population (85%) believes in some kind of deity or God (Kosmin & Keysar, 2009). As noted previously, even among some of the newer secular alternatives that have conducted membership surveys in the United States, almost half or more express religious beliefs and/or behaviors. Also, due to the disinhibiting effects of alcohol and other drugs, individuals suffering from SUD have often engaged in behaviors that run counter to their own values or moral code. Over time, this can lead to chronic self-denigration and self-blame. AA and similar 12-step organizations offer spiritual and quasireligious concepts that by their nature may provide an appealing and compassionate framework for self-forgiveness for those suffering from alcohol and other drug addiction that is not present in other mutual-help organizations (Kelly et al., 2011).

Finally, another possible reason why non-12-step mutual-help alternatives have not grown as rapidly as 12-step organizations may be due to a clinically related “catch 22” scenario: Clinicians are reluctant to refer patients to groups, such as WFS or LifeRing, because of the limited community availability of such groups; and fewer referrals, in turn, perpetuate this limited availability. Furthermore, smaller numbers of groups add to the difficulties of conducting research, positive findings from which could enhance confidence in their clinical utility and impact. The issue of conducting rigorous research on community organizations is not without challenges even under optimal conditions, particularly in conducting the gold standard of treatment research: the randomized controlled trial (RCT). The tightly controlled and highly insulated context of an RCT runs counter to the way real-world mutual-help groups are conducted. Nearly all are attended anonymously and (usually) voluntarily. No records are kept regarding who attends and what is said. Groups vary widely in their size and content. Because mutual-help groups are freely accessible in the community, it can be seen as unethical to randomly assign some RCT participants to attend and prohibit the attendance of others. These issues have led researchers to examine mutual-help groups mostly through other methods, such as through naturalistic,

prospective effectiveness studies, but RCTs have been conducted on professionally delivered TSF interventions designed to engage individuals with these groups such as AA. These kinds of studies would be fairly straightforward to implement also with other mutual-help groups, such as SMART Recovery or LifeRing.

It is hoped that this “catch 22” trend can be reversed by greater clinical open-mindedness and willingness to take an extra step to learn more about the local availability of alternatives and therefore present patients with an informed choice that may ultimately increase the chances of some kind of engagement with a recovery resource (Kelly, Humphreys, & Yeterian, 2012).

The more recent non-12-step mutual-help alternatives may never grow as large as AA for some of the reasons outlined earlier. Nevertheless, they play a vital role in our society's overall response to the prodigious social, medical, and economic burden attributable to substance misuse by providing an array of potentially appealing alternatives. These alternatives merely reflect the demographic diversity and the varieties of addiction experiences and recovery preferences held by individuals suffering from SUD. Providing and supporting greater choice and more options will broaden the base of addiction mutual help. This, in turn, is very likely to enhance the chances of recovery for more individuals.

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