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SMART Recovery: Self-Empowering, Science-Based Addiction Recovery Support

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Self-Management and Recovery Training (SMART Recovery) is an international nonprofit organization that provides free, self-empowering, science-based mutual aid groups for abstaining from any substance or activity addiction. This article summarizes the development of the organization, the current status of face-to-face and online meetings, the characteristics of participants, the nature of the SMART Recovery approach to recovery (i.e., the intersection of what is self-empowering, evidence-based, and likely to be of use in a mutual aid group facilitated by a nonprofessional volunteer), the limited evidence of effectiveness currently available, and some of the prominent questions in need of investigation about SMART Recovery.

KEYWORDS SMART Recovery, self-empowering recovery, addiction recovery, recovery support, mutual aid groups

INTRODUCTION

Self-Management and Recovery Training (SMART Recovery) is an international nonprofit organization that offers free face-to-face and online mutual aid groups for individuals who are seeking to abstain, or who are considering abstinence, from one or more substance or activity addictions. Activity addictions, such as excessive gambling, spending, or video gaming, are also termed process or behavioral addictions. The SMART Recovery program of recovery is the intersection of what is self-empowering, evidence-based, and likely to be of use in a mutual aid group typically facilitated by a

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nonprofessional volunteer. Like the other "alternative" groups (Horvath, 2011), SMART Recovery offers a substantially different approach to recovery and a different meeting format than that of the 12-step spiritual fellowship, which is the dominant addiction mutual aid-group approach in the United States. These alternatives emerged out of frustration with the lack of diversity in addiction recovery support. Founded in 1994, SMART Recovery now appears likely to endure and to be of interest to individuals specifically seeking a science-based, self-empowering, and self-reliant approach to addiction recovery. This approach significantly differs from the powerlessness approach of the 12-step spiritual fellowships, or, except for Moderation Management, the generally less science-based approaches of the other alternatives. The SMART Recovery tools for recovery aim to increase the participant's capacity to maintain motivation, identify and cope with cravings, identify and modify irrational thinking and beliefs, and live with greater balance and attention to long-term goals in addition to short-term ones. Even at the beginning of the recovery process, these tools have face validity for individuals who prefer an active (vs. passive) coping style. The SMART Recovery slogan—"Discover the power of choice!"—appears to exemplify what these individuals are seeking from addiction recovery support.

ORIGINS AND HISTORICAL DEVELOPMENT

SMART Recovery was incorporated as a nonprofit U.S. organization in 1992. It began operating under the name SMART Recovery in 1994, before which it was named the Rational Recovery Self-Help Network and was affiliated with Rational Recovery Systems, Inc. (RRS), founded by Jack Trimpey in the 1980s. RRS originally contained a substantial component of rational emotive behavior therapy (REBT), developed by psychologist Albert Ellis. There continues to be no significant literature on REBT as an evidence-based addiction treatment. However, REBT was generally consistent with the emerging evidence base on cognitive-behavioral therapy (CBT) as an addiction treatment. Many professionals seeking to support or refer clients to a CBT-oriented addiction mutual aid group were drawn to RRS.

In February 1991, about 20 addiction professionals from around the United States gathered in Dallas, TX, at the invitation of Trimpey, to begin work on expanding the fledgling network of mutual aid groups Trimpey had created as he traveled around the United States promoting his work. The first author attended this meeting and has been continuously involved with SMART Recovery as a volunteer ever since.

This informal board met again in August 1992 in Sacramento and decided to pursue incorporation as a nonprofit. The nonprofit would promote the expansion of the mutual aid network, while Trimpey would operate his for-profit business. The nonprofit and the for-profit were to be mutually

supportive. Incorporation was completed late in 1992. Galanter, Egelko, and Edwards (1993) conducted the first survey of RRS mutual aid participants in that year.

The next meeting, in Boston in 1993, established the nonprofit board of directors, with Joe Gerstein, M.D., as president. In 1994, the annual board meeting was held in San Diego, in conjunction with the annual meeting of the Association for Advancement of Behavior Therapy (now the Association for Behavioral and Cognitive Therapies). Increasing tension between Trimpey and the board culminated in the nonprofit changing its name and ending its affiliation with Trimpey.

This tension arose because the original intent of most board members was to establish a CBT-oriented group. Changes that Trimpey was making with RRS were taking that organization in other directions. The simplest resolution of the tension appeared to be for the organizations to end their affiliation. RRS continues to offer services and describes itself as "the exclusive, worldwide source of information, counseling, guidance, and direct instruction on independent recovery through planned, permanent abstinence, i.e., Addictive Voice Recognition Technique" (RRS, 2011).

Groups were informed of the change and offered the option of continuing their affiliation with the renamed nonprofit. For 2 months, the organization operated under the name Alcohol and Drug Abuse Self-Help Network, before choosing SMART Recovery as its operating name.

Without the leadership of Joe Gerstein from 1993 to 1995, SMART Recovery may not have survived. There was strong belief among board members and local affiliates that there was sufficient support for such an organization. SMART Recovery leaders were aware that Women for Sobriety and Secular Organizations for Sobriety already existed and were making progress despite the near monopoly of the 12-step spiritual fellowship. SMART Recovery garnered support because it was to be the first mutual aid group that explicitly looked to evidence-based addiction treatment for its approach, which would evolve as that evidence base evolved. However, even though conditions were promising, SMART Recovery might have dissipated without Gerstein's leadership, the multiple aspects of which are recorded by Allwood and White (2011). Gerstein's contributions have continued to the present time.

The board at that time consisted primarily of mental health professionals. Most localities had a professional advisor (later termed a volunteer advisor). The "peer professional partnership" model, although in operation from the beginning, would not be fully articulated until about 2008. For the first decade, as a solid base of recovering and longstanding volunteers emerged, SMART Recovery was governed primarily by professionals.

After its separation from RRS, SMART Recovery set about reestablishing itself. A central office was created in Beachwood (near Cleveland), OH, to coincide with the locations of the initial staff. Later, the office moved to Mentor, OH, also near Cleveland. Ultimately, Shari Allwood was appointed

full-time executive director in 2005. Her history with SMART Recovery began in 1994. Without her administrative and interpersonal skills, the organization would likely not have prospered as it has.

The first decade of SMART Recovery included the following significant developments:

- 1994: A quarterly newsletter (*SMART Recovery News and Views*) began. A version of SMART Recovery was offered in the Danbury, CT, federal women's prison.
- 1995: The foundational document of SMART Recovery (*SMART Recovery Purposes and Methods*) was ratified. The first Web site (later moved to http://www.smartrecovery.org) was established.
- 1996: A training grant was received from the Robert Wood Johnson Foundation, leading to the annual conference, Internet listservs for internal communication, and a recommended reading list.
- 1997: SMART Recovery entered the Arizona state prison system.
- 1998: Online meetings, an online message board, and an international advisory council were established. Joe and Barbara Gerstein gave the first of many international presentations, in the United Kingdom.
- 1999: SMART Recovery was established in Australia (by Alex Wodak and Bronwyn Crosby). The SMART Recovery Tools for recovery were written. The National Institute on Drug Abuse (NIDA) mentioned SMART Recovery in the Principles of Drug Addiction Treatment (then inexplicably deleted this reference in the revised 2009 edition). A Small Business Innovative Research (SBIR) grant from the National Institutes of Health for creation of the SMART Recovery correctional (prison) program, InsideOut, was made to Inflexxion. The Board of Directors began seeking nominations for membership from meeting participants and volunteers.
- 2000: At the beginning of the year, RRS announced that it no longer sponsored mutual aid groups, ending any competition between the organizations. Monthly training by conference call for volunteers began. The practice, which had occurred since the organization's inception, that there is no requirement that a facilitator be in recovery, was expanded to include active outreach for nonrecovering facilitators. SMART Recovery was introduced into the Scottish prison system. By the end of the year, SMART Recovery had more than 300 meetings.
- 2001: Online facilitators and face-to-face facilitators held their first joint meeting.
- 2002: Bimonthly online trainings began.
- 2003: A half million dollar anonymous unrestricted donation was received. The board decided to spend this money as seed money rather than reserve it as endowment (a decision that might have bankrupted the organization, but was validated by later growth). Translations of basic SMART Recovery materials were completed in Spanish, Portuguese, and Russian. The

Substance Abuse and Mental Health Services Administration awarded a training grant, which funded a conference and the development of several training videos.

- 2004: The SMART Recovery Handbook was published to replace the Member's Manual. The Australian organization received a grant for $250,000 for basic operations. Linda Sobell conducted a motivational interviewing workshop as part of the 10th anniversary celebration at the annual conference in Phoenix. The board held its first strategic planning meeting and established the following five goals: marketing, facilitator development and support, enhancing the Internet presence, fundraising, and the development of SMART Recovery Therapy (the last goal was dropped several years later).

In SMART Recovery's second decade, most of the established directions of the organization continued. There have been additional licensing agreements with organizations in other countries and increasing emphasis on international operations, translation of the handbook into eight languages, publication of additional written works and videos, presentations to outside groups and other marketing efforts, the award to Reid Hester of a second SMART Recovery-related SBIR grant for the development of a SMART Recovery Web course, the establishment of an annual participant survey, and the offering of advertising opportunities (taken up thus far only by treatment centers) to generate additional revenue. The Web site (http://www.smartrecovery.org) and its activities continued as a central focus of the organization. The first non-English online meeting (in Mandarin Chinese) occurred in Spring 2012.

The organization also established policy positions with respect to medications (that appropriate use of prescribed medications was acceptable) and the disease concept (that participants could believe whatever they believed about addiction as a disease, because that concept was irrelevant to the SMART Recovery approach to recovery). The disease concept position reflected an update from an original position that addiction was a complex maladaptive behavior rather than a disease. The new position paralleled the position taken from the beginning about belief in a higher power, that such a belief or lack of it was a personal matter for each participant and not relevant to SMART Recovery participation.

At present, funding comes from three primary sources: publication sales, advertising, and donations (individual donors and pass-the-hat contributions at meetings). The organization is operationally frugal, with fewer than three full-time-equivalent administrative staff in the United States and some additional contract workers for the Web site. As a further example of frugality, members of the board pay for their own travel expenses for annual meetings and are expected to donate themselves or help the organization raise funds.

The context in which SMART Recovery emerged was one of increasing frustration with the lack of diversity in addiction recovery. As CBT and other non-12-step approaches to treatment and recovery were emerging in the scientific literature, evidence-based practitioners observed that the treatment industry was adopting these developments very slowly or not at all. With the establishment of the National Institute on Alcohol Abuse and Alcoholism and the NIDA in the 1970s, there has been substantial funding for both research and training in addiction treatment.

In addition to professional frustration in the United States with the lack of alternatives to 12-step recovery, atheists and agnostics and their organizations object to the higher-power belief proposed by the 12 steps. Advocates of the separation of church and state, as required by the First Amendment of the US Constitution, have objected to the government, typically via a judge or probation officer, ordering individuals to attend 12-step groups, which can be viewed as having a religious aspect. A full discussion of the religious aspect of the 12-step spiritual fellowship goes beyond the scope of this article. However, a significant factor in the growth of non-12-step mutual aid groups has been the set of judicial decisions that prohibit the government from ordering individuals to attend 12-step groups because of their religious aspect. Although 12-step groups are often viewed as "spiritual but not religious," between 1996 and 2007, five U.S. federal circuit courts of appeal have rejected that distinction. It remains the government's option to order someone to attend a mutual aid group or treatment, provided that a nonreligious option is available. The SMART Recovery Web site maintains an updated list of relevant court decisions (SMART Recovery, 2011).

For SMART Recovery long-term volunteers (some affiliated for more than 20 years), perhaps the most noteworthy frustration has been the slow growth of the organization given the large need for it. Long-term volunteers appear to maintain their motivation by savoring the immediate feedback from newcomers, who describe how happy they are to find an alternative to the 12-step spiritual fellowship, and from ongoing participants, who often credit their recovery to involvement with SMART Recovery. Volunteers also hope that a "tipping point" is approaching, after which SMART Recovery and other non-12-step groups will be widely viewed as being of equal value to 12-step groups and will be equally available.

MEMBERSHIP

As of May 2012, SMART Recovery had more than 690 groups throughout the world, including multiple daily online meetings (S. Allwood, personal communication, May 31, 2012). Most face-to-face meetings occur in the United States, where they are available in most states. Significant meeting concentrations also exist in Australia and the United Kingdom. The SMART Recovery

Web site maintains a current listing of all meetings. Online meetings provide either voice or text communication. Although many addiction professionals have been generally frustrated by the lack of diversity in addiction recovery, many SMART Recovery participants seek out the organization because of quite specific frustrations. They seek a recovery approach that does not, for instance, involve a higher power, or powerlessness, or the labels "addict" or "alcoholic," or belief in addiction as disease, or lifetime attendance (Horvath & Sokoloff, 2011).

Data on SMART Recovery's membership are available, as are data on its precursor, RRS. The earliest of these studies is a national survey of 433 RRS attendees (Galanter et al., 1993), which found that respondents were mostly college-educated males in their 40s who were seeking help for an alcohol problem. A much smaller study of SMART Recovery found a very similar member profile (67% male; $M_{age} = 46$; 82% had a college or graduate degree; Li, Feifer, & Strohm, 2000). The 2010 SMART Recovery participant survey ($N = 444$) also found that two thirds of participants were male. This survey found that while more than half of respondents were relatively new to SMART Recovery (i.e., had been attending for less than 6 months), most respondents were regular attendees at meetings, with 68% of the total sample attending at least one face-to-face meeting per week. A survey of 154 SMART Recovery Online users revealed that 58% of respondents were women, 95% were White, and 69% were between the ages of 40 and 59 (von Breton, 2009). A UK study found that among the 65 people who attended the SMART Recovery groups created by the Alcohol Concern Project, 32% were women, the average age was 47, and 77% were seeking help for an alcohol problem (with an additional 11% seeking help for alcohol and drugs and 9% for drugs only). One quarter of attendees had at least 1 year of abstinence at the time they were surveyed.

THEORETICAL BASIS OF SMART RECOVERY

It might be stated that SMART Recovery does not have a theoretical basis. SMART Recovery teaches tools for recovery that are based on what has been shown to be efficacious in the addiction treatment literature and on what is otherwise known about addiction recovery. These tools could be drawn from any evidence-based approach, or any other finding about recovery, provided that two additional criteria are met: (1) Is the tool self-empowering? And (2) would the tool be suitable in a mutual aid group facilitated by a nonprofessional volunteer? Even though these three elements (evidence, self-empowerment, suitability in a mutual aid group) were not fully articulated until SMART Recovery's second decade, they have provided an ongoing and largely unchanged foundation for the organization's approach to recovery. On that foundation, the specific tools for recovery taught in a SMART

Recovery meeting will evolve as the scientific evidence about addiction and recovery evolves.

There is preliminary evidence that internal locus of control is predictive of participation in SMART Recovery (Li et al., 2000). When such individuals look to their futures, they perceive addictive behavior as an issue they can manage by learning new ideas and techniques and practicing them sufficiently until the goal is accomplished. In contrast, the external locus-of-control individual looks to the future and believes that life will be largely shaped by what happens to the individual, with the individual having much less capacity to change outcomes. These individuals appear to be more suitable for the 12-step approach, which is oriented around powerlessness and acceptance.

A description of this difference between internal and external locus of control can be based on the Serenity Prayer, by Reinhold Niebhur. This prayer is widely used in 12-step groups: "God, grant me serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference." If this prayer were used in SMART Recovery, it might be transformed into the Courage Intention: "I intend to have courage to change the things I can, serenity to accept the things I cannot, and wisdom to know the difference."

Recovery as well as life appears to require a mixture of both serenity (acceptance) and courage (effort). Internal locus-of-control individuals favor active and courageous solutions, whereas external locus-of-control individuals favor acceptance. These individuals may view themselves, at least with respect to addiction, as powerless.

For example, an acceptance approach to coping with craving might emphasize the inevitability of cravings, the impossibility of coping directly with them, and the need for reliance on outside support to get past them safely. An active and courageous approach might emphasize: (1) exposure and response prevention for eliminating over time or at least greatly reducing the intensity, frequency, and duration of cravings; (2) memory practice for recalling fundamental aspects of craving (craving is time-limited, does not harm one, and cannot force one to use) to outlast each craving; and (3) relapse prevention or recovery maintenance techniques for managing the environment to reduce the occurrence of cravings and to reduce the risk in high-risk situations.

SMART Recovery emphasizes this courageous and active approach to recovery, while recognizing that some courage and activity are likely necessary in any approach to recovery, and that acceptance of powerlessness over some aspects of life, such as aging and death, is necessary if one is to remain in contact with reality.

The SMART Recovery approach is therefore based on ideas, tools, and techniques arising from the addiction treatment and recovery literature that empower the individual to gain control over the antecedents of addictive

behavior. At present, evidence-based treatment approaches can be broadly divided into the following categories: CBT (including relapse prevention), motivational interviewing, behavioral couples, contingency management, addiction medication (e.g., methadone, buprenorphine, disulfiram), chemical counter-conditioning, and 12-step facilitation (Manuel, Hagedorn, & Finney, 2011). SMART Recovery tools draw inspiration primarily from CBT and motivational interviewing.

In addition to being self-empowering, the SMART Recovery approach needs to be workable in the mutual aid group environment, as facilitated by a nonprofessional volunteer. Therefore, many elements of the evidence-based addiction treatments just mentioned would not be applicable in SMART Recovery, even though they are self-empowering (e.g., couples sessions, the application of contingency management, medication management, and counter-conditioning procedures).

A last source of inspiration for the SMART Recovery approach is the accumulated wisdom about what might work in any mutual aid group. Meetings are structured enough to provide a sense of order. There are multiple opportunities for individuals to participate, but no requirement to do so. Social learning is facilitated by an emphasis on discussion rather than on monologue. In the 12-step spiritual fellowship, social learning is also facilitated by discussions with a sponsor, but there are no sponsors in SMART Recovery. Discussions are kept focused on the SMART Recovery approach as it might apply to the participants by a facilitator who is trained to be clearly in charge of the meeting. At least one SMART Recovery tool, brainstorming, arises from the need to maintain a cohesive group experience rather than from the addiction treatment literature.

REBT, developed by Albert Ellis, has also been a substantial influence on SMART Recovery, even though REBT itself is not an evidence-based treatment for addiction. However, REBT can be considered the pioneering form of CBT, which has clear empirical support. REBT includes a self-empowering philosophy of living and offers a wide range of literature that may be useful to participants. The ABC, a basic REBT technique (Activating event, underlying Belief, emotional or behavior Consequence), is one way to implement the core idea of CBT: It is not events but our interpretations of events that gives rise to our deliberate behavior. As Shakespeare has Hamlet state, “There is nothing either good or bad but thinking makes it so” (Act II, Scene 2).

SMART Recovery will continue to evolve as the scientific findings about addiction treatment and recovery evolve. It is conceivable that the SMART Recovery 4-Point Program might also evolve. For the present, these 4 points appear to provide an adequate framework for organizing the SMART Recovery approach, which supports participants in: (1) building and maintaining motivation, (2) coping with urges, (3) managing thoughts, feelings, and behaviors, and (4) living a balanced life. At present, these 4 points are implemented using a primary set of recovery tools, as shown in Table 1. The

TABLE 1 SMART Recovery Tools

Stages of Change: How ready am I to change?
Change Plan Worksheet: What do I want to change? Why? How much? How will I do it? What might get in the way?
Cost–Benefit Analysis: What are the costs and benefits of addiction, and of recovery? What conclusions do I draw after listing and comparing them?
ABC of REBT for Urge Coping: When I have a craving, what irrational beliefs do I typically have (e.g., craving makes me use, I can't stand having a craving so I need to use)?
ABC of REBT for Emotional Upsets: What irrational beliefs do I have about myself, others, or life and the world in general? Can I perceive how these beliefs lead to unnecessary emotional upset?
Destructive Imagery and Self-Talk Awareness and Refusal Method): I can expose the faulty thinking and misleading images that give rise to my cravings and vigorously counter-attack with an assertion of thoughts and images consistent with my long-term interests.
Brainstorming: In a meeting, all participants freely express any idea about a particular issue. Only after ideas are collected does discussion and evaluation of the ideas begin.
Role-Playing and Rehearsing: In a meeting, an expected difficult encounter is re-created for a participant to allow for practicing a constructive response.
Hierarchy of Values: What do I say is most important to me? Based on how I behave, what in fact appears to be most important to me? How different is what I say and what I do? What do I want to do about any discrepancies?

SMART Recovery Web site includes detailed descriptions about how to use each of these tools, as well as worksheets, exercises, coping statements, and information on additional tools. The tools will look familiar to professionals knowledgeable about CBT and motivational enhancement addiction treatment techniques. The tools will also appear to be "common sense" and thus have face validity to many participants unfamiliar with addiction treatment or the recovery literature.

The 4 points are not steps to be accomplished in a specific order, but tasks common to most individuals intending to maintain recovery. At different times in the course of recovery, different points may be more salient for specific individuals. Points 3 and 4 are ongoing challenges for all human beings. The tools are not a curriculum for recovery. They are presented as options for helping participants accomplish the 4 points. Most participants are likely to use only a few tools on a regular basis. The ABC and the CBA are the most commonly used tools.

A SMART Recovery meeting has the following sections: Welcome, Check-In, Agenda Setting, Discussion, Pass the Hat/Pass the Brochure and Announcements, Check-Out and Closing. The Welcome typically mentions that there is no charge for the meeting but donations are requested, that no one is required to participate, that the discussion should flow freely and interactively without monologues, that maintaining confidentiality after the meeting is expected, and that if anyone does not like how the meeting is unfolding, concern should be stated. In the around-the-room Check-In, participants may mention anything relevant to their recovery, except that

criticism of other recovery approaches is discouraged. The Check-In gives the facilitator a general sense of what might make for a good discussion with this particular group of participants. Which tool or tools to apply is at the discretion of the facilitator, although groups with experienced participants may collaborate with the facilitator during Agenda Setting to decide how Discussion time will be used. A participant may request Discussion time to address a personal concern. The facilitator may warm up a Discussion by beginning with a group exercise. During Pass the Hat, Announcements may include a reminder to inform others about SMART Recovery and an invitation to participate in scientific studies that SMART Recovery is supporting. The Check-Out is often the most interesting part of the meeting, as participants reveal what was most meaningful to them about what occurred. The management of the meeting process requires a confident and trained facilitator.

Because of SMART Recovery's commitment to evolving as scientific findings evolve, the ongoing involvement of professionals (both clinicians and researchers) is essential. At present, about half of the board of directors is professionals, and the other half are participants. Some directors are in both categories. The majority of the organization's approximately 700 volunteers began as participants, but a significant number are volunteer advisors (professionals) who support other volunteers in their localities and in some cases facilitate meetings. The International Advisory Council is listed in Table 2.

EVIDENCE FOR EFFECTIVENESS

Although the SMART Recovery program is based largely on evidence-based CBT techniques and secondarily on motivational enhancement techniques, there has been little research on the effectiveness of SMART Recovery itself. Little is known from an empirical perspective about the potential benefits of attending SMART Recovery meetings or the mechanisms through which involvement in the organization may exert its beneficial effects. Of the existing research, two cross-sectional, survey-based studies have examined characteristics of SMART Recovery members (e.g., religiosity, locus of control) relative to members of other mutual-help organizations, such as Alcoholics Anonymous (AA; Atkins & Hawdon, 2007; Li et al., 2000). One of these studies (Atkins & Hawdon) found a positive relationship between the extent of participation in mutual-help groups, including SMART Recovery, and the duration of continuous abstinence. This relationship did not differ according to the type of mutual-help group in which respondents participated, suggesting that participating in SMART Recovery may be just as helpful as participating in other mutual aid groups.

Another study compared 12-step-based and SMART-based intensive outpatient treatment programs for dually diagnosed patients (Brooks & Penn, 2003). This study found that the SMART Recovery-based treatment was less

TABLE 2 SMART Recovery International Advisory Council

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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. However, this study also suffered from several methodological problems that limited its internal validity (e.g., high dropout rate, unequal levels of treatment exposure across conditions) and external validity (e.g., intensive outpatient (IOP) treatment context that is not comparable to the context in which SMART Recovery groups typically occur, use of a sample of dually diagnosed individuals who may not be representative of most SMART Recovery members).

A qualitative study conducted in the United Kingdom provides information about the perceived helpfulness of SMART Recovery groups from the

perspectives of members (MacGregor & Herring, 2010). This study found that the vast majority of the SMART Recovery attendees who were surveyed found the groups to be very helpful and intended to continue attending within the next 3 months. Most had previously attended other mutual aid groups and reported that SMART Recovery was more useful than these other groups. Some of the benefits mentioned by participants were the emphasis on moving forward, the nonhierarchical nature of groups, and the shared experiences of group members.

RESEARCH OPPORTUNITIES

Because little research on SMART Recovery has been conducted to date, there are numerous research opportunities remaining. One of the most pressing practical issues is how to match participants to groups. For instance, it appears that having an internal locus of control is a predictor of interest in SMART Recovery, but the question has not been asked in a controlled fashion. There is also a small contingent of "atheist" AA meetings, which raises the question of whether participants in these meetings would fare better in SMART Recovery.

Given the comparable degree of success produced by widely divergent approaches to addiction treatment, the question about the effectiveness of a particular mutual aid group seems less important than the matching question. Presumably, all mutual aid groups will be found to be helpful in general, but there may be differences in effectiveness that depend on the goodness of fit between the group and the individual. Knowing more about who is more likely to benefit from SMART Recovery as compared with other mutual aid groups, for example, could save participants time and effort in the search for a suitable group. Given that searching for a suitable group may exhaust a limited supply of motivation, this question appears more pressing than the effectiveness question alone.

A set of questions that may be unique to SMART Recovery concerns facilitators. Numerous anecdotal reports suggest that the facilitator having an authoritative style (vs. laissez-faire or authoritarian style) is generally more important to the success of a SMART Recovery meeting than if the facilitator has knowledge of the SMART Recovery program itself. Unless the meeting is new, participants generally have sufficient knowledge about the program so that the facilitator's knowledge is not essential to the success of the meeting. However, a poorly managed meeting is a poor meeting regardless of the facilitator's program knowledge.

The laissez-faire ("anything goes") leader is unlikely to create a discussion environment in which participants feel safe enough to reveal themselves in any depth. The depth of self-disclosure, in any mutual aid group, is a predictor of the value of the discussion to participants. Typical problems

in an "anything goes" meeting include lengthy monologues rather than discussion, arguments, and off-topic discussions. The authoritarian facilitator squelches self-expression with an overemphasis on rules. Although the meeting may appear well organized, the heart of the activity, which is the sharing of personal experiences and perspectives, is lost. The authoritative facilitator balances enforcing a few rules with support for self-disclosure. Related research questions include: How easily can this authoritative style be taught? How can facilitators be selected to minimize training needs?

There are also questions about how to gain greater acceptance for SMART Recovery and other alternative approaches in the United States, where 12-step approaches dominate addiction recovery. Will change need to occur "retirement by retirement" or can overzealous 12-step supporters be persuaded to consider the diversity of recovery rather than insist that all individuals in recovery attend 12-step meetings? How might this persuasion occur? These questions may be as much political as they are scientific.

How should SMART Recovery respond to the numerous individuals who report having negative experiences or even feeling traumatized by their 12-step experiences (often when confronted about wanting an alternative approach)? SMART Recovery has elected to keep its meetings focused on addiction recovery and not focus on trauma experienced in other mutual aid groups. Should these issues be dealt with as part of SMART Recovery, in a separate mutual aid group established for that purpose, or in professional treatment?

Currently, many SMART Recovery participants also attend 12-step meetings. Many report that they attend "SMART Recovery for the tools and 12-step for the fellowship." Will this dual attendance diminish as more SMART Recovery meetings become available? How do dual participants benefit from both approaches?

What remains unknown is whether 12-step groups attract individuals who would have recovered even without a 12-step group, or would have recovered attending other types of groups, or would have recovered by being involved in some aspect of 12-step recovery that may be distant from the basic elements of the 12-step program. For instance, for some participants, the effectiveness of 12-step recovery might arise primarily from being somewhat public about making a commitment to change, or from having a regular activity to attend, or from having a new social network. Another approach to recovery that involved public commitment, regular activity, or a new social network might work as well.

It may be difficult to persuade investigators and funders to study alternative mutual aid groups when their availability is so limited, and 12-step groups are nearly ubiquitous. Nevertheless, a small body of literature on alternatives has emerged, and additional studies are in progress. Of central interest might be the question of efficacy. However, alternatives probably cannot overcome an issue already noted for the conduct of research on

12-step groups: "These studies are necessarily correlational, evaluating the extent to which these two factors—attendance and outcome—covary, without establishing whether one causes the other" (Miller, Forcehimes, & Zweben, 2011, p. 228).

However, efficacy (in controlled scientific trials) may be too high a standard for any mutual aid group, especially given the difficulty of studying them in a controlled fashion. A group could be considered effective (in the real world) if participants elect to attend. By this standard, 12-step groups have been very effective, because so many individual have attended them. However, given that most individuals who are referred to AA do not attend, and most who attend drop out quickly (National Academy of Sciences, 1990), 12-step groups alone are ineffective relative to the size of the population that needs recovery. Although it appears unlikely that any other single mutual aid group would fare better, it is highly plausible that a more diverse array of recovery mutual aid groups would attract a larger portion of the population that needs recovery. Therefore, there would appear to be incentive for studying emerging mutual aid groups and for whom they are a good match, even if for the moment they are not widely available.

FUTURE DIRECTIONS

Future directions for the SMART Recovery program will largely be based on new scientific evidence about what approaches or techniques are effective for helping individuals overcome addiction. Future directions for the organization are largely centered on how to achieve a sufficient size (perhaps 5,000 meetings in the United States) so that participants are not significantly inconvenienced, relative to 12-step meetings, to attend SMART Recovery. To achieve this size, the organization will need to continue to improve its capacity to recruit, train, support, and oversee volunteer nonprofessional facilitators, who are the backbone of the organization.

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