The Good, The Bad and the Unknown: Updates in 12 Step and Recovery-Oriented Approaches

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Objectives

- Understand how current changes in frameworks for the provision of healthcare serve as contextual forces that may benefit or threaten addiction treatment.
- Understand weaknesses in the evidence-based practice movement, and the associated difficulties with researching 12 step recovery and 12 step facilitation practices.
- Examine research findings related to 12 step recovery practices and their relevance to sobriety and recovery management following formal treatment.
- Identify how individual patient variables and styles of 12 step engagement can be understood to improve 12 step facilitation during formal treatment.
- Identify directions for future research in understanding the mechanisms of 12 step recovery in clinical populations.
Sources of Controversy

- DSM
- Diagnosis
- Psychopharmacology
- Psychiatric genetics
- Market pressures
- Vested institutional interests
Recent Literature

A Special Article

Post-treatment Evaluation vs Recovery Monitoring

• Tom McLellan: Addiction Severity Index (ASI) for pre/post measure of addiction treatment.

• Michael Dennis: Global Appraisal of Individual Needs (GAIN)

• Bill White: Recovery Oriented Systems of Care (ROSC).

• Trend: Continuous Recovery Monitoring
  – Disease management/recovery management approach
  – Coaching/assessment blended
  – Recovery support and functional outcomes
Background
Background

• Jung:
  – “real religious insight” and
  – “protective wall of human community” characterized by a
  – “personal and honest contact with friends”.

Background

- Cult
- Doesn’t work
- Saved my life
- Only way to recover

Background

• Clients use treatment and 12 step programs as recovery activities.

Background

12 step principles have been added to short term treatment, therapeutic community, psychotherapy, adolescent programs

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<th>Formal Treatment</th>
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<td>• Weeks or months duration</td>
<td>Life-long participation</td>
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<td>• Professionally delivered</td>
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<td>• Fee</td>
<td>Free</td>
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<tr>
<td>• Wide array of services</td>
<td>Limited focus</td>
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Demographics
Demographics

• 3% of Americans will attend an AA meeting at some point in their lives.

Demographics

- 55,000 AA groups meeting weekly (2008) with 5 million attending annually.

Demographics

• AA started in 1935
  – 2 million members worldwide
  – 200,000 weekly meetings
• NA reports 58,000 meetings worldwide.

Demographics

• 40% of AA members report no prior treatment.

Demographics

• 78% of those in outpatient treatment have attended a 12 step meeting

• These are not mutually exclusive recovery alternatives.

Demographics

• Those staying in AA longer attended AA first (rather than going to treatment first).

Demographics

• Looked at new self-help members
• 57% had an agency or professional described as main factor motivating their first attendance – majority of them, compulsory.

Demographics

• Abstinence co-varies with:
  – older
  – self-identified as religious
  – treatment (greater baseline severity)

Demographics

- Women attend as much or more and get as much or more out of attending;
- Working with men?
- More women were in the 3 highest classes of attendance by year 9, than in the drop out classes.

Demographics

- **High and rising** attendance classes had higher average baseline problem severity.
- **Descending** attendance class and early drop out were older.

Demographics of the 4 class solution

• Atheist/agnostic:
  – 22% of the Low group
  – 17% of High group
  – 12% of Medium group
  – 10% of Descending group

• Low attendance group had:
  – Lower baseline alcohol and drug problems on ASI;
  – No other ASI domains were different;
  – Lowest treatment rates over time.

Demographics

- Attendance vs Abstinence by year 9:
  - 75% of *high attendance* class reported 30 day abstinence at all follow ups
  - 57% of *descending*
  - 53% of early *drop out*
  - *Rising* were 46% at yr 1; 65% at yr 9
  - *Low* were fluctuating in the 40’s% at all contacts

- No attendance = 42% yr 1, and about 33% stable at all further follow ups

- Overall, high is best and none is worst

Critique of Empiricist Approaches
Critique of empiricist approaches

• “Evidence-Based Practice” and “Best Practice” are often used interchangeably.
• Prominence due to search for, and promotion of, “Empirically Supported Treatment”
• Growing demand for proof of effectiveness, impacting type and quantity of services: what gets reimbursed, practiced, included in educational curricula (at expense of other approaches)
• Criteria for what constitutes EBP: concerns on conceptual, cultural and methodological grounds

Critique of empiricist approaches

- EBP is considered by some a pretense to promote narrow/medicalized approaches to research methods and easily measured outcomes
- “Best” becomes institutionally dominant;
- Other recovery and clinical practices are marginalized
- Emphasis on treatment models at expense of
  - Person (counselor; patient)
  - Counseling relationship
  - Non-diagnostic characteristics
Critique of empiricist approaches

• Terminology includes
  – “Empirically-validated treatment”
  – “Empirically-supported treatment”

• Developing standards for content of treatment manuals
• Manualized does not need to mean
  – mechanistic
  – unresponsive

• Guarding against deterioration in certain interpersonal and interactive aspects?
Critique of empiricist approaches

• What suffers under manualized approaches?
  – Clinical judgment
  – Intuition
  – Creativity
  – Flexibility

• Reduced appreciation of:
  – Diversity considerations
  – Developmental frameworks
  – Person-centered considerations
  – Wellness
  – Strengths
  – Recovery-orientation
Critique of empiricist approaches

• Research trial world:
  – Single diagnosis
  – Focus on short-term
  – Symptom reduction or acute treatment response

• Real-world:
  – Not a pre-fixed duration
  – Is self-correcting
  – Focus on overall improvement or recovery
  – Longer term focus
Critique of empiricist approaches

• CBT lends itself to EBP evaluation methodology
  – Reductionistic
  – Objectivism
  – Structured
  – Symptom focused
  – Shorter term

• Less focus on: satisfaction, wellness, progress, insight, improved self-esteem, sense of personhood, emotional self-awareness

• Are EBP’s an artifact of methodological logistics?
Critique of empiricist approaches

**Assumption**: that diagnosis is best indicator of appropriate treatment, versus

- Multiple dimensions
- Personality factors
- Developmental dynamics
- Sociocultural factors
- Environmental context, and
- Other non-diagnostic characteristics and circumstances
Critique of empiricist approaches

Assumption: treatment itself is the primary determinant of outcome – that is, “ingredients” vs:
- Other factors by higher percentage
- Client factors
- Expectancies
- Therapist variables, etc.

Assumptive world: Research culture of quantitative empiricism and a medicalized conception of counseling, emphasizing diagnosis and prescriptive technique
Critique of empiricist approaches

Consequences:

• Randomized controlled trials go to schools of medicine in large research universities;
  – Thus, which models tend to be studied?

• Are we measuring what is most likely to be studied or most likely to work?
  – Other approaches face obsolescence or even malpractice scrutiny.

• Counselors are reduced to expert technicians implementing BP guidelines, and clients are reduced to disorders
  – Pre-packaged, time-limited treatment,
  – Harder for counselors to explore subjective dimensions of client concerns and their sense of change strategies
Critique of empiricist approaches

• Efficacy of EBP with various minority groups not well explored;
• EBP’s bear imprint of Western, middle-class values:
  – individual autonomy and satisfaction over
  – interpersonal harmony and collective responsibility
• EBP’s dominated by CBT and DSM, marginalizing contextual and socio-political influences on mental health, limiting helping.
• What is the assumptive-world antecedent to EBP’s?
• Are EBP’s an artifact of what was established before the fact?
Critique of empiricist approaches

Needed Lines of Inquiry

• Focus on understanding
  – the basic principles and strategies of change
  – rather than theoretically linked techniques

• Explore 12 step facilitation, alliance, empathy, goal consensus, and collaboration

• Develop tailored therapeutic strategies factoring in levels of:
  – Reactance
  – Internalizing/externalizing coping style
  – Treatment preferences
  – Readiness for change
Critique of empiricist approaches

Lines of Inquiry

• If interest is limited to *observable and external symptoms and behaviors*, then narrow empiricism is justifiable.

• If interest is in *internal dynamics, self-concept, meaning and life narratives*; a qualitative approach should be added, and can still have rigor.

• What can we learn without excessive weighting of random controlled trials?

• **Develop practices resting on 3 pillars:**
  - Best research
  - Clinical expertise
  - Client non-diagnostic characteristics
Critique of empiricist approaches

• 1,391 people considered; excluded based on:
  – no use last 60 days
  – treatment in the last 30 days
  – less than grade 6 reading level
  – no stable residence
  – on methadone, or naltrexone, or antabuse
  – regular IV use past 6 mos
  – gross cognitive impairment
  – medical or legal problems interfering
  – no collateral,
  – no interest in participating
  – did not regularly attend 1 wk of IOP.

Critique of empiricist approaches

Of the original 1,391:

- 16.9% met eligibility criteria and further approached
- 36% declined or entered and dropped out of the study
- 149 enrolled and completed the study.

Critique of empiricist approaches

- Randomized trials are difficult with 12 step attendance and abstinence.

How To Look At This?
How To Look At This?

- Look at frequency, duration, trajectory, etc. rather than AA participation as a dichotomous variable.
- Look at impacts across delayed entry following treatment, and if they are independent of treatment.
- Need to look at psychological and social outcomes, not just drinking; look at drinking-related outcomes other than abstinence.

12 step - Impact Treatment?
12 step - Impact Treatment?

- Those with prior 12 step affiliation state staying off of drugs and changing their drug-using lifestyle as reasons for entering treatment (vs. criminal justice or family reasons).

- Weekly or more frequent pretreatment attendance of 12 step meetings only predicts about 1% of variation in weeks of treatment participation.

- Frequent 12 step participation pre-treatment is associated with staying in treatment slightly longer, and more likely to discharge successfully (not a mere function of treatment motivation, drug use severity, treatment history or demographic differences).

12 step - Impact Treatment?

- Self-help affiliation is a predictor of reduced substance use in Partial Hospital level of care, but is unrelated to symptom reduction.

Treatment – Impact 12 Step?
Treatment Impact on 12 Step

Treatment Completion Status

• Length of treatment is associated with post-treatment 12 step involvement.
  – Treatment completion status is not

• Treatment completion status per se does not predict contact with a sponsor.

Treatment Impact on 12 Step

• Treatment intensity beats content of counseling for self-help affiliation, but both are significant

Treatment Impact on 12 Step Attendance Trajectory

- 349 alcohol dependent individuals entering treatment re-interviewed at 1, 3 and 5 yrs.
- 4 groups fell from the sample, with no differences in ethnicity, gender or age:
  - Low attendance group attended for first 12 months
  - Medium attendance group sustained attendance
  - High attendance group sustained attendance with some decline at yr 5
  - Declining group started as high group for yr 1, medium group for yr 3, and low group at yr 5;
    - This group has “wet” or “using” influences
Treatment Impact on 12 Step

• By year 5:
  – All supports in all groups declined, but “high” and “medium” groups had twice the amount of people supporting them as “low” and “declining”
  – 80% of high group were abstinent
  – 75% of medium group
  – 20% of low group

Treatment Impact on 12 Step

• Little evidence of a strong relationship between treatment exposure and attendance over time.
• For the descending group there is an inverse relationship between treatment and AA, so one may influence the other as a “substitute”.

Duration vs. Frequency
Duration vs. Frequency

- **Frequency** of participation is associated with
  - higher abstinence
  - higher social functioning

- **Duration** of participation in the first year is related to
  - better status on all 3 of the 8-year outcomes
  - better self-efficacy

Duration vs. Frequency

- Frequency of AA participation was independently associated only with abstinence.
  - 2 or more meetings per week = more likely to be abstinent than no attendance
  - No attendance = 21% abstinent
  - 2-4 meetings per week = 42% abstinent
  - More than 4 meetings per week = 61% abstinent
Duration vs. Frequency

- Duration of AA participation predicted better status on alcohol related outcomes (abstinence, drinking related problems, and dependence symptoms) and social functioning
  - 1-16 weeks = no better 1yr outcomes than non-attenders
  - 7-32 weeks = better 1 yr outcomes on all 3 alcohol variables than non-attenders
  - 33 or more weeks = better 1 yr alcohol outcomes as well as social functioning
Duration vs. Frequency

• 8 yr follow up:
  – 1-16 weeks in year 1 = no difference from non-attenders
  – 17-32 weeks in year 1 = better on alcohol indices & self efficacy than non-attenders
  – No attendance year 1 = 35% abstinent
  – 2-4 per week year 1 = 57 %
  – More than 4 per week year 1 = 73%

  – Those delaying participation for a year = no different from those that did not participate; looks associated with depression.
Duration vs. Frequency

• Over the long haul, duration seems vital, vs frequency.

Mechanisms of Change
Mechanisms of Change: Big Picture

• Claims it helps due to spirituality.

Mechanisms of Change: Big Picture

- Changes accounted for by:
  - free
  - long-term
  - easy access
  - recovery-related therapeutic elements
  - similar to therapy content

- Overall, the 12 step “program” and the “fellowship” are two broad components at work

Specific Mechanisms of Change

• 3 mechanisms seem to be in operation:
  – Common processes
  – AA-specific
  – Social and spiritual

• Common process factors:
  – Enhancing self-efficacy
  – Coping skills
  – Motivation
  – Adaptive social network changes

• Little empirical support for specific practices and spiritual mechanisms

Specific Mechanisms of Change

• Mechanisms seem to include:
  – cognitive changes
  – affective changes
  – spiritual changes
  – behavioral changes
  – mutual sharing
  – helping others
  – observational learning
  – group dynamics
  – health-promoting social network development

Specific Mechanisms of Change

Common factors:
- Greater use severity = more AA participation; impacting one’s belief in capacity to abstain
- Mediating factors
  - self-efficacy
  - commitment to abstinence
  - active coping efforts
  - primary appraisal
- May have a developmentally-specific nature

Specific Mechanisms of Change

AA-specific factors:

– Commitment to abstinence and intention to avoid high risk situations predict abstinence at follow up

– AA-related commitment and belief in HP predict lower relapse severity.

Specific Mechanisms of Change

• Participation helps by:
  – facilitating change in social networks
  – coping
  – motivation
  – self-efficacy in high risk situations
  – reducing negative affect and
  – improving psychological wellbeing

• Spirituality and social network changes are sources of variance, and may differ in individuals.

• Social change appears important across stages of treatment.

Specific Mechanisms of Change

• AA attendance during first 3 months of treatment is associated with benefits 1 year later, with social variables weighing heaviest:
  – reducing pro-drinking network, and
  – enhancing self-efficacy

• During recovery, AA is effective in:
  – helping avoid alcohol-related cues, and
  – gaining social support for stress

Specific Mechanisms of Change

Spiritual framework benefits:
- structure for self-forgiveness and
- reduces depression

Specific Mechanisms of Change

• AA attendance is associated with increases in spirituality, and this is associated with sober days

• Spirituality associated with percent of days abstinent, and inversely with drinks per drinking day

• Pathway is the use of spirituality outside of meetings: generalizability and promotes further change
  – Same as with other illnesses.

• Own HP leads to reduced barriers, and increases beliefs and practices, thus reinforcement

Specific Mechanisms of Change

• 3 spiritual styles:
  – self-directing
  – deferring
  – collaborative

• “Collaborative” spiritual style increased coping with chronic illnesses

What Works?

• 12 step facilitation (TSF) overall matches CBT and MET
• TSF has superior results for those with lower psychiatric severity and those with more alcohol severity.

What Works?

- Those treated in TSF have greater 12 step participation than CBT (higher dose and frequency of care with CBT, and inpatient days);
- TSF had greater abstinence rates at 2 year follow up
  - CBT still relying on clinical services

What Works?

- TSF beats CBT for substance-specific coping
- Those with higher alcohol severity in TSF = higher changes in:
  - meeting attendance
  - reading AA literature
  - step work
- These are associated with better 12 month outcomes

What Works?

• Stronger relationship between self-help affiliation and outcome for 12 step-based treatment
  – compared to eclectic care or CBT
• Therefore, similar orientations are important.

• Combining weakens therapeutic effect of self-help affiliation.

What Works?

- Proximal outcomes could merely influence common factors
  - Reading literature works, but why? Renews commitment to common factors?

What Works?

• EBP’s *do exist* to help increase AA participation.

What Works?

• Over a quarter of treatment effect size is explained by social support;
  – important to intervene on this variable
• Control of comfort being and speaking at 12 step meetings is important;
  – comfort variables are highly predictive of abstinence
• Those with less AA exposure may need to focus on basic principles of 12 step philosophy (education) before they benefit from measures that emphasize comfort with 12 step fellowship

Co-Occurring

- Is AA an antidote to negative affect of early recovery?
- Attendance associated with reduction in depression, through reduction of drinking.
- More attendance associated with greater beneficial impact.
- Principles of instilling hope, universality, group cohesion, and catharsis are operative in improving psychological adjustment
  - vs the belief that AA emphasizes powerlessness, surrender and character defects, resulting in negative impacts

Sponsorship

Any AA attendance is better than little or no attendance, but what about connection with sponsor?

• After controlling for attendance, high sponsorship predicts better abstinence outcomes.

• High sponsor = higher odds of abstinence.

Sponsorship

• Low, descending and high involvement over years.

• Gradients found for attendance, by sponsorship class:
  – 81% of low sponsor class = low attendance
  – 40% of descending sponsor class = descending attendance
  – High sponsor class = similar proportions from high, descending and medium attendance classes

• Gradients found for abstinence, by sponsorship class:
  – 75% of high and 56% of descending in the high abstinence class
  – 66% of low abstinence were in the low sponsorship class

• High and descending sponsor = higher odds of abstinence, controlled for attendance

Sponsorship

Overall:

• Over half reduce their attendance and sponsorship over time, and remain abstinent

• Majority of those with low abstinence over time reported the lowest attendance and sponsorship

Helping

- Helping during treatment predicted 12 step involvement at follow up
  - This effect held after excluding service work and sponsoring

- 12 step participation at baseline did not predict helping during treatment – may be explained by gap in time

Helping

- Helping may help due to:
  - Increasing commitment
  - Perception of importance to others
  - Social status
  - Sense of independence
  - Known association between helping and psychological health

- Altruism is one of Yalom’s 12 curative factors

- “Helping” consisted of:
  - Sharing
  - Giving moral support
  - Giving encouragement
  - Explaining how to get help (this provided the lowest impact)

Helping during treatment may:
- Prepare people to share reciprocally
- Understand and accept 12 step philosophy
- Respond positively to social demands,
- Facilitate integration with 12 step groups

Therefore, make helping part of treatment
- Programs clearly influence helping behavior
- Those drinking while attending may avoid interdependent relationships – needs to be examined.

A Tool

• “Recovery Interview” assesses self-help affiliation and 12 step behaviors. Looks at:
  – Attendance
  – Reliance on sponsor
  – Engagement in 12 step activities
  – Attendance at Step meeting
  – Use of prayer or meditation
  – Use of 12 step resources for advice and information,
    degree of 12 step centered life

Overall Results
Overall Results

• Prior 12 step involvement, not treatment motivation, predicts:
  – Treatment completion
  – 12 step involvement after treatment
  – Abstinence

• Additive effects in odds of abstinence are provided by:
  – Treatment participation
  – Length of treatment
  – Weekly 12 step involvement
  – Separately, more is better – collectively much more is much better.

Overall Results

• Regardless of type of original treatment, those attending AA have better outcomes.

Overall Results

• 4 class solution:
  – Low = largest = less than 5 meetings at most follow ups (since last follow-up)
  – Medium = about 50 meetings in year prior to each follow up
  – Descending = attendance at 1 yr declined steeply then stabilized
  – High = high with steady decline

Overall Results

- Abstinence lowest among Low, and highest among High
- Initial decline in attendance of the Descending group did not correspond with reductions in abstinence, nor was the drop in in the High group
- Rather, abstinence was up for both groups at yr 7.

Overall Results

- Gender and marital status do not predict 1 yr outcome except that:
  - women had fewer drinking problems than men and
  - married report fewer dependence symptoms and more self-efficacy than those not married

Overall Results

Looked at 3 groups of individuals over 16 yrs, untreated previous to the study:

• Joined AA, but no treatment in the first year
• Treatment, but no AA in the first year
• Treatment and AA in the first year

Examined:

• Patterns of participation
• Motivations and perceptions of benefits
• …and…

Overall Results

• Remission rates with a look at frequency and duration:
  – Tx only = sees problem less important and treatment as less helpful (vs AA only, and Tx+AA)
    • AA = treatment priming?
  – Tx+AA = higher remission than Treatment-only
  – Tx+AA = longer AA duration and more frequent meetings in the first year

• Duration has a higher correlation with abstinence than frequency

Overall Results

• Those with greater use and higher problem severity = do poorly when not affiliated with self-help

• Treatment facilitates self-help affiliation:
  – Affiliation during treatment predicts affiliation after treatment…
  – …which predicts post-treatment sobriety; level of OP primary care was not a factor

• Lower functioning overall is associated with higher affiliation needs for good outcomes

Overall Results

Dropping out or not attending:

• Longer average treatment is associated with early drop out;

• Those with no attendance had shorter treatment episodes than all other classes

Take-Aways

• “Social neuroscience with primates shows it is plausible that rich social integration that occurs in AA may accelerate up-regulation of dopamine D2 receptors, a higher density of which is shown to protect against relapse”.

Take-Aways

• AA participation reduces overall need for treatment.
• Non-connection with first choice of helping modality at higher risk.


• Coming back bodes well for abstinence.

Take-Aways

• Some:
  – never connect
  – connect but don’t stay with it
  – immediately connect and stay almost daily
  – connect and stay with it but not so tightly
  – take it to heart and feel like a member but attend few meetings

• AA graduate? AA tourist?

• Positive disengagement vs “slip” vs “falling off” vs “successful”

Take-Aways

• Treatment primes longer and more frequent participation in AA in yr 1

• Prior treatment predicts declining AA attendance after treatment, therefore programs should help people connect beyond mere attendance.
Take-Aways

• These 4 classes/groups seem robust across samples
• High group needs high participation, descending group does not; medium group gets what they need

• There is high drop out over the long term. So, assess barriers and other variables that threaten AA involvement
Take-Aways

• Treatment should focus on reducing barriers to AA; this would raise remission

• Promote high attendance early
  – early drop outs that had attendance near to the high attendance group = a fairly high abstinence rate at year 9

• Avoid indiscriminate and generalized recommendations as identical for all problem severities
Future Studies
Future Studies

• Drift of individuals across groups was found = area for further study.

• Examine step work, reading, sponsor relationship, number of friends in Fellowship as variables.

• Examine characteristics of who will benefit and optimal frequency and duration; as well as personal and contextual factors of drop out; role of AA and other life context factors
Future Studies

• Why and how do varying SA severities benefit? What and how, to engage and facilitate?

• Need to move beyond brand-name (CBT, eg) interventions and examine proximal outcomes that facilitate end point outcomes; move beyond top-down research to bottom-up approaches focusing on process – rather than simple race horse comparisons between community and science-based interventions.
Future Studies

• Treatment length is less clearly associated with abstinence in binge drinkers;
• Future research should look at examining why they are less likely to benefit from formal treatment and how to associate helping with binge drinking – they do benefit from informal relationships, it seems

Future Studies

• Areas to examine:
  – Treatment careers, natural course of treated populations;
  – Medical utilization
  • Predisposing (propensity to seek out services)
  • Enabling (formal and informal resources that influence doing something about one’s problem)
  • Severity factors that serve to facilitate or impede help seeking (need; imperative; problem severity)

A Special Article


• Using data sets from 6 NIH random controlled trials, employed a statistical technique to estimate whether AA participation itself improves outcomes, or if improved outcomes are an artifact of self-selection.

• Evaluated percent days abstinent and percent days attending a meeting – from before start of treatment and at 3 month and 15 month follow-up after the start of treatment
Humphries, et al Continued

• “AA appears to actually benefit people with drinking problems rather than simply cobbling together individuals who would have improved without it.”

• “AA involvement was effective at increasing days of abstinence. These benefits were in addition to those of the core AA Facilitation Intervention itself.”

• Benefits persisted to the 15-month follow-up.

• Exception for those with a high level of pre-existing AA involvement: the value of even higher attendance was blocked by an apparent ceiling effect.

• Greatest gains are in going from no attendance to some, and from light attendance to steady – rather than heavy attendance to even more heavy.
• AA participation had a benefit not attributable to self-selection bias.

• Reasonable, as meetings are characterized by many processes generally found to be therapeutic:
  – Social support for behavior change
  – Dry friendship networks
  – Opportunities for altruism
  – Availability of role models
  – Installation of hope
  – Practical skill teaching
Future Path for Research


• Develops possible links “to the way certain biologically grounded mechanisms, empirically derived, can play a role in the way that such fellowships achieve their effectiveness.”

• **Long-term abstinence** and **recovery processes**
  – Distinguished from our current model of addiction disease that is based on acute drug effects and shorter-term changes in neural function.
  – Work on comparable neural mechanisms (e.g. models of craving).
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Galanter 2014 continued

- **Mirroring and mutuality** (not “self-help”)
  - Connecting to other members
  - Ability to resonate with experience of others, understanding one’s own mental state: “mentalizing”
  - When an experimental subject, monkey or human, sees another perform an action.
  - 1. Mentalizing; 2. Sharing of self-other representation (experience sharing); 3. Helping

- **Two types of empathy**
  - “Emotional contagion” (e.g. the emotional impact of an infant on an adult).
  - Cognitively grounded empathy/perspective taking
  - Example of hearing one qualify at a meeting; sharing the experience of the struggle
• Integration of memories obtained from new information
  – Procedural memory: skills executed automatically and unconsciously (vs. explicit memory recall)
  – Imaging studies show procedural learning, memory, and retrieval found to take place outside of awareness
  – Aspects of the 12 Step program can be acquired in passive attendance, without speaking with others (loitering with the intent to recover?)
  – Embeds information, perspective, ideologic orientation, and sustains singularity of message
• **Schemas**
  - Tolman: “Cognitive map”
  - Piaget: children acquiring and integrating information into coherent concepts
  - Past reactions and experiences summed in storytelling
  - Self-schemas and social stimuli
  - Once established, schemas provide a basis for dealing with new stimuli, and associated thoughts and behaviors.
Galanter 2014 continued

• **Storytelling**
  – Reinforcement of the acquisition of shared identity
  – Occurs through shaping, including shaping of neuronally-grounded personal schemas
  – Self-disclosure is associated with increased activation in the mesolimbic DA system
  – In experimental situations, subjects are willing to forego money in order to disclose about themselves

• **Personal Values**
  – Acknowledging role in problems previously attributed to others; later making amends; helping others
  – Management of social norms; examination of empathic concern for members of two teams – opposing team member vs fan-team
  – Activation of anterior insula predictive of helping the in-group member (favored team)
• Higher Power
  – Turning one’s life over to God as we understood Him; Re-framed as resolution of cognitive dissonance
  – See self as capable of non-problematic drinking at times
  – Avoid drinking at other times
  – Through attendance, understand self as “powerless over alcohol” resulting in dissonance
  – Acceptance of Higher Power that governs/guides toward reconstructed abstinent recovery
  – Obviates living with two dissonant beliefs: control and lack of control
  – Brain regions associated with dissonance and associated mechanisms, reconciling conflicting perceived stimuli, negative affect and autonomic arousal
A Few Resources

Web sites:
• A large repository of articles can be found at www.williamwhitepapers.org
• Examples of tech-based recovery supports can be found at www.mobilewellnessandrecovery.com
• A collection of guidelines for evidence-based practice (and supporting papers) can be found at www.bhrm.org
References


References


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Afterward 1 of 4:

- What about practice-based evidence?
  - Inclusion/exclusion criteria of research participants and protocols tested are so tight that they have no applicability to real clinical practice. That is, clinicians are not able in real practice to filter their patients so extremely, or conduct a protocol so tightly.
  - The field needs research trials in real-world clinical services with real-world inclusion criteria.
  - One criticism of the traditional residential program is that it is too cookie-cutter. But what’s more cookie-cutter than a CBT manualized protocol?
Afterward 2 of 4:

• The plural of “anecdote” is “data”.
  – Researchers relegate anecdotal data to last-place in value. But the lives of people in recovery aggregate to a large data sample.
  – A surgeon who has done 10,000 of the same procedure has something valuable to say about the illness and course of care.
• “CBT is best” derives from, and is an artifact of, our limitations in measurement technology.
  – CBT lends itself to being measured within our current abilities to measure, so it wins.
  – Future advancements in measurement technology might allow other therapies to compete equally and demonstrate higher efficacy.
Afterward 4 of 4:

- Why is addiction treatment held to a standard of symptom-free remission?
  - Chronic diseases have patterns of remitting and returning symptoms.
  - If it were any other disease, a return to symptoms after stopping care would be interpreted as care being effective.
  - Corollary: why require someone to “fail” at a lower level of care first? Do no harm?