

President's Column

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The scientific foundation of SMART Recovery

(This article is based on a presentation made by Dr. Horvath at the SMART Recovery Annual Training Conference in Washington, DC, on November 7, 1999)

Consider how prescription medications (and medical devices) become available in the US. To simplify, if a medication is thought to have promise, it is tested in a series of experiments. The final stage of experimentation is the clinical trial, a test of effectiveness using humans who have the disorder the medication is intended to treat. The medication is tested against placebo (a pill that contains no medication) or against a medication (or other treatment) that has known effectiveness in treating the disorder. Half of the patients in the clinical trial are given placebo (or known medication) and half are given the medication being tested. If the new medication performs better than placebo, or comparably well to the known medication, it is approved by the Food and Drug Administration (FDA) and becomes available for healthcare providers to prescribe.

Consider how non-medication, non-device treatment procedures become available. There is no "FDA" for procedures, and no formalized process of becoming "approved." As procedures are developed and become known, it is up to the individual healthcare provider to "approve" them for recommendation to individual patients. Of course, providers operate in communities, and treatment guidelines and standards of practice are developed, based on the findings of scientific research. Procedures are tested in the same way as medications, in clinical trials where the new procedure is compared to a no-treatment control group, or to a comparison group treated with a procedure of known effectiveness.

Treatment guidelines and standards of practice, however, may vary from region to region, and profession to profession, because there is no single authority like the FDA. There is also no required "labeling" for procedures, as there is for medications, and thus no easy way for the patient to learn about the procedures under his or her consideration. Thus the provider has considerably more flexibility in selecting a procedure than in selecting a medication (which can only be chosen from an approved list), and the patient has a greater burden if in depth information about the procedure is desired.

What about treatments for addiction problems? Although there are a handful of addiction medications (which have been approved as described above), most available addiction treatments are procedures. The number of clinical trials has been greatest for alcohol problems. Procedures for treating other substances are second, and procedures for activity addictions are a distant third.

Let us focus on alcohol treatment procedures. There are over 250 clinical trials reported in the scientific literature (including some medication trials). There is reason to think that treatment procedures for alcohol problems may generalize to other addictions, so these studies shed some light on treating addiction generally. What do they reveal? To answer that question you would need to review the studies individually. Or, you could consult the summaries written by scientists who have already done this. There are a handful of scholarly summaries of the alcohol treatment literature. The most accessible is the *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, edited by Hester & Miller (Allyn & Bacon, 1995). This book has a lengthy chapter to review the scientific evidence (211 studies as of that date), and chapters describing those treatment procedures that have been found to be effective. Of the many treatment procedures for which clinical trials have been conducted, one half dozen are clearly shown to be effective.

This effectiveness is supported by consistent findings across several studies. What are these treatments, and what might they have in common? The treatments include the community reinforcement approach, behavioral self-control training (moderation training), brief intervention (not the same as the Johnson Institute "intervention" in which someone is unexpectedly confronted), behavioral marital therapy, motivational enhancement therapy, and coping and social skills training. You may recognize the last two treatments as being in Project MATCH (the third treatment in MATCH was 12-step facilitation therapy).

These treatments have several characteristics in common: They are not household words (as opposed to 12-step based treatment and support groups). They do not have a spiritual or disease model or 12-step foundation. No treatment stands out as clearly more effective than another (although there may be personal or clinical considerations for choosing one over another). All these treatments are essentially cognitive-behavioral in nature, and involve the correction of distorted thinking, the identification of goals, and the development of new habits. For SMART Recovery perhaps the most exciting commonality of these treatments is that another way to summarize them is the SMART 4-point program (motivation, coping with craving, problem solving, and lifestyle balance).

Several qualifications are in order. These clinical trials have primarily tested treatments, not support groups. AA itself has been tested insufficiently to draw any firm conclusions about it (although the initial results are not promising). If AA itself is shown to be effective for some, it will take further trials to sort out whether the essential factor promoting change is the 12 steps themselves (doubtful except in a few cases) or simply the power of social support (which is well established to be helpful to individuals with almost any kind of problem).

Although a clinical trial involving SMART Recovery is nearing completion (published results available in a few years), SMART is not included in the Hester & Miller review, except indirectly. The indirect connection is that SMART draws its ideas and techniques from those treatments.

In summary, the scientific foundation of SMART is the body of clinical trials of addiction treatment, as summarized by Hester & Miller (and others). This body of work is in a broad way consistent with the self-empowering, thought correcting, habit building approach of SMART, and on the other hand, provides little support for traditional 12-step based treatment or 12-step support groups. The first significant support of 12-step based treatment was not published until the Project MATCH report of December, 1996, and that support consists of its equal effectiveness (in that unique study) to two treatments of known effectiveness, motivational enhancement therapy and coping and social skills training.

Some readers may be disappointed that there is no single definitive study that once and for all time declares SMART and its approach effective. What we have instead is strength in numbers (the number of studies consistent with our approach). We also have the near certainty that over time (perhaps decades), if SMART evolves to keep pace with evolving scientifically gained knowledge, SMART will be different than it is today. I hope you will find it comforting to consider that as we evolve we will not only be different, but even better.