

# Self-help groups for substance addiction

Substance addiction is a disorder that requires long-term treatment and adequate cooperation. Self-help groups can help solve certain problems associated with continuity, but are not suitable for all substance abusers in general.

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In spite of the prevailing rhetoric in the field of addiction that claims that addiction disorder is a chronic condition, this is not reflected in the interventions being made. Most of today's treatment of substance abuse takes the form of an emergency, intermittent and temporary effort in a start-stop fashion (1). The forms of treatment that have a longer duration, where these still exist, may be seen as merely longer versions of the same cycle, with an emphasis on access to treatment, stabilisation, repair and discharge, where the patients may participate in a follow-up scheme for a short period. The basic idea appears to be that substance addiction can only be cured if we are able to determine the correct therapeutic methods and the appropriate length and intensity of the cure.

To achieve continuity in the treatment of addiction disorders we need more emphasis on models that take a long-term perspective, and where there is adequate overlap between the ongoing and the continuous efforts.

## Are self-help groups the solution?

To solve the problem of continuity, the use of twelve-step self-help groups, such as those used by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), have been brought forward as a useful, but insufficiently exploited resource in Norway (2). The self-help groups represent a long-term and easily accessible programme for substance abusers – not only as a kind of follow-up after other forms of treatment, but also as a relevant intervention during the period the patient spends waiting for treatment (3). Several controversies and possible explanations can be found for why self-help groups are not used more frequently than they are in this country, such as lack of knowledge of the methods used by these groups and their effectiveness (3).

The purpose of this article is to elucidate the effective elements of the self-help methodology, as they are practised in twelve-step self-help groups in organisations such as AA and NA.

## Rehabilitation is «contagious»

Studies have shown that persons who spend more time in the company of people who do not abuse substances or have succeeded in rehabilitating themselves from their addiction stand a better chance of succeeding in their own rehabilitation (4).

This kind of research has helped establish a new understanding of the protective mechanisms that are inherent in good social relationships and a drug-free environment for people who are undergoing a rehabilitation phase (5). The closest thing to such drug-free social communities that can be found today are the twelve-step self-help groups run by AA and NA.

## Self-help methodology

The basis for the self-help methodology is found in the experience-based knowledge of the individual participants (6), a type of knowledge which is acquired through life experience accumulated through living as a substance abuser over a prolonged period. Through its association with the subjective individual experiences of addiction, it is therefore specific and unique. However, even though experience-based knowledge is unique and subjective it still provides an opportunity for recognition of certain general traits in others, and may thereby also be meaningful to others.

The instrument which is used to achieve recognition, identification and establishment of a shared meaning in the self-help groups is a sharing of personal stories. Local AA and NA groups make use of this practice. The typical storytelling format is described as a kind of narrative method that includes a description of the problem and how a solution to it was found (7). Sharing of experiences in this manner implies that the narrator becomes a pivotal storyteller and a communicator of meaning within a social community, which can be a redeeming experience for many participants.

## The importance of community and affiliation

All members of the self-help groups are equals. Herein we may possibly find part of the source of what makes rehabilitation from addiction disorders «contagious» between individuals. Not as an infection, but as affection, created by spending time together and giving and receiving help from others who strive for the same goal, a drug-free and better life. The participants form strong social bonds, resulting in an experience of affiliation and community on the part of each individual (8). These interpersonal relationships are also qualitatively different from those between a patient and a professional.

In this latter relationship, the patient will naturally assume a more passive role, and there is less room for reciprocity, equality and a sense of community – the patient is in need of help, and the professional is the expert. In the self-help groups, the problem is of an individual nature as well as shared by everybody, and this also helps de-stigmatise it. Seeking help for an addiction disorder is still seen as a shameful act, but less so when help is sought from peers. This is because all participants are equals and are regarded as contributors, not merely as passive recipients of assistance.

## Mutual aid and the helper therapy principle

The importance of mutuality and equality is better reflected in the literature written in English on self-help. There, the twelve-step self-help groups are referred to as «mutual aid groups», which is a more precise and apt term for the activity of these groups than the Norwegian term. An unfortunate aspect of term «self-help groups» is the risk it involves for associating participation in twelve-step groups with a behaviour that focuses on the individual self, and for believing that people participate in these groups exclusively to help themselves. In the twelve-step groups, however, the focus is not on the individual self, but on the group or the community.

Mutual aid and equality are the core principles of the twelve-step groups.



That is why the first of the twelve steps is formulated in this manner: «We admitted we were powerless over alcohol, and that our lives had become unmanageable.» This implies a kind of capitulation and recognition that one can no longer fight the forces represented by the substance by will-power alone. Step 2: «We came to believe that a power greater than ourselves could restore us to sanity.» Many professionals and outsiders have interpreted this as indicating that the twelve-step groups are religious organisations, but what is «a power greater than ourselves» really referring to in this context?

The twelve-step self-help groups promote what they refer to as a spiritual programme, which is based on a fundamental recognition that individual substance addicts are unable to fight addiction by themselves. The founders of AA, Bill and Bob, came to this conclusion when they met sometime during the thirties in Akron, USA. Professionals had declared both of them to be hopeless alcoholics, and they had gone through innumerable rehabilitation programmes. When they met, they discovered to their surprise that by meeting and sharing their personal histories they were able to stay sober (10). In other words, they discovered how rehabilitation can become «contagious» through the practice of self-help or the helper therapy principle.

Today, this principle constitutes the very hub of the spiritual programme practised by AA and NA. In the final analysis, this is an attempt to reduce the egocentricity of each substance abuser, which AA perceives as the root of the problem (11). The «power» referred to in several of the twelve steps

Available public and private treatment models are not suitable for all patients suffering from addiction disorder, and neither are self-help groups. However, the principles and methods employed by the self-help groups could also be applicable in other arenas. The principles of mutual aid and the helper therapy method could be more widely used as part of existing Norwegian treatment models, in public as well as private institutions. Future research and professional development should study how the public treatment institutions and the users could jointly establish and operate such arenas where the «contagious» and positive conditions that are conducive to rehabilitation are allowed to develop and flourish, including in the local communities of patients with addiction disorders. The

specialist health services can obviously not incorporate, or operate in such arenas, even though they must have a role. The question is: What role?

When the responsibility for treatment of addiction was transferred to the specialist health services in 2004, the patients concerned obtained the same patient rights as other groups. This is all well and good, but it may be unfortunate if we are in the process of organising ourselves away from a form of treatment that sustains the potential inherent in experience-based knowledge, mutual aid and the helper therapy method.

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**Conflicts of interest: None declared.**

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**References**

1. Laudet AB. The road to recovery: where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Subst Use Misuse* 2008; 43: 2001–20.
2. Vederhus JK, Kristensen Ø, Tveit H et al. Tolvtrinnbaserte selvhjelpsgrupper. En ressurs i rehabiliteringen av rusmiddelavhengige. *Tidsskrift for Norsk Psykologforening* 2008; 45: 1268–75.
3. Vederhus JK, Hjerkin B, Kristensen Ø. Selvhjelpsgrupper for rusmiddelavhengige. *Tidsskr Nor Legeforen* 2011; 131: 1204–6.
4. Litt MD, Kadden RM, Kabela-Cormier E et al. Changing network support for drinking: initial findings from the network support project. *J Consult Clin Psychol* 2007; 75: 542–55.
5. Best D, Laudet A. The potential of recovery capital. RSA projects. [www.thersa.org/projects/our-projects/reports/the-potential-of-recovery-capital](http://www.thersa.org/projects/our-projects/reports/the-potential-of-recovery-capital) (30.6.2011).
6. Borkman TJ. Experiential knowledge: a new concept for the analysis of self-help Groups. *Soc Serv Rev* 1976; 50: 445–56.
7. Denzin NK. *The alcoholic society: addiction and recovery of the self*. New Brunswick: Transaction Publishers, 1987.
8. Lieberman MA. A group therapist perspective on self-help groups. *Int J Group Psychother* 1990; 40: 251–78.
9. Riessman F. The «helper» therapy principle. *Soc Work* 1965; 10: 27–32.
10. Alcoholics Anonymous. *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, 1981.
11. Pagano ME, Post SG, Johnson SM. Alcoholic Anonymous-related helping and the helper therapy principle. *Alcohol Treat Q* 2011; 29: 23–34.

*Received 6 July 2011, first revision submitted*

*11 October 2011, approved 27 October 2011.*

*Medical editor: Petter Gjersvik.*