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Problem Gambling Counseling and Treatment Approaches
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CHAPTER NINE

The Place of Mutual Help Groups in Supporting Recovery from Gambling-Related Harm

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Mutual help groups (MHGs), often referred to as self-help groups, are the most common form of support worldwide for those dealing with addictive behaviours, including substance-related problems and problematic gambling (Kelly & Yeterian, 2008). This is especially true in some countries, depending on the funding and availability of other services and interventions (Brown et al., 2001). The most common form of MHG is that based on the twelve-step programme, originally developed by Alcoholics Anonymous (AA) and now used in many similar addiction support groups, including Gamblers Anonymous (GA). But some have raised objections to the AA model because it is based on a quasi-religious ideology that promotes total abstinence as the only path. Increasingly, alternatives not tied to this paradigm are being offered, including "Smart Recovery," which is now available in twenty-three countries (Smart Recovery International, 2021). In all cases, MHGs provide an adaptable and low-cost approach in which individuals who are struggling with an addiction receive support from others who have experienced similar problems at times when professional interventions may not be available (i.e., evenings and weekends), and in response to moments of crisis when they may be most vulnerable to relapse.

This chapter explains the history of MHGs, particularly as a form of support for those with problematic gambling, assessing the benefits and drawbacks, the scale of their use across the globe, what the limited research evidence tells us about them, and how they could complement individual therapy. Other forms of group-based support that are part of formal treatment programmes and/or professionally led are not considered here.

A Brief History of Mutual Help Groups

Mutual help has been a feature of human communities throughout the history of our species. As social animals, we naturally turn to others facing similar problems, when looking for support in dealing with those problems. The term mutual help was popularised by the Russian political philosopher Peter Kropotkin (Dugatkin, 2011) in his 1902 book *Mutual Aid: A Force for Evolution.* Kropotkin challenged the crude, one-dimensional "survival of the fittest" interpretation of Darwinism which was gaining traction and being applied to social policy at the time, attempting to show that co-operation was the norm in human societies rather than pure competition (Kropotkin,1902).

One does not have to look far in any culture to see numerous examples of mutual aid in action. Historians have traced the development of more formalised and recorded mutual help movements, such as the development of friendly societies in a number of European countries (Cordery, 2003). The significance of friendly societies as sources of mutual help in the form of mutual insurance and regular social gatherings can be seen in the fact that half of adult males in Britain were members of one or another such society by 1904 (Cordery, 2003). Since De Tocqueville (1835) identified the powerful role of mutual help groups in fostering an emerging democracy in the USA, mutual help groups have been a key element in functional civil societies, alongside government and family.

By the end of the nineteenth century, mutual aid groups had become widespread and familiar, applying to widespread social issues such as addiction, and other examples dating back centuries (White, 1998). The temperance movement, preaching moderation and later total abstinence from alcohol, had become popular in many countries, including America (Aaron & Musto, 1981), New Zealand (Watson, 2018) and the UK (Holmes, 2018). In the UK, it is estimated that some 3.5 million were part of the temperance movement by 1897, which was over 10% of the population at the time (Holmes, 2018). This led to the development of many mutual help groups for dealing with alcohol addiction, or "rescuing drunkards" as it might be called at the time. This included many groups associated with non-conformist

churches, but also some linked to the established church such as the Church of England temperance society (Shiman, 1972).

Across the religious and cultural spectrum, myriad groups have aimed at tackling the widespread problem of excess drinking and its consequences. White (1998) suggests that the earliest abstinence-based mutual aid recovery societies were Native American recovery "circles," with known examples as early as 1737. Despite this potential origin, the widespread adoption of mutual aid approaches to addiction in recent decades has been a largely white male dominated endeavour with a notable lack of diversity, including the lack of women (Sanders, 2009) and people of ethnic minority groups and indigenous populations (Dale et al., 2019).

Alcoholics Anonymous

Alcoholics Anonymous (AA) is the most well-known and archetypal example of mutual help group for managing addictive behaviours. The story of its birth has been well told many times (WW, 1949; Trice & Staudenmeier,1989), starting with the meeting of two people with a history of alcohol problems and the founding of AA in Ohio in 1935. The approach of AA quickly became popular and started to spread to other countries. It developed from a blend of medical and religious ideas into a programme emphasising several key elements set out in twelve formal steps for an alcoholic to take, including: admitting powerlessness over the addiction and acknowledging its damage, listing and striving to correct personal failings, making amends for past misdeeds, and continued personal and spiritual development whilst helping other alcoholics towards sobriety through the programme.

Gamblers Anonymous

Gamblers Anonymous (GA) was formed in 1957, largely based on the Alcoholics Anonymous model. Indeed, the founder of GA had been a member of AA and used that experience to develop GA (George, 2013). Helped by newspaper publicity, an initial meeting of 13 people in Los Angeles led on the

establishment of many groups, first across the US and then internationally. The Reverend Gordon Moody started the first GA group in the UK before going on to develop the residential treatment programme, which continues to this day and is discussed elsewhere in this book.

Gamblers Anonymous ostensibly follows the same twelve-step programme established by AA, as do a range of other groups such as Narcotics Anonymous (NA). However, there are some notable differences in how GA operates in some places. The fourth step, the ”moral inventory”, has been modified for GA into a “financial and moral inventory” (Gamblers Anonymous, 1957). This pragmatic adaptation of the twelve-step model to gambling-specific problems reflects that debt is one of the most significant issues for problem gamblers and their families. Ferentzy et al. (2006) note that the making amends process, as part of both steps four and nine, mean that dealing with debt and its consequences is a key focus of the programme brought forward in GA meetings, often via what is called a “pressure group.” These groups target newcomers, requiring them to give an honest account of their debts and financial problems in the presence of their family, so that the financial consequences of gambling problems are out in the open from the start. Such a group also enables a clear plan of action for paying off debts to be put into place.

While common in the USA and Canada (GA in the US produced a “pressure group meetings handbook” [GAISO, 1978]), these pressure groups are not used worldwide. For example, they are rarely conducted by GA in Japan (Doi, 2005), where members instead prefer to go to lawyers or other financial help organisations. Pressure groups are also not used in the UK. Instead, advice agencies such as the Citizens Advice Bureau have become involved in developing and offering tailored financial advice to problem gamblers in recent years.

In UK studies, we observed little emphasis generally on the formal twelve steps in GA meetings (Rogers, 2018). Typically, a meeting there lasts two hours with a short mid-way break, starting with each attendee introducing themselves by name, followed with “I am a compulsive gambler,” and how long it has been since their last bet. After introductions, it is common for the chair to ask for individuals to volunteer to share anything of concern to them at that moment, and after several people have done so, to then ask

about the individuals who had not spoken. The second half commences with short readings from GA literature, generally "the combo book", (GAISO, 1990), which contains the standard 20 questions and answers about compulsive gambling which are used in GA, along with elements of the GA recovery programme, and practical advice on maintaining abstinence, all condensed into a pocket-sized booklet. The sharing in the meetings focusses on accounts of gambling and personal difficulties, to which other members frequently respond with reminders of the importance of abstinence and attending GA meetings regularly.

Other Mutual Help Approaches

Whilst AA can justifiably claim to be the biggest mutual help group in the world, and GA remains the most widely available source of face-to-face help for problem gamblers in several countries, the twelve-step approach is not for everyone. For many, the first step of admitting powerlessness is problematic, going against the grain of recovery philosophies founded on an opposite tenet of personal empowerment. It has also been criticised for propagating a disease model of addiction (White & Kurtz, 2008), and the religious language and concepts of the twelve steps are problematic for many. The concepts and wording used by the founders of AA were borrowed directly from the Oxford movement, which was a religious revival movement of the early twentieth century (Alcoholics Anonymous, 1976), and have been altered little since then.

This discomfort with twelve-step programmes has driven the development of other group based approaches based on different frameworks. In 1975, Jean Kirkpatrick founded one of the first alternatives to AA, Women for Sobriety. A decade later, the so called "rational recovery" movement was established, and SMART recovery (Self-Management and Recovery Training) emerged a decade after that, offering a secular and more scientifically informed approach. Established as a not-for-profit organisation in the US in 1994, the programme emphasises choice and encourages members to try various approaches. The SMART approach is similar to those used in statutory addiction services, namely cognitive behavioural therapy (CBT) and motivational interviewing. In brief, there are four key points in the programme: (1) building and

maintaining motivation, (2) coping with urges, (3) managing thoughts, feelings and behaviours; and (4) living a balanced life (Beck et al., 2017; Smart Recovery, n.d.).

Benefits and Drawbacks of MHGs

As noted in the introduction to this chapter, MHGs provide adaptable, low-cost support, at times when professional interventions may not be available (evenings and weekends). As such, these organizations provide an adaptive, community-based system that is highly responsive to undulating relapse risk (Kelly & Yeterian, 2011).

Another benefit of the twelve-step approach is the function of the sponsor, which though never formalised, has developed as the way the last step is put into practice. Assisting others is achieved not only through discussions at meetings but by providing active support for newcomers to the programme (Kelly et al., 2016). Several studies have indicated that those with a sponsor are more likely to achieve positive outcomes than those without (Pageno et al., 2004; Tonigan et al., 2010). McGovern et al. (2021) have also found evidence that the sponsors themselves receive benefits from their role in terms of social skills, psychological well-being and sustaining a non-addictive identity. Similar findings have been noted, specifically with attendees at Gamblers Anonymous (Rogers, 2020).

Other clear benefits of GA and other MHGs which have been identified include: role modelling, inspiration, friendship and social connection, routine and ways to fill the time, normalization of a life away from addiction, useful advice on what has worked for others, and simple-to-follow guidelines (Ferentzy et al., 2003; Kelly et al., 2016).

At the same time, several drawbacks have been highlighted by both researchers and those who have been involved in MHGs. These are summarized below:

- Lack of professional guidance or leadership at meetings can sometimes make them unproductive. Meetings can end up being a forum for some members to endlessly retell their “war stories” of addiction in a way that does not help recovery. This also makes effective participation for all

attendees more difficult to achieve.

- Women can feel like they don't have a place there, as the meetings are often male dominated, and harassment by some of these men can occur. In a review of the experiences of women in GA, it was noted that there is sometimes a climate and discourse which is dismissive of women's experiences, but that internal barriers like shame and stigma, as well as external barriers such as problems with travel or the timing and accessibility of meetings, all contributed to lower participation rates (Rogers et al., 2019).
- Twelve-step programmes have a dogmatic insistence on abstinence only and do not acknowledge harm reduction as a legitimate approach.
- Gamblers Anonymous was not designed to offer formal treatment and is not equipped to deal with the mental health problems and other co-morbidities that often co-occur with gambling problems. It also does not facilitate dealing with the gambling cognitions which are known to be correlated very often with the development of problems (Donovan et al., 2013).

SMART recovery has attempted to address some of these problems—particularly those around leadership—by offering more of a hybrid model that blends some professional leadership with the peer management of groups. Facilitators may be paid staff members or volunteers but will always have received some training for the role (as such, they may not be pure mutual help groups). This brings the advantage of more consistent chairing and leadership of meetings, but also the need for greater of funding to provide the necessary training, administration and quality assurance processes.

There have been several initiatives aimed at addressing the gender issues. As with MHGs in general, there are more mutual support options for women dealing with alcohol than those looking for support with gambling related issues. There are a limited number of "women preferred" meetings offered by GA, which are intended to be women only, and some of these have been made more accessible by moving online. SMART recovery also offers some women-only meetings.

Current MHG Use Worldwide

Twelve-step programmes continue to dominate the addiction treatment landscape, particularly in North America (Ferentzy et al., 2004; Schuler et al., 2016), constituting much of the available help for people trying to recover from both substance addictions and behavioural addictions such as gambling. Gamblers Anonymous remains the most widely available source of face-to-face help for many with gambling disorders worldwide (Viets & Miller, 1997; Rogers, 2018). With over 150 weekly meetings across the UK, GA is a major source of face-to-face help and is often considered one of the main avenues of support for disordered gamblers seeking treatment (Abbott et al., 2004; Rogers, 2018).

Worldwide, GA groups vary by country. In the USA there are over 1000 GA groups, and the GA approach is also integrated into many other treatment programmes (Petry, 2005). Australia has over 130 GA groups, Japan over 120, and rates vary across European countries between two in Norway and 97 in Italy (Gamblers Anonymous, 2017). It is unclear why some or all twelve-step programmes have taken root much more in certain countries and regions than others, but a range of cultural and social factors are likely to be responsible.

In terms of other groups, SMART recovery now offers help in 23 different countries, and estimate that there are over 3000 meetings per week. It is unclear how many gamblers attend SMART recovery groups, as many of the meetings include participants with a range of addictions, rather than being only focused on gambling.

Both GA and SMART recovery have also been increasingly offering online meetings—particularly since they were made necessary by the COVID-19 pandemic—with virtual meetings every day and at many different times of day now available. As online gambling platforms have made gambling opportunities more easily accessible at all times of day, those who experience gambling related harms have become much more likely to report online gambling as a major part of their problem. People are now reporting that when faced with the temptation to gamble on their phone at any given time of day, they can find support at that time in

an online community through chat forums, as well as full scale mutual help meetings done online (Penfold & Ogden, 2021). Even if it is early morning or the middle of the night, it will be daytime in a different country where a meeting will be taking place.

Research on Experiences and Outcomes

Despite sustained critiques of twelve-step programmes from a range of perspectives, (Humphreys, 2015) including concerns around the language and religiously based approach, there is also a growing body of evidence demonstrating their helpful role in recovery for many. The literature pertaining to SMART recovery is less extensive, although their approach uses elements that in themselves have an existing strong evidence base (CBT and Motivational Interviewing). The following section summarises some of the most relevant evidence in relation to both approaches to mutual support groups for problem gamblers.

In his book *Circles of Recovery* (2004), Humphreys summarised the evidence at the time for mutual help groups. A particularly strong and influential piece of evidence came from Project Match, one of the largest and most careful investigations of outcomes of treatment for those with alcohol dependence at that time, in which a manualised version of the AA approach was compared to CBT and Motivational Interviewing. To the surprise of many professionals all three approaches were found to be equally effective. All helped some of the participants, but by no means all, and there was no superiority of one approach over another.

Since then, further evidence has accumulated to indicate that MHGs, including AA and GA, are effective for many of those in recovery from addiction (Parkman et al., 2015). The most recent systematic reviews of evidence found that AA and NA had equally effective outcomes as many other interventions while having lower costs (Kelly et al., 2017; White, 2020).

Schuler et al. (2017) conducted a more focussed survey of the literature on GA and found 17 eligible studies published since 2002, all but three of which were conducted in the USA or Canada. Their review found inconsistency in the evidence for the effectiveness of GA, with positive outcomes reported in some

studies but not in others. They identified several important pillars of GA's recovery culture: an emphasis on patience, absolute assertion of identity as a compulsive gambler, and learning to accept the reality of your situation by reciting the "Serenity Prayer"—an adapted excerpt of something written by the theologian Reinhold Niebuhr. This is the version used in twelve-step programmes:

God grant me the Serenity to accept the things I cannot change,

the Courage to change the things I can,

and the Wisdom to know the difference.

Ferentzy argues that serenity and patience are particularly important to gamblers because they have to forgo the instant gratification of trying to win money, which can be particularly tempting given the financial problems caused by their gambling that could *hypothetically* be solved by winning money. Some GA members use this prayer as a mantra up to 100 times per day to gain acceptance of their financial situation. They also use the prayer to help gain acceptance of the realities around spousal relations, parenting, work relations and friendships (Ferentzy et al., 2010).

The equivalence in terms of outcomes which followed very different types of support in the Project Match study, including 12 step approaches, led some professionals to re evaluate their view of that approach. The finding that very different types of approaches can lead to equally beneficial outcomes may not be a surprise to therapists acquainted with the extensive literature on the outcomes of therapy. A very clear and consistent finding there is

that much of the variance in outcomes relates to elements of the therapist-client relationship, and has less to do with the specific type of intervention (Duncan et al., 2010). In other words, it is relationships which are key, rather than a programme or therapeutic ideology.

To quantify this, a recent literature review and meta-analysis summarised 295 independent studies covering over 30,000 patients (Fluckiger et al., 2018). They found a significant association between the therapeutic alliance and patient outcomes, even after controlling for a range of factors like severity and nature of problems and intervention type.

The literature seems to indicate that the relationship rather than the therapeutic approach is the key to one-on-one therapy. This has also been found for group settings, in the sense that group cohesion is one of the biggest influences on outcomes (Norcross & Lambert, 2018). Irvin D. Yalom, a significant scholar in this field, identified other key elements of groups that promote recovery, including the fostering of hope, altruism, providing role models, and social learning (Yalom, 1975). Clearly various types of support groups can be powerful agents of change, but this is only a likely outcome with sustained engagement. Research shows that intensive involvement and frequent attendance are linked to greater success in both AA (Gossop et al., 2008) and GA (Oei & Gordon, 2008).

Some early studies have suggested high attrition rates for Gamblers Anonymous. For example, Stewart and Brown (1988) found a large dropout rate among GA attendees in the UK, with almost a quarter of first-timers never returning, and nearly 70% having dropped out after by the tenth meeting. Subsequent studies have found lower but still significant dropout rates. Critics argue that the programme would have far better retention if had real merit, but defenders point out that many kinds of treatment have similar levels of attrition (Palmer et al., 2009). Regardless, a challenge remains in getting people to sustain engagement beyond the first few meetings. Regular attendance and active involvement by becoming a sponsor or some other active role have also been found to be associated with better outcomes for both AA (Subbaraman et al., 2011) and GA (Rogers, 2020).

The literature on outcomes for SMART recovery approaches is developing but still limited. A systematic review by Beck et al. (2017) found twelve studies, including only three evaluations of effectiveness. The primary focus in most studies was alcohol outcomes, and information about gambling or other behavioural issues was limited to a small amount of prevalence data. Positive effects were reported for alcohol outcomes, but the authors were unable to make any conclusions about efficacy due to small sample sizes and diverse methods. One other study of SMART recovery is worth noting here.

Zemore et al. (2018) compared various MHGs in terms of outcomes for women with a lifetime alcohol use disorder. After participating in one of SMART recovery, Women for Sobriety, LifeRing, or

AA, there were no differences in effectiveness between these approaches at six or twelve months. One difference that was noted was that the best outcomes were achieved when the individual committed to lifetime abstinence at the outset. We cannot assume that the same would hold true for different mutual help approaches to gambling related problems, but this study does reinforce the message of Project Match, among other studies, that different approaches can be equally useful and achieve similar levels of outcomes.

Online/Remote Meetings

We all had to adapt our lives and ways of working in many ways in 2020 during the COVID-19 pandemic. An obvious casualty of the necessary lockdowns was all manner of group-based activities, including mutual aid groups. This has been mitigated to some degree by the ability to meet online in various formats, and many mutual help groups, including GA, offered online meetings during the lockdown periods. Now that this method of delivery has become more normalised it is more for people to choose the convenience of online meetings over in person meetings, regardless of public health measures. In this context, a recently published study by Penfold and Ogden (2021) investigated how GA in the UK had adapted to online meetings, and noted mixed outcomes. On the one hand, the move of many GA meetings to online delivery meant that people were able to attend meetings other than their usual local ones regardless of geography, and for some this meant bolstered social networks. On the other hand, participants reported that in general they behaved more individualistically and less collectively than during in-person meetings. In the same period, SMART recovery also massively expanded their use of online meetings, bringing them to a number of countries for the first time. In the United States, the available number of groups hosting online meetings increased from 40 to over 1200 (Kelly et al., 2021).

Mutual Help Groups for Friends, Family and Significant Others

One further element of mutual help groups that is important to address is the benefits they can have for the family and friends of problematic gamblers. There has been some belated recognition in recent

years that family, friends and wider social networks are also affected by problematic gambling, and that some attention should be given to supporting them as well. It is estimated that for every problem gambler, between six and ten other people are adversely affected (Goodwin et al., 2017). And overall, between 2% and 19% of the general population are affected, depending on definitions and measurements used (Castren et al., 2021).

The twelve-step programmes recognised this issue early in their development and created parallel support groups for affected others. GamAnon, a partner group of GA, offers meetings designed to support to anyone who has been affected by a loved one's gambling problem (Gamblers Anonymous, n.d.). GamAnon and GA meetings are usually held at the same time and venue, but in separate rooms. What is said in each room is kept confidential so that members in both rooms feel free to share their problems and concerns. Unfortunately, research on the processes or outcomes for these groups is even more sparse than that on the main organisations.

Similarly, the SMART recovery movement offers parallel meetings for family and friends. They also offer online meetings restricted to only women and only LBGTQ+, as well as specially tailored programmes for supervised offenders, military personnel, and teenagers (Smart Recovery, 2021).

How Mutual Help Groups Complement Other Interventions

A contemporary definition describes mutual aid groups for addiction as “non-clinical, community-based forums where members give and receive social, emotional, and practical support promoting long-term recovery from addiction” (Public Health England, 2015, p. 37). This definition well captures the essence of the approach and appropriately highlights the importance of the mutual support element of the process over the particular therapeutic approach taken.

Most therapists and mental health professionals are familiar with social learning theory, which has been postulated as a key element of recovery in mutual help groups. In addition to social learning, White (2008) argues the following as core social functions of these groups:

(1) Emotional support – involving empathy, care, consideration, concern and encouragement.

(2) Informational support – providing knowledge about recovery and the recovery support services and groups available.

(3) Instrumental support – help connecting to recovery groups, as well as supportive housing and childcare services, and development of leisure and sporting activities.

(4) Companionship.

(5) Validation – sharing and supporting their recovery experiences.

By moving the research lens from the confines of therapy to the broader context of people's lives in recent years, it has become clear that although treatment may be a necessary catalyst and central feature of the recovery process, recovery does not primarily take place in one-to-one treatment sessions. Strong social networks can be even more important, and mutual aid groups provide a strong source for this. In researching Gamblers Anonymous we observed clearly that these social functions were at play, and that these general social support mechanisms were valued and discussed much more than any specific aspects of the twelve-step programme (Rogers, 2018).

The evidence that social factors like mutual support and social learning are key parts of the process of mutual help groups reinforces the point that its value comes as a distinct complement to one-one-one therapeutic intervention. A wealth of evidence indicates one-on-one therapy/counselling to be helpful for an array of problems, including those related to gambling (Petry et al., 2017). Equally compelling evidence now shoes that group-based support offers something additional and complementary, whether professionally led groups or mutual help groups (Bodor et al., 2021). Mental health providers should therefore consider the broad range of benefits mutual help groups can provide, in addition to one-on-one interventions.

Membership in an MHG can provide important social capital and sense of community, which some commentators have bemoaned the decline of in modern times (Putnam, 2001). At the same time, there has been increasing interest in the study of social networks and social capital and a developing understanding

of their importance for personal development and flourishing. Social capital has been the subject of much debate, but one straightforward approach divides it into three main categories:

(1) Bonds – Links to people based on a sense of common identity such as family, close friends and people who share a culture or ethnicity.

(2) Bridges – Links that stretch beyond a shared sense of identity, for example to distant friends, colleagues and associates.

(3) Linkages – Links to people or groups further up or lower down the social ladder. The OECD define them as "networks together with shared norms, values and understandings that facilitate co-operation within or among groups" (OECD, 2007).

Assisting with the development of social networks may be particularly important for those experiencing addiction-related problems, since these individuals are known to have poorer social networks, and to be more lonely and isolated (Christie, 2021; Savoleinen et al., 2020). Evidence suggests that MHGs do indeed help in this way. In a pan-European study, Martinelli et al. (2021) found that membership in mutual aid groups is strongly associated with more self-reported social participation and changes in social networks, and with greater social capital (sometimes called "recovery capital" in this context). It has been found that the addition of just one abstinent person to a drinker's social network increases their probability of staying sober in the next year by 27% (Public Health England, 2015), and membership in an MHG can add many abstinent people.

The large Project Match study involved several complex analyses of the mechanisms leading to good outcomes of MHGs. Overall, AA was found to confer benefit through multiple mechanisms simultaneously, but especially through facilitating adaptive social network changes. Mutual help groups can provide social capital often lacking for people with addiction issues that individual therapy cannot.

Current Guidance and Advice

The evidence for the benefits of mutual help groups has been set out above and clearly shows them to provide clear benefits through social interaction and therapeutic help. This evidence has now started to influence official guidelines for therapists and health professionals in some jurisdictions. For example, current UK guidelines on drug misuse state that "*self-help and mutual aid approaches, including 12-Step and SMART Recovery groups, have been found to be highly effective for some individuals in supporting recovery, and patients seeking post-treatment support should be signposted to them*" (Department of Health and Social Care, 2017, p. 47)

So, some guidance for people working in the field does exist. However, there is often a gap between policy and practice, which can narrow or widen for a variety of reasons. In the case of mutual help groups, there are several reasons why this gap has been wide. In the case of the twelve-step groups, having the word "anonymous" in their title—for understandable reasons—has often lead them to not get involved in any kind of promotion or collaboration with other groups. They also adopted a *modus operandi* wherein the experience of attending the groups was open only to those with lived experience of the problem, causing them to be fairly closed to research and evaluation, a problem noted by a number of authors (Greene, 2021).

Therapists, and workers in statutory treatment services (ie those provided by state health services such as the NHS in the UK), hewing to their professional training and standards, have sometimes viewed mutual help groups with scepticism. Twelve-step programmes are sometimes seen as cult-like (Day et al., 2005), overly rigid in their insistence on abstinence, or dangerous due to lack of qualified leadership. Day et al. (2005) explored barriers to accessing 12-step meetings in statutory addiction treatment clients by assessing the opinions of 346 treatment staff, of which only 46% recommended that their clients attend AA or NA meetings. The view of many workers that addiction is a bad habit rather than a disease was a deterrent to actively encouraging clients to attend 12-step meetings. They also concluded that there were fundamental differences in receptiveness to the 12-step philosophy in the UK relative to the US, with UK staff much less open to its merits. In the relatively shorter history of SMART recovery groups, they have worked hard to liaise with and integrate with other treatment providers and professionals.

Best (2018) has argued that it is not satisfactory to rely on people to find their way to mutual aid groups that may or may not exist in their area: "it is incumbent on addiction professionals not only to know about the community resources available, but to enable and support them wherever possible" (Best, 2018, p. 24). An important message for all involved in therapy, then, is to be open minded about and actively direct people to other available resources. The resources provided by mutual help groups do not compete with therapy and are usually compatible, complementary and valuable additions to the recovery toolkit. This is important since the attitudes of therapists and referring agents can affect recovery outcomes. Best et al. (2010) argue that "for clients in addiction treatment, affiliation with and benefits from recovery mutual aid societies are influenced by counsellor attitudes toward mutual aid, the style of linkage (assertive versus passive, degree of choice, and personal matching), and the timing of linkage (during treatment versus following treatment)" (p. 36).

Conclusion

Mutual help groups continue to provide an essential function in society. In relation to addiction issues, they offer an important adjunct to one-on-one therapy and professionally led group support, especially given their availability at times and places when these other forms of support may not be. Therapists can refer problem gamblers to GA, SMART, or other available groups, knowing that they will have the opportunity there to find a community of support. If local groups are not available, the online space is now fuller than ever with meetings. Unless offering some kind of family therapy, most therapists will be interacting with a single individual, but will be aware of the impacts they have on family and wider networks. Knowing which support groups are available to offer support to affected others can also be helpful. Contact details for the different MHGs discussed in this chapter are provided below:

Gamblers Anonymous – US and International - https://www.gamblersanonymous.org/ga/content/about-us
Gamblers Anonymous – UK - https://www.gamblersanonymous.org.uk/
SMART Recovery - https://smartrecovery.org/

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