Received: 18 September 2024 | Revised: 9 March 2025 | Accepted: 13 March 2025

DOI: 10.1111/dar.14048

ORIGINAL PAPER

Drug and Alcohol REVIEW APSAD WILEY

Sociocultural context of SMART recovery in Singapore: A qualitative exploration of members and facilitators perspectives and experiences

Wan Jie Tan[1] | **Briony Larance**[1] | **Matthew J. Schweickle**[1] | **Angie S. X. Lim**[1] | **Kate Lowe**[2] | **Peter J. Kelly**[1]

[1]School of Psychology, University of Wollongong, Wollongong, Australia

[2]Department of Sociology, The University of Hong Kong, Pok Fu Lam, Hong Kong

Correspondence
Wan Jie Tan and Peter J. Kelly, School of Psychology, University of Wollongong, Building 41, Northfields Ave, Wollongong, NSW 2522, Australia.
Email: wjt639@uowmail.edu.au and pkelly@uow.edu.au

Funding information
University of Wollongong

Abstract

Introduction: Various services and mutual-aid groups, such as SMART Recovery, provide support for substance use rehabilitation in Singapore. Despite this, substance use remains a growing public health concern with a large treatment gap. This suggests potential barriers to accessing substance use treatment unique to Singapore's sociocultural context. Culture can play a significant role in shaping members' experiences. Hence, this study sought to explore members' and facilitators' experiences and perspectives of SMART Recovery within Singapore's sociocultural context.

Methods: A critical realist position guided the present study. Semi-structured, in-depth interviews were conducted with 18 participants (14 members and 4 facilitators) in 2023. Data were analysed using reflexive thematic analysis.

Results: Five themes were generated from the data: (i) Non-disclosure from fear of negative social evaluation; (ii) Stigma and shame surrounding the use of substances; (iii) Linguistic challenges as a barrier to participation; (iv) A 'second family' fostered through continued engagement with SMART Recovery; and (v) Facilitation approach and quality affected by sociocultural factors (e.g., sensitivity to relational cues). Although there were initial sociocultural challenges, this improved through continued engagement, and the experience of SMART Recovery was largely positive. Facilitators also identified that their facilitation style is influenced by sociocultural factors, which in turn affects members' experience of SMART Recovery.

Discussion and Conclusions: Members and facilitators in Singapore face sociocultural challenges that influence their experience of SMART Recovery. This study highlights the need to optimise services to the needs of this population. Future research can identify processes of change that foster members' engagement in SMART Recovery.

KEYWORDS
addiction, cross-cultural, implementation, self-help groups, substance-related disorders

Key Points

- Members' experience is affected by fear of negative evaluation, stigma and shame.
- Desire for SMART Recovery to be provided in various languages in Singapore.
- Continued engagement is necessary to improve members' experience.
- Identification of strategies to retain members and improve engagement are needed.
- Sociocultural factors can also influence facilitators' experience and style.

1 | INTRODUCTION

Substance use is a growing public health concern worldwide, including Singapore. Singapore enforces strict drug laws that criminalise the possession and use of illicit drugs (e.g., *Misuse of Drugs Act* 1973 [1]) while simultaneously providing comprehensive rehabilitation and reintegration pathways for individuals recovering from substance use disorders. Individuals found to use illicit substances could be admitted to the Drug Rehabilitation Centre or placed on the Drug Supervision Scheme [2]. As part of the Drug Rehabilitation Centre, community-based programs are provided to help individuals reintegrate into society, involving counselling, vocational training and aftercare monitoring [3, 4]. Despite this, issues and challenges remain. Using the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revised, two nationwide epidemiological surveys found that the lifetime prevalence of alcohol abuse in Singapore has significantly increased from 3.1% between 2009 and 2010 to 4.1% between 2016 and 2018 [5], while the lifetime prevalence of illicit drug consumption was 2.3% between 2021 and 2022 [6]. According to the Central Narcotics Bureau [7], there was a 10% increase in the number of people that were arrested in 2023 for using illicit drugs compared to the previous year. Of the arrests in 2023, 30% were new users, which was an 18% increase from 2022 [7].

Several resources and services are provided in Singapore to support rehabilitation and treatment of substance use. An integral resource is mutual-aid groups, also known as self-help groups [8, 9]. These mutual-aid groups are delivered by organisations (e.g., Alcoholics Anonymous) and recovery centres in Singapore, which are community-based organisations offering groups such as 12-step programs and SMART Recovery [10, 11]. Despite the availability of these resources, there is limited publicly accessible research and reports on mutual-aid groups and their effectiveness in Singapore. Nonetheless, a growing body of international evidence has documented that mutual-aid groups are easily accessible [9] and cost-effective to implement [9, 12].

Self-Management and Recovery Training (SMART Recovery) is one such mutual-aid group. In contrast to the well-known and studied 12-step groups, which are entirely peer-led, SMART Recovery is a secular and science-based approach that is led by a trained facilitator who may or may not possess lived experience of addiction themselves [13]. Facilitators manage group dynamics [14] and provide skills in a didactic format using the principles of motivational interviewing and cognitive behavioural therapy [13, 15, 16]. Since its inception in 1994, SMART Recovery has grown rapidly and is among the most widely used mutual-aid groups internationally. Research indicates that SMART Recovery and 12-step groups offer distinct benefits, with individuals engaging in the former for its recovery tools and the latter for its sense of fellowship [13, 14, 17]. Randomised controlled trials have shown that greater 12-step participation is associated with greater improvements in substance use recovery [18–20]. Although studies on the comparative influence of SMART Recovery relative to other mutual-aid groups have yet to be systematically evaluated, emerging evidence has demonstrated its effectiveness in reducing substance-related problems [21–24] and comparable efficacy to 12-step groups after adjusting for baseline recovery goals [25]. One randomised controlled trial has found that participation in mutual-aid groups, including SMART Recovery, helps participants reduce problem drinking [21]. These findings suggest SMART Recovery is feasible, well-accepted, and highly valued by members, contributing to improvements in substance use outcomes and psychological well-being [23]. SMART Recovery is currently delivered across 35 countries, with a global community of over 3000 SMART Recovery groups (https://www.smartrecoveryinternational.org/). In Asia, SMART Recovery is delivered in many countries such as Brunei, Hong Kong, Indonesia, India, Malaysia, Singapore, South Korea and Thailand [26].

Despite the implementation of SMART Recovery and other resources for substance use recovery in Singapore, it has been recognised that there remains a treatment gap. Results from the Singapore Mental Health Study showed that 97% of individuals with alcohol use disorder were not accessing treatment [27]. The large treatment gap in the population is concerning and highlights potential barriers to help-seeking and uptake of treatment unique to the Singaporean context, such as

individual (financial, attitudinal, lack of awareness) or cultural (values, stigma) factors [27].

Although studies have examined SMART Recovery members' engagement and experience [e.g., 13, 28], most research on SMART recovery has been conducted almost exclusively in the United States and Australia [29]. There is a dearth of literature from Asia, and the role of culture on the suitability or perceived helpfulness of SMART Recovery for this population is often overlooked. Additionally, narratives on drug use in Singapore remain underexplored [30], contributing to a gap in research in this area. For SMART Recovery to be effective, it must align with the cultural context and needs of the members. Given that most research focuses on Western cultures, there is a pressing need to examine SMART Recovery's applicability in Singapore.

Culture refers to the shared belief systems, value orientations, norms and practices of a given racial or ethnic group [31], which provide a framework to understand the experience and expression of the symptoms, signs and behaviours [32]. It is vital to acknowledge that the values in Asian cultures can differ from Western cultures. Self-orientation and independence (e.g., self-direction, differentiation, competition and autonomy) are commonly practiced in Western societies. In contrast, other-orientation and interdependence (e.g., sense of duty towards one's group, conformity and social cohesion) take precedence in Asian cultures [33–36].

The emphasis on other-orientation and interdependence is similarly observed in Singapore, a multicultural city-nation located at the southern tip of the Malay peninsula in the Asia-Pacific region [37, 38]. Since the introduction of '*Our Shared Values*' in 1988 [see 39] and their integration into the academic curriculum through the 21st Century Competencies Framework and Character and Citizenship Education, Singapore has promoted core values of respect, responsibility, resilience, integrity, care and harmony [40–43]. These values emphasise the importance of the community in forming and shaping an individual's behaviour and identity [39], forming the foundation for developing social and emotional responsibility for both self and others [41] and fostering interdependence.

These cultural differences in values between Western and Asian societies are a critical factor to consider in substance use treatment, as traditions and social practices can influence behaviour and treatment response substantially [44]. Interventions that have been adapted to specific participant characteristics and culture are frequently more effective than generic interventions [45, 46]. As SMART Recovery requires members to come together and share their experiences through mutual support, culture can play a vital role in shaping their experience. In view of this knowledge gap, the main objective of the present study was to explore how participants perceive and experience SMART Recovery in Singapore using a qualitative methodology. The ecological validity model (EVM) [47] has been used as a way of examining the cultural adaptation of substance use treatments. It comprises eight culturally sensitive domains: Language (culturally appropriate and syntonic language); Persons (ethnic/racial similarities); Metaphors (symbols or concepts meaningful to the cultural group); Content (cultural knowledge of values, traditions and customs); Concepts (materials aligned with the local culture); Goals (agreement on objectives between members and facilitator); Methods (procedures to achieve goals); and Context (economic, social and history factors) [47, 48]. By applying the EVM as a structured framework, the present study also aimed to identify domains and sociocultural factors influencing this experience of SMART Recovery. Findings from the present study make a unique contribution to the international literature by adding a cross-cultural perspective, which can be used to inform the delivery of SMART Recovery in Singapore and broader Asia.

2 | METHOD

2.1 | Research design

The current study is reported according to the guidelines listed in the American Psychological Association [49] Qualitative Design Reporting Standards (JARS-Qual) to enhance the scientific rigour of research reporting, increase accuracy and transparency. A critical realist position was used to inform the present study, which integrates a realist ontology (the belief that there is a real and independent world existing beyond an individual's perception and beliefs) with a constructivist epistemology (the belief that understanding of this world is socially and culturally embedded, and is inherently partial and fallible) [50, 51]. This philosophical position is most suitable to capture the complexity of the experiences in the present study as it emphasised the subjective interpretations and nuanced meanings of the participants in a given context while recognising the independent social, cultural and systemic structures that can shape these personal narratives [52]. Ethics approval was obtained from the University of Wollongong Human Research Ethics Committee (protocol number: 2022/303) with letters of support from organisations that run SMART Recovery groups.

2.2 | Recruitment process and participant selection

Recruitment was carried out by visiting recovery centres in Singapore that offered SMART Recovery. These recovery centres offer mutual-aid groups and other substance

use recovery services such as counselling sessions. Individuals with substance use problems could approach these recovery centres or be referred through the Drug Rehabilitation Centre, and they can choose to attend various programs offered in the recovery centres as part of their treatment program. Potential participants were invited to take part in the study via an explanatory statement on a flyer. To reflect a range of perspectives, participants were recruited using purposive sampling with an emphasis on variation across ethnicity, gender, age, educational attainment, income level and duration of participation in SMART Recovery. Potential participants were screened for suitability based on the following eligibility criteria: (i) residing in Singapore; (ii) over 18 years old; (iii) attending or having attended SMART Recovery for a substance problem; and (iv) having a working understanding of English. All participants provided written informed consent before being interviewed. Participants were provided with SGD50 (USD37) e-vouchers for use at a local supermarket to compensate for their time to complete the study. Interviews were conducted between February and March 2023 by the first author (WJT), who is independent from SMART Recovery with no prior relationship to the participants.

2.3 | Data collection

Our critical realist position acknowledges that meaning is hidden and must be brought to the surface through deep reflection and is jointly created (co-constructed) through an interactive dialogue and interpretation between the researcher and participant [53]. Thus, two in-depth interview schedules for members and facilitators that adopted a semi-structured, open-ended approach were utilised. Participants were invited to reflect on their experiences and engagement with SMART Recovery and to describe what worked or did not work well. The interview ended with more neutral questions about participants' experiences and an overall reflection on the discussion to allow for sensitive interview closure. Sufficient flexibility was provided for the interviewer to explore narratives and unanticipated material that arose spontaneously during the interview. Given the criticisms of using data saturation to justify sample size in a reflexive thematic analysis approach [54], the adequacy of the sample size was evaluated based on information power (i.e., richness of the data set) [55]. The premise of information power is that samples with greater information power require a smaller sample size and vice versa. Following the recommendation by Malterud et al. [56] when determining sample size sufficiency, information power in the present study was ensured by maintaining a narrow aim (i.e., important factors that can affect the experience of SMART Recovery and how these can be influenced by culture), recruiting participants from diverse demographics with dense experiences and knowledge of SMART Recovery, conducting strong dialogue-based interviews, and applying appropriate reflexive thematic analyses. Recruitment continued until there was adequate data to inform a rich, complex and multi-faceted story where a sequence of events could be woven together that achieved the aims of the present study [57].

Seventeen interviews were conducted in-person at the recovery centre in Singapore where SMART Recovery meetings were held, and one was conducted online via Zoom software. Interviews lasted between 25 and 60 min, with an average interview time of 40 min. Audio recordings of the interviews were de-identified and transcribed verbatim by WJT before the analysis. Transcripts were then reviewed against the audio recordings again to ensure accuracy. All interviews were retained for analysis.

2.4 | Data analysis

Reflexive thematic analysis was conducted [55]. Attention to reflexivity is central in a critical realist paradigm as the researchers' own social context, experiences, values and assumptions can play an active role in shaping their interpretations of meaning from the data [58]. Analysis was conducted on the entire transcript following the six-phase process described by Braun and Clarke [55, 59]: (i) familiarising with the data; (ii) generating initial codes using a latent process; (iii) searching for themes; (iv) reviewing themes; (v) defining and naming themes; and (vi) producing the report. This was done manually using Microsoft Excel 365 (Version 2410). An iterative process of inductive and deductive reasoning was used, where observations were made and worked backwards to uncover multiple explanations that could logically have produced the explicated event [60, 61]. Artificial intelligence (AI) and AI-assisted technologies were not used in the present study. Participants were assigned a pseudonym to protect their confidentiality.

2.5 | Reflexivity and rigour

WJT conducted the interviews and is a female clinical psychologist trainee, bilingual native speaker from Singapore. Reflexive discussions with the authorship team and a reflective journal were utilised throughout the study to facilitate reflexivity and create transparency in the research process [62]. Analysis was conducted by the first author and findings were presented to the co-authors serving as critical friends. BL, KL and PJK are members of the SMART

TABLE 1 Participant characteristics ($n = 18$).

	n	% of total
Ethnicity		
Chinese	12	66.7
Malay	2	11.1
Indian	2	11.1
Other	2	11.1
Sikh	1	5.6
Mixed	1	5.6
Gender		
Male	12	66.7
Female	5	27.8
Non-binary/third gender	1	5.6
Age, years (*M*, *SD*)	40.9	9.1
20–29	1	5.6
30–39	8	44.4
40–49	5	27.8
50–59	4	22.2
Education attainment		
Primary school	1	5.6
Secondary school	4	22.2
Post-secondary education	13	72.2
Polytechnic diploma/Institute of Technical Education/junior college	4	22.2
Bachelor's degree	1	5.6
Postgraduate diploma/degree	8	44.4
Sources of income[a]		
Employed	10	55.6
Full-time	6	33.3
Part-time	3	16.7
Not specified	1	5.6
Temporary benefit (e.g., government welfare)	5	27.8
Dependent on others	1	5.6
No income	3	16.7
Attendance in other mutual-aid groups ($n = 14$)[b]		
12-step groups (e.g., AA, NA)	11	78.6
Other mutual-aid groups (e.g., peer support meetings)	9	64.3

[a]Does not sum up to 18 as participants may have multiple sources of income.
[b]Does not sum up to 14 as members may attend multiple mutual-aid groups.

Recovery Research Advisory Committee and have experience working with people with substance use disorders. MJS and ASXL are familiar with qualitative approaches to research, including reflexive thematic analyses. ASXL is from Malaysia and shares a similar culture as the participants. The critical friend process involved deliberation of any discrepancies and data obtained through the interviews, offering constructive criticism, and providing a different lens to examine the data [63]. Findings were also presented to key stakeholders (i.e., centre staff, service users and facilitators) as part of critical friend discussions, which provided additional rigour and strengthened the credibility of the interpretations.

3 | RESULTS

Eighteen SMART Recovery members ($n = 14$) and facilitators ($n = 4$) participated in the study. Participants were 29–57 years old (mean age = 41 years) and attended SMART Recovery between 2 months and 5 years (average = 2.38 years). All participant members reported that they were also involved in at least one other mutual-aid group. Table 1 summarises the participant characteristics and mutual-aid group involvement. Five themes were generated from the data: (i) Non-disclosure from fear of negative social evaluation; (ii) Stigma and shame surrounding the use of substances; (iii) Linguistic challenges as a barrier to participation; (iv) A 'second family' fostered through continued engagement with SMART Recovery; and (v) Facilitation approach and quality affected by sociocultural factors. Themes, codes, and examples of raw data from the analysis are reported in Table 2.

3.1 | Non-disclosure from fear of negative social evaluation

One of the unique core elements in SMART Recovery is crosstalk, whereby members 'exchange points of view' (Eddie, member, age 30–39). This was different from the other groups members had attended. For George (member, age 40–49), 'the first time was totally a culture shock. I didn't realise that the people (members) here are actually quite open, and they are very eager to express themselves and tell things'. Many participants explained that they are 'shy' or 'reserved', therefore coming to such a community for the first time can be a scary initial experience. One participant explained that 'the culture, maybe Singaporeans, most of us are brought up to be very conscious of what other people feel about us' (Finn, member, age 40–49). In Singapore, it is regarded as respectful when an individual listens and speaking up can be seen as rude and out of place. Participants 'want acceptance and all that' (Parker, member, 50–59), thus opting to

TABLE 2 Themes, codes and examples of raw data from the thematic analysis.

Themes	Codes	Example of raw data
Non-disclosure from fear of negative social evaluation	*Heightened sensitivity to relational cues*	"I think the culture, maybe Singaporeans, most of us are brought up to be very conscious of what other people feel about us."
	Different and unfamiliar setting	"I didn't realise that the people here are actually quite open, and they are very eager to express themselves and tell things."
	Reluctance to act in ways that could be inappropriate	"I experienced similar things and wanted to share. But I felt hesitant about sharing because there were people already talking about it."
	Desire to avoid losing face	"I won't go and ask for help even if I knew that I was struggling. Because everyone is seeing."
Stigma and shame surrounding the use of substances	*Negative public perception*	"When someone tells you that she's an addict, I think most of the people will be like, kinda wanna stay away from them."
	Shame	"It's like, so hard to face people, you know. Even if they don't know you and you don't know them right, for me it's very hard to face anybody."
	Sense of rejection	"We are still condemned. Addiction is still addicts. Nobody wants to change us, nobody wanted to help, care or ask."
	Interconnected relationships	"I think being Asian, how I feel and how much I share will also affect my family."
Linguistic challenges as a barrier to participation	*Language proficiency*	"English is one big problem already. I couldn't understand all the thing because SMART uses English is more difficult."
	Reducing benefits	"You can get the point from other people, but you may not participate."
A "second family" fostered through continued engagement with SMART Recovery	*Welcoming new members*	"If they are newcomers, or you know, most of us, if we see a newcomer, like the person is a bit out of place, we will try to include them in conversations and activities."
	Building of trust	"The more I attend, the more I trust the people, the more I dare to share."
	Belonging	"At least I know that there's a place that I can always come to."
	Feeling important and valued	"Personally, I feel that everyone's voice in SMART mattered."
Facilitation approach and quality affected by sociocultural factors	*Similar culture as members*	"All the facilitators are the same, you know, Asian."
	Challenges with different facilitation method	"It's more of the facilitator taking the facilitator role, not a lecturer role. So that was very refreshing for me. But it was very scary going in with that."
	Importance of good facilitation	"There's no involvement and then we just sit and listen, sometimes we don't really learn much from it."

remain quiet in meetings to avoid standing out or risk doing something that is considered inappropriate.

> 'I experienced similar things and wanted to share. But I felt hesitant about sharing because there were people already talking about it. And I was a bit shy. Then to say "eh, can I share" or "there is something I want to say". So, the culture, I think, also has a part to play. We are not so, like, "Yeah! I got something to share". And then everyone just talks. Sometimes, it's like, I've got something to share but I [am embarrassed] … I don't want to [interrupt], suddenly volunteer my experience.' (Finn, member, age 40–49).

The concept of gaining or losing face is also ingrained in everyday life in Singapore. Face refers to the preservation of one's reputation and dignity in the peer group or society and is used as a self-regulating system. As one member explained, 'they (Asians) don't tell people their problems. They always like to report blessings. Good news. And bad news or whatever, they will always keep … Bad things all keep to ourselves … So, we bottle up a lot' (George, member, age 40–49). This can deter participants from talking about their problems in meetings. As one participant described, 'I won't go and ask for help even if I knew that I was struggling. Because everyone is seeing. So, it's all about the face value and keeping up with it'. (Miles, member, age 30–39).

3.2 | Stigma and shame surrounding the use of substances

The stigma and shame associated with substance use was reported by many participants. Daisy (facilitator, 30–39) explained that there is the public perception that 'addiction is not something like depression or anxiety ... [because] they feel that drug is a choice'. Due to Singapore's strict national policy of zero tolerance towards illicit drug use (e.g., incarceration and detention for mandatory treatment and rehabilitation), participants felt that as individuals recovering from substance use, they are 'condemned' and 'looked down upon' by society. Several participants also shared that their relatives are unaware of their substance use recovery. One participant was 'taught that you cannot share everything ... talking about it (substance use) is ridiculous' (Kaylee, member, age 50–59). She continues,

> 'My culture, my family upbringing is such that this (substance use) is a very big no-no. I mean, yeah, common. Government also catch [sic] you and then put you in prison, right. I never told my distant relative, like my mum's uncles and my mum's siblings. None of them know that I'm in recovery. They only know that I have depression ... There is always a stigma. I mean, it's not easy to tell "Hey", you know, "I'm sorry, I've done this. I'm a recovery addict". You know. No! I will get disowned.' (Kaylee, member, age 50–59)

Participants explained that 'shame is very much in our culture' (Owen, member, age 40–49). There is fear associated with bringing shame not only to themselves but also to their families. This became a powerful incentive for participants to avoid disclosing and sharing about their substance use problems.

> 'I think being Asian, how I feel and how much I share will also affect my family. And my mum being one of the people who is very ashamed of me. No, don't talk about prison. Don't talk about all these things. Don't talk about your using days. My mum will be very, very against me talking about all these things also because it's something she wants to hide.' (Owen, member, age 40–49)

As such, feeling ashamed of one's substance use can further deter participants from seeking help for their substance use problems. Not having support from their family is also a challenge for participants to attend the meetings as 'they don't understand why I am spending a lot of time here' (Owen, member, age 40–49). As a result, participants had to keep their substance use recovery a 'secret', often feeling like an 'outcast ... fighting a lonely battle' (George, member, age 40–49).

3.3 | Linguistic challenges as a barrier to participation

SMART Recovery meetings are held in English as Singapore uses English as a lingua franca. However, a few participants highlighted that there are members who could not understand the content due to their English proficiency. Compared to other mutual-aid groups, SMART Recovery provides skills and strategies to members, which can have more complex terminology and 'uses English [that] is more difficult' (Quinton, member, age 20–29). This challenge was also observed by facilitators, who commented that members may not speak out even if they do not understand so as not to disrupt the meeting.

> 'One, they don't want to hold everybody up, they are not quite sure whether people understand them, what they are saying. And it's intimidating enough to be sharing in front of another 15 people. And then two, not be able to express well enough.' (Calvin, facilitator, age 30–39)

For some participants, language proficiency posed as an additional barrier for them to engage in SMART Recovery. This had a negative impact on how much they benefitted from the meetings.

> 'I still remember, last time when I started, I don't know how to share. Don't know everything. But every time after the meeting, I feel very sad about it. Because I never [say] what I need help [for]. I never say. Like, you never share means you no problems. But you have a problem, only you don't know how to explain it. My English [is] no good.' (Quinton, member, age 20–29)

Facilitators address this challenge by using simple English and diagrams to aid understanding, and other members also help to interpret the content. As a result, members revealed that their English proficiency have improved since attending SMART Recovery. Participants also highlighted that what they learnt in the meetings were relevant and useful in their recovery.

> 'SMART is my favourite meeting ... because I like the [facilitators]. And one thing is they help me a lot. It's why it become my favourite. Because this is the voice I always use for my recovery ... Let me continue recovery, not relapse. So, this is why, the reasons. Yeah, can use for the real life ... It's like, which is more like, you need to learn step-by-step ... In SMART, actually it's like, how you problem [sic] and go to solve the problem.' (Quinton, member, age 20–29)

While such strategies help non-English speaking members understand the content of the meetings, English proficiency remains an obstacle. This is because 'if you don't understand the question, you will be like "mm, okay" ... you can get the point from other people, but you may not participate.' (Daisy, facilitator, 30–39). Members and facilitators suggested conducting SMART Recovery in different languages to increase engagement and, in turn, promote participation.

3.4 | A 'second family' fostered through continued engagement with SMART recovery

Despite the initial apprehension with SMART Recovery, continued engagement in meetings generated a sense of belongingness and trust among participants. For Finn (member, age 40–49), attending the meetings with friends or peers is important, and not having any 'might also stop me from attending meeting because I'm very scared'. If a new member 'is a bit out of place, we will try to include them in conversations and activities ... so that they feel more comfortable' (Finn, member, age 40–49). Regular attendance allowed participants to become familiar with each other. One participant describes, 'the more I attend, the more I trust the people, the more I dare to share' (Rose, member, age 50–59).

> 'For me when I go to a SMART meeting, I always go into a familiar face. I see familiar faces. Maybe that's one thing. That to me, also helps with that building of trust ... Familiarity actually allows me safety. I think being familiar with the people there also makes me feel like I'm walking into a family meeting. And that's very cosy and supportive.' (Owen, member, age 40–49)

In SMART Recovery meetings, members share similar experiences and difficulties with each other. This helped to develop camaraderie and sense of belonging, making it feel 'like a second family' (Eddie, member, age 30–39). Members reported feeling alone in their recovery, therefore it is important for them to 'know that there's a place that I can always come to' (Kaylee, member, age 50–59). Hearing similar experiences alleviated some of the shame surrounding their substance use, and members felt validated. There was the feeling 'that everyone's voice in SMART mattered ... and see that other people are relating to it, it feels good. It feels ... like you are valued' (Harry, member, age 30–39).

> 'I feel like, so I'm not alone. You know? This feeling I have, this problem that I'm facing, I am not the only one facing. Everyone around here is facing the same problem. And I used to be so ashamed to talk about our triggers and cravings that we have. But when we come here, everyone is facing that same problem, you see. It's easier to share.' (Kaylee, member, age 50–59)

Many participants commented that their contribution to SMART Recovery meetings was a 'very big change' (Finn, member, age 40–49). Participants felt that the established relationships, familiarity and bond between members helped to mitigate some of the sociocultural barriers that inhibited their initial participation in SMART Recovery. As shared by one member 'I do want to walk this journey with people I know, relationships that I built along the way, rather than walking with strangers all the time' (Owen, member, age 40–49).

3.5 | Facilitation approach and quality are affected by sociocultural factors

Facilitators' experience of running SMART Recovery meetings is also influenced by cultural values and norms in Singapore. Aaron (facilitator, age 50–59) shared,

> 'I think in the Asian context right, there is this leaning towards the-the top-down. Alright, because I think, as I said, you know, it's like— not because that the facilitator don't [sic] want to bounce off ideas. I don't think it's that, but it's more of the members, they are not so expressive ... "I am so trained to listen to instructions", you know, "so I don't have the tendency to talk so much".'

A top-down approach in group facilitation follows a hierarchical structure. Authority primarily rests with the

facilitator, who takes a directive role by making key decisions about the process and content of the group. In contrast, SMART Recovery meetings adopt a more member-driven approach, where discussions are shaped by the topics that members choose to talk about. Hence, running a group like SMART Recovery can be a 'harrowing' and 'scary' experience, particularly when members are not contributing or if discussions get carried away. Aaron (facilitator, age 50–59) reflected that being Singaporean, facilitators share the same cultural influences as the facilitator also fears feeling judged 'without knowing what are the topics that might interest the other person'. He continued,

> 'It's more of the facilitator taking the facilitator role, not a lecturer role. So that was very refreshing for me. But it was very scary going in with that ... So, I struggled a bit. Because I wanted to try the new method, but I am always afraid. And it shows ... It was very scary, and people can see. Can see my fear, you know.' (Aaron, facilitator, age 50–59)

Many members found that the helpfulness of SMART Recovery meetings depends on the facilitator. Owen (member, age 40–49) clarified that 'some of the facilitators are very good at making sure that we are very focused and helping us move through the topic in a very helpful manner. Sometimes, when the facilitator is not too strong (assertive), we do get lost and sometimes we do get distracted as well.' Facilitators commented that when they do not feel confident in managing group discussions, there is a tendency to take on a more directive approach.

> 'Some people, when they facilitate, they already have a tool (from the SMART Recovery manual) in mind that they want to teach irregardless [sic] of what the problems are ... and sometimes right, the tool wasn't very relevant.' (Aaron, facilitator, age 50–59)

For members, a directive approach can 'change into a lecture style' (Owen, member, age 40–49) and members struggle to understand when 'a very simple concept ... end up so scientific' (Nick, member, age 40–49). Furthermore, when members take on a passive role, 'there's no involvement and then we just sit and listen, sometimes we don't really learn much from it' (Finn, member, age 40–49). Facilitators reflected that their experience improved when they 'keep trying' and become more accustomed to facilitating discussions in SMART Recovery. By having a mix of new and more experienced members, it aided facilitation as older members familiar with the structure 'helps other individuals become more comfortable with sharing' (Calvin, facilitator, age 30–39). Calvin (facilitator, age 30–39) added, 'like in any kind of therapeutic relationship, rapport and relationship is the most important portion'. Once trust and connection have been built with the members, there is more engagement, which also made facilitation easier.

4 | DISCUSSION

The present study contributes to and expands upon the small body of research on the sociocultural influences underlying members' and facilitators' experiences and perspectives of SMART Recovery. Barriers associated with their engagement and participation in meetings were also identified. Throughout the interviews, members' recent experience of SMART Recovery was largely positive, lending preliminary support to the satisfaction of the group for substance use recovery in Singapore. This adds to prior research demonstrating members' satisfaction with SMART Recovery [e.g., 25, 64]. Furthermore, findings are consistent with current literature, indicating that positive perceptions of services from members and facilitators (i.e., experiences and satisfaction) are vital in its uptake and acceptance [65, 66].

Nonetheless, members' retrospection of their early experience of SMART Recovery indicated that the initial process of engaging in the meetings can be challenging. Several sociocultural factors contributed to this experience, particularly the fear of negative evaluation, stigma, and shame surrounding substance use, and how this can negatively reflect on them or their families. The self in many Asian contexts, such as Singapore, is characterised as interdependent and integrally connected to others [36, 67]. Individuals with interdependent self-construal (i.e., how individuals view themselves) are motivated to fit in and adjust themselves to the expectations and needs of others [36]. Hence, importance is placed on maintaining familial ties and fulfilling obligations to self, family, and community [41, 42, 68]. One of the central responsibilities and traditional values in Asian cultures is to avoid bringing shame or loss of dignity on the family, and doing so is in itself a source of shame [69]. This is congruous with the accounts from participants in the present study, who described a heightened sensitivity to relational cues. Therefore, to avoid bringing shame or embarrassment to themselves or their families, members implemented social strategies such as selectively presenting information to obtain approval or recognition from others (competent self-image goals), or minimising self-disclosure to avoid being ostracised (likable self-image goals) [70]. This is in line with prior research with Asian communities across various disciplines, indicating that shame is a powerful

incentive not to disclose difficulties, even at the expense of individual well-being [71–73].

These findings can be understood through the EVM. Participants highlighted factors important in shaping their experiences of SMART Recovery, which aligned with certain dimensions of the EVM (i.e., methods, language, context and persons). When considering the methods to foster engagement, knowledge about the local culture is essential. Findings suggest that the purpose of self-disclosure in SMART Recovery may need to be better conveyed to members to help build trust, rather than be perceived as shaming. Providing facilitators with training on how to provide culturally safe care to members is therefore imperative, given members' fear of being judged by others.

Several issues related to language were identified during the interviews. SMART Recovery material could contain more complex terminology, which can affect comprehensibility and acceptability. Results emphasised the importance of the translation of materials into the most common languages spoken by the members, or the use of strategies such as using simple language or visual representations. Despite Singapore adopting English as a lingua franca and the major medium of instruction [74], there are still variations in English proficiency due to differences in the home literacy environment (i.e., mainly speaking a language other than English at home) and socioeconomic status [75, 76]. In the latest government household survey conducted in Singapore, 36.9% of respondents spoke mainly English at home, followed by 34.9% Mandarin, 12.2% Chinese dialects, 10.7% Malay, 3.3% Tamil and 2.0% other languages [77]. The use of English was also less prevalent among older Singaporeans [77]. This underlines the importance of providing SMART Recovery in other languages in addition to English. A growing body of evidence has shown the correlation between interventions conducted in the target population's primary language (if other than English), and treatment retention and engagement [78–82]. In a randomised controlled trial on Alcoholic Anonymous (another mutual-aid group for alcohol use), retention rate was greater in the group that has been translated to the primary language compared to the English group [81]. Interventions conducted in client's primary language were also twice as effective compared to interventions in English [78]. Hence, offering translated groups can improve treatment adherence within a population that is at high risk of treatment dropout.

Despite the initial challenges, participants indicated that continued engagement in SMART Recovery is a necessary component that led to positive changes in members' experiences. Consistent with the context and persons dimension in the EVM, participants are from recovery centres and share a similar culture, experiences and difficulties with other members. As a result, other members became like 'family' which made them more comfortable being vulnerable in meetings. This could be explained by the close interpersonal relationships developed among participants over time. 'Face' concerns are more salient in interactions with strangers or acquaintances, rather than close others [83]. Furthermore, individuals with interdependent self-construal are more likely to gain self-esteem from a strong identification with the reputation of groups to which they belong and tend to prioritise the fulfilment of their roles and obligations to these groups [35]. By utilising other members in the group as social support, it can therefore encourage greater participation.

The overall results of this study reinforce the need for culturally responsive practices [84, 85]. The aim was to explore participants' experiences, hence a detailed examination of the dimensions of the EVM is beyond the scope of the present study. Future studies are needed to investigate other dimensions of the EVM (e.g., metaphors, concepts, content and goals) within this context to elucidate factors that foster members' engagement in SMART Recovery and overall recovery. Facilitators who were able to consider the role of culture in group participation can accurately and realistically address these issues in a flexible way that is comfortable and safe [86]. Thus, identification of strategies for retaining members and improving engagement in SMART Recovery is needed. Nonetheless, while facilitator's cultural responsivity is an important component, few studies have examined how culture can also influence facilitation style. Facilitators described a tendency for members to be more accustomed to listening than actively participating in meetings. As a result, this dynamic can create a challenge for facilitators, particularly when they feel unprepared to manage members' engagement effectively. Given the impact of facilitation style on participants' experience of SMART Recovery, it is important to recognise that sociocultural factors can similarly affect facilitation styles. Although the present study did not extensively explore the top-down approach within this sociocultural context, future research could investigate it in greater depth.

The present study had several limitations. The ability to draw broad conclusions is constrained by the small sample size and representativeness of the sample. Recruitment efforts were impacted by the limited number of trained SMART facilitators. Additionally, participants were recruited through recovery centres, potentially leading to an atypical sample of engaged members, whose experiences may differ from those who were less engaged or had stopped attending SMART Recovery. The views of participants completing the interview might only be representative of those who are keen to engage with SMART Recovery and might be over-represented by those that have had a positive experience. Furthermore, purposive sampling was

employed to recruit individuals with a working understanding of English, aiming to capture diverse experiences and perspectives. This approach may have resulted in a sample that does not fully reflect the broader population of individuals who use substances in Singapore. The present sample was predominantly composed of Chinese individuals with higher levels of education. While this demographic aligns with Singapore's ethnic composition (75.6% of the population in 2023 was Chinese) [38], drug-related statistics show that 30% and 48% of those apprehended for drug use were Chinese and Malay, respectively [7]. This may limit the generalisability of the findings to other contexts or demographics. Exploring the perceptions and experiences across communities could be an important consideration for future research to better understand unique barriers to participation. For example, future research could investigate how cultural factors may interact with gender, language discordance, and principal drug of concern to influence engagement and recovery outcomes. Longitudinal qualitive approaches can also be employed to provide insights into the continuity and change in members' experiences of SMART Recovery, as well as recovery pathways and engagement in other mutual-aid groups and activities that support recovery. Despite these limitations, the present findings have important implications in understanding participation in SMART Recovery in Singapore. Findings also have broader implications in understanding help-seeking and treatment engagement for members in Singapore and the way mutual-aid groups can be designed and delivered to individuals in Singapore.

This study highlights the sociocultural challenges that members and facilitators experience when engaging in SMART Recovery. The experience and perspectives described by members and facilitators of SMART Recovery in Singapore in the present study reflect the undeniable need to acknowledge the unique cultural challenges and complexities that can affect individuals from accessing SMART Recovery. Facilitators validated these challenges and recognised that they can be similarly affected by these sociocultural influences. Given the growing rate of substance use among this population and their need for support in recovery, there is a dire need to ensure that SMART Recovery and other services are tailored to the needs of this population. When the experience of these services is optimised, it can encourage uptake and engagement, thus improving health outcomes.

AUTHOR CONTRIBUTIONS

WJT: Conceptualisation; Data curation; Formal analysis; Investigation; Methodology; Project administration; Writing—original draft; Writing—review and editing. **BL:** Conceptualisation; Methodology; Supervision; Writing—review and editing. **MJS:** Methodology; Validation; Writing—review and editing. **ASXL:** Validation; Writing—review and editing. **KL:** Conceptualisation; Writing—review and editing. **PJK:** Conceptualisation; Methodology; Supervision; Writing—review and editing.

ACKNOWLEDGEMENTS

The authors would like to extend their sincere gratitude to the members and facilitators who contributed to this research by sharing their experiences and insights. The authors would also like to thank Sam Nugraha, SMART Recovery Indonesia, and staff members of the recovery centres in Singapore for their invaluable support and contributions to the study. Open access publishing facilitated by University of Wollongong, as part of the Wiley - University of Wollongong agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

The first author conducted this study as part of her PhD dissertation and is supported by the International Postgraduate Tuition Awards and University Postgraduate Award at the University of Wollongong.

CONFLICT OF INTEREST STATEMENT

The funding source had no role in study design, analysis and interpretation of data, preparation of manuscript, or any decision to submit the manuscript. BL, KL and PJK are members of the SMART Recovery Global Research Advisory Committee.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Wan Jie Tan https://orcid.org/0000-0002-0095-1303
Briony Larance https://orcid.org/0000-0003-3800-7673
Matthew J. Schweickle https://orcid.org/0000-0001-7752-8573
Angie S. X. Lim https://orcid.org/0009-0004-1173-3127
Kate Lowe https://orcid.org/0000-0001-5536-6657
Peter J. Kelly https://orcid.org/0000-0003-0500-1865

REFERENCES

1. Singapore Statutes Online. Misuse of Drugs Act 1973: 2020 revised edition. 2020. Available from: https://sso.agc.gov.sg/Act/MDA1973
2. Central Narcotics Bureau. CNB Explains: Where do adult drug abusers go when caught? 2022. Available from: https://www.cnb.gov.sg/CNBExplains/where-do-adult-drug-abusers-go-when-caught
3. Singapore Prison Service. Community Based Programmes 2024. Available from: https://www.sps.gov.sg/learn-about-corrections/community-transition/cbp/
4. Support Go Where. Project SAFE 1.1. 2024. Available from: https://supportgowhere.life.gov.sg/services/SVC-PS/project-safe-11

5. Subramaniam M, Abdin E, Vaingankar JA, Shafie S, Chua BY, Sambasivam R, et al. Tracking the mental health of a nation: prevalence and correlates of mental disorders in the second Singapore mental health study. Epidemiol Psychiatr Sci. 2019; 29:e29–e.
6. Subramaniam M, Koh YS, Sambasivam R, Abdin E, Asharani PV, Vaingankar JA, et al. Prevalence of consumption of illicit drugs and associated factors from a nationwide epidemiological survey: the Singapore health and lifestyle survey. Ann Acad Med Singapore. 2024;53:222–32.
7. Central Narcotics Bureau. Singapore Drug Situation Report 2023; 2024. Available from: https://www.cnb.gov.sg/docs/default-source/drug-situation-report-documents/cnb-annual-statistics-2023.pdf
8. Dawson DA, Grant BF, Stinson FS, Chou PS. Estimating the effect of help-seeking on achieving recovery from alcohol dependence. Addiction. 2006;101:824–34.
9. Hai AH, Oh S, Lee CS, Kelly JF, Vaughn MG, Salas-Wright CP. Mutual-help group participation for substance use problems in the US: correlates and trends from 2002 to 2018. Addict Behav. 2022;128:107232.
10. Singapore Anti-Narcotics Association. Addiction Treatment/Support Groups. n.d. Available from: https://www.sana.org.sg/help-addiction-treatment-support-groups/
11. We Care Community Services. Recovery Support Groups. 2025. Available from: https://www.wecare.org.sg/services-recovery-support-groups.php
12. Kelly JF, Humphreys K, Ferri M. Alcoholics anonymous and other 12-step programs for alcohol use disorder. Cochrane Database Syst Rev. 2020;3:CD012880.
13. Kelly JF, Levy S, Matlack M. A systematic qualitative study investigating why individuals attend, and what they like, dislike, and find most helpful about, smart recovery, alcoholics anonymous, both, or neither. J Subst Use Addict Treat. 2024;161:209337.
14. Penn PE, Brooke D, Brooks AJ, Gallagher SM, Barnard AD. Co-occurring conditions clients and counselors compare 12-step and smart recovery mutual help. J Groups Addict Recover. 2016;11:76–92.
15. Gray RM, Kelly PJ, Beck AK, Baker AL, Deane FP, Neale J, et al. A qualitative exploration of SMART recovery meetings in Australia and the role of a digital platform to support routine outcome monitoring. Addict Behav. 2020;101:106144.
16. Kidd M. A firsthand account of service user groups in the United Kingdom: an evaluation of their purpose, effectiveness, and place within the recovery movement. J Groups Addict Recover. 2011;6:164–75.
17. Horvath AT, Yeterian J. SMART recovery: self-empowering, science-based addiction recovery support. J Groups Addict Recover. 2012;7:102–17.
18. Bogenschutz MP, Rice SL, Tonigan JS, Vogel HS, Nowinski J, Hume D, et al. 12-step facilitation for the dually diagnosed: a randomized clinical trial. J Subst Abuse Treat. 2014;46:403–11.
19. Kelly JF, Kaminer Y, Kahler CW, Hoeppner B, Yeterian J, Cristello JV, et al. A pilot randomized clinical trial testing integrated 12-step facilitation (iTSF) treatment for adolescent substance use disorder. Addiction. 2017;112:2155–66.
20. Timko C, DeBenedetti A. A randomized controlled trial of intensive referral to 12-step self-help groups: one-year outcomes. Drug Alcohol Depend. 2007;90:270–9.
21. Campbell W, Hester RK, Lenberg KL, Delaney HD. Overcoming addictions, a web-based application, and SMART recovery, an online and in-person mutual help Group for Problem Drinkers, part 2: six-month outcomes of a randomized controlled trial and qualitative feedback from participants. J Med Internet Res. 2016;18:e262.
22. Hester RK, Lenberg KL, Campbell W, Delaney HD. Overcoming addictions, a web-based application, and SMART recovery, an online and in-person mutual help group for problem drinkers, part 1: three-month outcomes of a randomized controlled trial. J Med Internet Res. 2013;15:e134.
23. Kelly PJ, Beck AK, Deane FP, Larance B, Baker AL, Hides L, et al. Feasibility of a Mobile health app for routine outcome monitoring and feedback in SMART recovery mutual support groups: stage 1 mixed methods pilot study. J Med Internet Res. 2021;23:e25217-e.
24. Manning V, Roxburgh AD, Savic M. Piloting the integration of SMART recovery into outpatient alcohol and other drug treatment programs. Addict Sci Clin Pract. 2023;18:52.
25. Zemore SE, Kaskutas LA, Mericle A, Hemberg J. Comparison of 12-step groups to mutual help alternatives for AUD in a large, national study: differences in membership characteristics and group participation, cohesion, and satisfaction. J Subst Abuse Treat. 2017;73:16–26.
26. SMART Recovery Australia. Annual Report 2022. 2022. Available from: https://smartrecoveryaustralia.com.au/hubfs/23743336/SMART%20RECOVERY%20-%20Annual%20Report%20final_web.pdf?hsLang=en-au
27. Subramaniam M, Abdin E, Vaingankar JA, Shafie S, Chua HC, Tan WM, et al. Minding the treatment gap: results of the Singapore mental health study. Soc Psychiatry Psychiatr Epidemiol. 2020;55:1415–24.
28. Lum A, Damianidou D, Bailey K, Cassel S, Unwin K, Beck A, et al. SMART recovery for youth: a small, exploratory qualitative study examining the potential of a mutual-aid, peer support addictive behaviour change program for young people. Addict Sci Clin Pract. 2023;18:30.
29. Beck AK, Forbes E, Baker AL, Kelly PJ, Deane FP, Shakeshaft A, et al. Systematic review of SMART recovery: outcomes, process variables, and implications for research. Psychol Addict Behav. 2017;31:1–20.
30. Wah TH, Ong AJX, Naidu KNC, Hanafi S, Tan K, Tan A, et al. Navigating drug use, cessation, and recovery: a retrospective case notes review among sexual minority men at a community-based service in Singapore. Subst Abuse Treat Prev Policy. 2024;19:23.
31. Abdullah T, Brown TL. Mental illness stigma and ethnocultural beliefs, values, and norms: an integrative review. Clin Psychol Rev. 2011;31:934–48.
32. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5-TR. 5th ed. Washington, DC: American Psychiatric Association Publishing; 2022.
33. Green EGT, Deschamps J-C, Páez D. Variation of individualism and collectivism within and between 20 countries: a typological analysis. J Cross Cult Psychol. 2005;36:321–39.
34. Lomas T, Diego-Rosell P, Shiba K, Standridge P, Lee MT, Case B, et al. Complexifying individualism versus collectivism and west versus east: exploring global diversity in perspectives on self and other in the Gallup world poll. J Cross Cult Psychol. 2023;54:61–89.

35. Nilchaikovit T, Hill JM, Holland JC. The effects of culture on illness behavior and medical care. Gen Hosp Psychiatry. 1993; 15:41–50.
36. Uchida Y, Kitayama S, Mesquita B, Reyes JAS, Morling B. Is perceived emotional support beneficial? Well-being and health in independent and interdependent cultures. Pers Soc Psychol Bull. 2008;34:741–54.
37. Singapore Department of Statistics. Census of Population 2020—Religion. 2020. Available from: https://www.singstat.gov.sg/-/media/files/visualising_data/infographics/c2020/c2020-religion.ashx
38. Singapore Department of Statistics. Population in Brief 2023. 2023.
39. Tan C. "Our shared values" in Singapore: a confucian perspective. Educ Theory. 2012;62:449–63.
40. Lee WO. Education for future-oriented citizenship: implications for the education of twenty-first century competencies. Asia Pac J Educ. 2012;32:498–517.
41. Ministry of Education Singapore. 21st Century Competencies. 2023. Available from: https://www.moe.gov.sg/education-in-sg/21st-century-competencies
42. Ministry of Education Singapore. Character and Citizenship Education syllabus 2012. Available from: https://www.moe.gov.sg/-/media/files/primary/characterandcitizenshipeducationprimarysyllabusenglish.pdf
43. Tan C, Tan CS. Fostering social cohesion and cultural sustainability: character and citizenship education in Singapore. Diaspora Indig Minor Educ. 2014;8:191–206.
44. Burlew AK, Copeland VC, Ahuama-Jonas C, Calsyn DA. Does cultural adaptation have a role in substance abuse treatment? Soc Work Public Health. 2013;28:440–60.
45. Norcross JC, Wampold BE. What works for whom: tailoring psychotherapy to the person. J Clin Psychol. 2011;67:127–32.
46. Smith TB, Rodríguez MD, Bernal G. Culture. J Clin Psychol. 2011;67:166–75.
47. Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. J Abnorm Child Psychol. 1995;23:67–82.
48. Venner KL, Hernandez-Vallant A, Hirchak KA, Herron JL. A scoping review of cultural adaptations of substance use disorder treatments across Latinx communities: guidance for future research and practice. J Subst Abuse Treat. 2022;137:108716.
49. American Psychological Association. Qualitative design reporting standards guidelines. 2020 Available from: https://apastyle.apa.org/jars/qual-table-1.pdf
50. Maxwell JA. A realist approach for qualitative research. Thousand Oaks: SAGE Publications; 2012.
51. Williams M, Moser T. The art of coding and thematic exploration in qualitative research. Int Manag Rev. 2019;15:45–72.
52. Lawani A. Critical realism: what you should know and how to apply it. Qual Res J. 2021;21:320–33.
53. Ponterotto JG. Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. J Couns Psychol. 2005;52:126–36.
54. Braun V, Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. Qual Res Sport Exerc Health. 2021;13: 201–16.
55. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qual Res Sport Exerc Health. 2019;11:589–97.
56. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. Qual Health Res. 2016;26:1753–60.
57. Sim J, Saunders B, Waterfield J, Kingstone T. Can sample size in qualitative research be determined a priori? Int J Soc Res Method. 2018;21:619–34.
58. Kelly M, Dowling M, Millar M. The search for understanding: the role of paradigms. Nurse Res. 2018;25:9–13.
59. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3:77–101.
60. Mollinga PP. Knowledge, context and problemsheds: a critical realist method for interdisciplinary water studies. Water Int. 2020;45:388–415.
61. Wynn D, Williams CK. Principles for conducting critical realist case study research in information systems. Mis Q. 2012;36: 787–810.
62. Ortlipp M. Keeping and using reflective journals in the qualitative research process. Qual Rep. 2008;13:695–705.
63. Costa LA, Kallick B. Through the lens of a critical friend. Educ Leadersh. 1993;51:49.
64. Kelly PJ, Raftery D, Deane FP, Baker AL, Hunt D, Shakeshaft A. From both sides: participant and facilitator perceptions of SMART recovery groups. Drug Alcohol Rev. 2017;36:325–32.
65. Dawkins B, Renwick C, Ensor T, Shinkins B, Jayne D, Meads D. What factors affect patients' ability to access healthcare? An overview of systematic reviews. Trop Med Int Health. 2021;26:1177–88.
66. Hoover K, Lockhart S, Callister C, Holtrop JS, Calcaterra SL. Experiences of stigma in hospitals with addiction consultation services: a qualitative analysis of patients' and hospital-based providers' perspectives. J Subst Abuse Treat. 2022;138:108708.
67. Markus HR, Kitayama S. Culture and the self: implications for cognition, emotion, and motivation. Psychol Rev. 1991;98: 224–53.
68. Krishna LKR, Alsuwaigh R, Miti PT, Wei SS, Ling KH, Manoharan D. The influence of the family in conceptions of personhood in the palliative care setting in Singapore and its influence upon decision making. Am J Hosp Palliat Care. 2014; 31:645–54.
69. Kim BSK, Atkinson DR, Umemoto D. Asian cultural values and the counseling process: current knowledge and directions for future research. Counselor Psychol. 2001;29:570–603.
70. Niiya Y, Crocker J. Interdependent = compassionate? Compassionate and self-image goals and their relationships with interdependence in the United States and Japan. Front Psychol. 2019;10:192.
71. Abdul Latiff M, Fang L, Goh DA, Tan LJ. A systematic review of factors associated with disclosure of child sexual abuse. Child Abuse Negl. 2024;147:106564.
72. Hynes KC. Cultural values matter: the therapeutic Alliance with east Asian Americans. Contemp Fam Ther. 2019;41:392–400.
73. Yakeley J. Shame, culture and mental health. Nord J Psychiatry. 2018;72(Sup 1):S20–2.
74. Bo WV, Fu M, Lim WY. Revisiting English language proficiency and its impact on the academic performance of domestic university students in Singapore. Language Test. 2023;40:133–52.

75. Dixon LQ. The role of home and school factors in predicting English vocabulary among bilingual kindergarten children in Singapore. Appl Psycholinguist. 2011;32:141–68.
76. O'Brien BA, Ng SC, Arshad NA. The structure of home literacy environment and its relation to emergent English literacy skills in the multilingual context of Singapore. Early Child Res Q. 2020;53:441–52.
77. Department of Statistics Singapore. General Household Survey 2015. 2015. Available from: https://www.singstat.gov.sg/-/media/files/publications/ghs/ghs2015/ghs2015.pdf
78. Griner D, Smith TB. Culturally adapted mental health intervention: a meta-analytic review. Psychotherapy. 2006;43:531–48.
79. Guerrero EG, Khachikian T, Kim T, Kong Y, Vega WA. Spanish language proficiency among providers and Latino clients' engagement in substance abuse treatment. Addict Behav. 2013;38:2893–7.
80. Guerrero EG, Campos M, Urada D, Yang JC. Do cultural and linguistic competence matter in Latinos' completion of mandated substance abuse treatment? Subst Abuse Treat Prev Policy. 2012;7:34.
81. Lasebikan VO, Lasebikan GL. Translation of the 12-step alcoholic anonymous from English language to Yoruba language and its application within the Yoruba culture among patients with alcohol use disorder in Nigeria. Ment Health Relig Cult. 2017;20:898–910.
82. Puri N, Allen K, Rieb L. Treatment of alcohol use disorder among people of south Asian ancestry in Canada and the United States: a narrative review. J Ethn Subst Abuse. 2020;19:345–57.
83. Boiger M, Güngör D, Karasawa M, Mesquita B. Defending honour, keeping face: interpersonal affordances of anger and shame in Turkey and Japan. Cogn Emot. 2014;28:1255–69.
84. Lampe NM, Rodill ZE, Nowakowski ACH. "My support groups... have saved my life.": facilitators of positive or satisfactory experiences in behavioral healthcare for transgender and gender nonconforming older adults. Aging Ment Health. 2025;29:167–75.
85. Richer A, Roddy AL. Opioid use in indigenous populations: indigenous perspectives and directions in culturally responsive care. J Soc Work Pract Addict. 2022;22:255–63.
86. Both Gragg J, Wilson CM. Mexican American family's perceptions of the multirelational influences on their adolescent's engagement in substance use treatment. Family J. 2011;19:299–306.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Tan WJ, Larance B, Schweickle MJ, Lim ASX, Lowe K, Kelly PJ. Sociocultural context of SMART recovery in Singapore: A qualitative exploration of members and facilitators perspectives and experiences. Drug Alcohol Rev. 2025;44(4):961–74. https://doi.org/10.1111/dar.14048