
**National Institute on Alcohol Abuse and Alcoholism
Project MATCH Monograph Series
Volume 1**

TWELVE STEP FACILITATION THERAPY MANUAL

**A Clinical Research Guide for
Therapists Treating Individuals
With Alcohol Abuse and Dependence**

By:

Joseph Nowinski, Ph.D.

Stuart Baker, M.A., C.A.C.

Kathleen Carroll, Ph.D.

Project MATCH Monograph Series Editor:

Margaret E. Mattson, Ph.D.

U.S. Department of Health and Human Services
Public Health Service
National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism
6000 Executive Boulevard
Rockville, Maryland 20892-7003

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Project MATCH Research Group and Other Contributors

Principal and Coinvestigators at the Sites

William Miller, Ph.D.
Reid Hester, Ph.D.
Center on Alcoholism, Substance Abuse and Addictions
University of New Mexico
Albuquerque, NM

Gerard Connors, Ph.D.
Robert Rychtarik, Ph.D.
Research Institute on Alcoholism
Buffalo, NY

Carrie Randall, Ph.D.
Raymond Anton, M.D.
Medical University of South Carolina and
Veterans Administration Medical Center
Charleston, SC

Ronald Kadden, Ph.D.
Ned Cooney, Ph.D.
University of Connecticut School of Medicine
Farmington, CT

Carlo DiClemente, Ph.D.
Joseph Carbonari, Ed.D.
University of Houston
Houston, TX

Allen Zweben, D.S.W.
University of Wisconsin-Milwaukee
Milwaukee, WI

Richard Longabaugh, Ed.D.
Robert Stout, Ph.D.
Brown University
Providence, RI

Dale Walker, M.D.
Dennis Donovan, Ph.D.
University of Washington and Seattle VA Medical Center
Seattle, WA

Coordinating Center Principal and Coinvestigators

Thomas Babor, Ph.D.
Frances Del Boca, Ph.D.
University of Connecticut
Farmington, CT

Kathleen Carroll, Ph.D.
Bruce Rounsaville, M.D.
Yale University
New Haven, CT

NIAAA Staff

John Allen, Ph.D.
Project Officer for Project MATCH
Chief, Treatment Research Branch

Margaret Mattson, Ph.D.
Staff Collaborator for Project MATCH

**NIAAA
Cooperative
Education
Program
Participant**

Lisa Marshall
Gallaudet University
Washington, DC

Consultants

Larry Muenz, Ph.D.
Gaithersburg, MD

Philip Wirtz, Ph.D.
George Washington University
Washington, DC

Contractor

Jane K. Myers
President
Janus Associates
Bethesda, MD

Foreword

A major focus of the efforts of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in treatment research is to rigorously test the patient-treatment matching approach to the clinical management of alcoholism. This commitment is particularly reflected in its multi-site clinical trial, Project MATCH. This study is the first national, multisite trial of patient-treatment matching and one of the two largest current initiatives of NIAAA. Established under a cooperative agreement that allows direct collaboration between the Institute and the researcher, the project involves nine geographically representative clinical sites and a data coordinating center. Researchers in Project MATCH are among the most senior and experienced treatment scientists in the field. Both public and private treatment facilities, as well as hospital and university outpatient facilities, are represented.

The manuals in this series are the result of the collaborative efforts of the Project MATCH investigators and are used as guides by therapists in the trial. They are presented to the alcohol research community as standardized, well-documented intervention tools for alcoholism treatment research. The final reports of Project MATCH will inform us on the relative efficacy of the interventions being evaluated in the trial and on the types of clients who benefit the most from each of the therapies.

Until the final results from Project MATCH are presented to the community, these interim manuals will summarize the consensus of the investigators on reasonable intervention approaches based on present knowledge. We look forward to offering further refinements of these approaches as Project MATCH data are analyzed and published and as the alcohol treatment field advances through the efforts of other ongoing research.

Enoch Gordis, M.D.
Director
National Institute on Alcohol Abuse
and Alcoholism

Preface

This manual for therapists is provided to the public to permit replication of the treatment procedures employed in Project MATCH, a multisite clinical trial of patient-treatment matching sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It describes Twelve-Step Facilitation Therapy (TSF), one of three treatment approaches studied in Project MATCH. Therapist manuals for the other treatments—Motivational Enhancement Therapy (MET) and Cognitive-Behavioral Coping Skills Therapy (CBT)—are available in volumes 2 and 3 of this series, respectively.

Rationale for Patient-Treatment Matching

Although a number of therapies have had varying degrees of success, no single treatment has been shown to be effective for all individuals diagnosed with alcohol abuse or dependence. In recent years, interest in the field has increasingly focused on patient-treatment matching to improve outcome. The hypothesis is that more beneficial results can be obtained if treatment is prescribed on the basis of individual patient needs and characteristics as opposed to treating all patients with the same diagnosis in the same manner.

Many investigators have turned their attention from main effects evaluations (i.e., studies that ask whether one intervention is more effective than another) to studies specifically designed to identify interactions between particular treatments and patient variables. While treatments may not appear to differ in effectiveness when applied to a heterogeneous client population, specific treatments may indeed be more or less effective for specific, clinically meaningful subgroups.

This reasoning has led to a new generation of alcoholism treatment research studies whose design is driven by the objective of finding effective “matches.” Ultimately, the goal of this line of research is to provide the clinician with valid and practical rules applicable across a variety of treatment settings to assign patients to those treatment regimens particularly suited to them.

Project MATCH: An Overview

Project MATCH, a 5-year study, was initiated by the Treatment Research Branch of NIAAA in 1989. The details of the design and implementation of Project MATCH will be described in full in forthcoming publications. This section outlines the major features of the study.

The objective of Project MATCH is to determine if varying subgroups of alcohol abusing or dependent patients respond differentially to three treatments: (1) Twelve-Step Facilitation Therapy, (2) Cognitive-Behavioral Coping Skills Therapy, and (3) Motivational Enhancement Therapy. Each treatment is delivered during a 12-week period by trained therapists following a standardized protocol.

The project consists of two independent treatment-matching studies, one with clients recruited at five outpatient settings, the second with patients receiving aftercare treatment at four sites following an episode of standard inpatient treatment. Patients are randomly assigned to one of the three treatment approaches. Each study evaluates the interaction effects between selected patient characteristics and the three treatments.

Each of the nine study sites is recruiting approximately 150-200 clients. Clients are evaluated at intake and again at 3, 6, 9, 12, and 15 months. Outcome measures for the trial include drinking behavior, psychological and social function, and consequences of drinking. Analyses of a priori hypotheses, as well as exploratory analyses, will show whether different patient characteristics are associated with differential treatment outcomes in each of the three therapeutic interventions.

Twelve-Step Facilitation Approach. This therapy is grounded in the concept of alcoholism as a spiritual and medical disease. The content of this intervention is consistent with the 12 Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. In addition to abstinence from alcohol, a major goal of the treatment is to foster the patient's commitment to participation in AA. During the course of the program's 12 sessions, patients are actively encouraged to attend AA meetings and to maintain journals of their AA attendance and participation. Therapy sessions are highly structured, following a similar format each week that includes symptoms inquiry, review and reinforcement for AA participation, introduction and explication of the week's theme, and setting goals for AA participation for the next week. Material introduced during treatment sessions is complemented by reading assignments from AA literature.

Motivational Enhancement Therapy. MET is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead

employs motivational strategies to mobilize the client's own resources. MET consists of four carefully planned and individualized treatment sessions. The first two sessions focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions at the midpoint and end of treatment provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change.

Cognitive-Behavioral Therapy. This therapy is based on the principles of social learning theory and views drinking behavior as functionally related to major problems in the person's life. It posits that addressing this broad spectrum of problems will prove more effective than focusing on drinking alone. Emphasis is placed on overcoming skill deficits and increasing the person's ability to cope with high-risk situations that commonly precipitate relapse, including both interpersonal difficulties and intrapersonal discomfort, such as anger or depression. The program consists of 12 sessions with the goal of training the individual to use active behavioral or cognitive coping methods to deal with problems rather than relying on alcohol as a maladaptive coping strategy. The skills also provide a means of obtaining social support critical to the maintenance of sobriety.

Caveats and Critical Considerations

Although all three manuals were developed for a randomized clinical trial focusing on patient-treatment matching hypotheses, the substance of the interventions is equally suitable for other research questions and designs. However, the reader needs to be aware of the parameters of Project MATCH.

Therapy is delivered in a structured research situation. All three treatments are manual guided and administered by experienced therapists who receive specialized training in one of the three project interventions. Therapists closely follow the procedures outlined in their manual, with regular supervision (by observation of videotapes) from both local and projectwide clinical supervisors.

This manual is written for therapists with similar intensive training and supervision. A summary of the procedures used to select, train, and supervise therapists in Project MATCH is provided in appendix B.

There is an important difference between a therapy textbook and a therapy manual. A therapy textbook is a comprehensive presentation of a particular therapeutic approach, usually describing a conceptual model, general principles, and a broad range of applications and examples. It is typically meant to facilitate broad utilization of a therapeutic approach by a wide range of practitioners in a variety of settings. A therapy *manual*, on the other hand, is intended to operationalize and standardize a treatment approach to be used in a particular context, usually a specific clinical trial. In writing a therapy manual, the authors

must make a number of specific decisions (e.g., the number and timing of sessions, the content of each session) that are ordinarily left to clinical judgment in a therapy textbook.

This manual is designed to standardize TSF as a 12-session treatment modality within the particular context of Project MATCH. All treatments are preceded by the same extensive assessment battery, requiring approximately 7-8 hours. Abstinence is the expressed goal of all treatments and, except in unusual situations, all sessions are videotaped. Each treatment session is preceded by a breath test to ensure sobriety, and a positive breath alcohol reading results in rescheduling the session. Therapists are prohibited from mixing TSF with other treatment approaches, and the purity of approach is maintained by local and national supervisors who review videotapes. All therapy has to be completed within 90 days. A significant other can be invited to participate in up to two sessions.

Other design requirements of clinical trials are likewise standardized across all sites, including features such as defined patient eligibility criteria, randomized assignment of treatment, and guidelines for dealing with patients who are late or absent for treatment sessions or who show significant clinical deterioration during the course of the intervention. Guidelines regulate and document the amount and type of therapy over and above that provided by Project MATCH that a client receives during the study. Data collection and delivery of treatment are kept strictly separate, with the former being handled by research assistants under the supervision of the project coordinators. The three manuals refer to these Project MATCH-specific procedures with the knowledge that some readers may wish to follow similar guidelines while others may choose to devise new guidelines more appropriate to the requirements of their own project.

The therapeutic approach underlying this manual is grounded in the principles and 12 Steps of AA. It is important to note, however, that this manual has no official relationship with or sanction from Alcoholics Anonymous. The fellowship of AA is described in its official literature and is realized through its worldwide meetings. Alcoholics Anonymous does not sponsor or conduct research into alcoholism or its treatment or endorse any treatment program. While intended to be consistent with AA principles, this treatment program is designed for use in a research project. Its goals are to educate clients regarding the AA view of alcoholism and to facilitate their active participation in AA.

The general therapeutic principles underlying TSF can be applied in many other ways than those delineated here. Under ordinary circumstances, the number, duration, and distribution of sessions could be flexible. Significant others might be involved in all sessions or none at all. The goals of therapy might be more flexible, and the 12-Step facilitation procedures could be intermixed with other therapeutic strategies.

The specific prescriptions outlined in this manual are imposed for purposes of standardization and separation of treatments in Project MATCH. An expanded text on 12-Step facilitation, for broad use in the treatment of alcohol and drug dependence, will be published by a private firm in the fall of 1992.

The staff of Project MATCH and NIAAA make no claims or guarantees regarding the effectiveness of the treatment procedures described in this manual. Although 12-Step programs are widely used both in this country and abroad, the specific efficacy of TSF as outlined in this manual remains to be tested. The final reports of Project MATCH will provide clearer information on the efficacy of this approach relative to others and on the types of clients for whom it may be optimal. In the interim, it is our hope that these manuals will serve as a useful tool for the alcohol clinical research community by offering a detailed description of TSF procedures as constructed by consensus among the investigators and implemented by the therapists of Project MATCH. All manuals of this kind should be regarded as under development and subject to ongoing improvement based on subsequent research and experience.

The planning and operation of Project MATCH and the products now resulting from it, including this series of manuals, reflect the efforts of many individuals over a period of several years. Their dedication and collegial collaboration have been remarkable and will enrich the field of alcoholism treatment research for years to come.

Margaret E. Mattson, Ph.D.
Project MATCH Staff Collaborator
Project MATCH Monograph Series Editor
Division of Clinical and Prevention
Research
National Institute on Alcohol Abuse and
Alcoholism

Contents

	<i>Page</i>
Acknowledgments	iii
Foreword	vii
Preface	ix
Introduction	1
Therapist Guidelines	11
Part 1: Core Topics	19
Topic 1: Program Introduction	21
Format: Sessions 2-11	35
Topic 2: Step 1—Acceptance	37
Topic 3: Steps 2 and 3—Surrender	45
Topic 4: Getting Active	51
Part 2: Elective Topics	59
Topic 5: The Genogram	61
Topic 6: Enabling	67
Topic 7: People, Places, and Things	73
Topic 8: HALT (Hungry, Angry, Lonely, Tired)	79
Topic 9: Steps 4 and 5—Moral Inventories	87
Topic 10: Sober Living	93
Part 3: Termination	97
Final Core Session: Termination.....	99
Part 4: Conjoint Sessions	103
Conjoint Session 1: Enabling	105
Conjoint Session 2: Detaching	111
Appendix A—Jellinek Charts for Men and Women	115
Appendix B—Therapist Selection, Training, and Supervision in Project MATCH	121

Introduction

The facilitation program described in this manual is intended for use in brief individual outpatient treatment for persons who satisfy the criteria for a diagnosis of alcohol dependence and abuse. It is intended to be flexible enough to allow for individual treatment planning and for use as a primary treatment for persons who have never been exposed to the 12 Steps of Alcoholics Anonymous (AA), as well as for individuals who have had such exposure, for example, through prior treatment.

The program described here is intended to be consistent with active involvement in Alcoholics Anonymous. It assumes that alcoholism is a progressive illness that affects the body, mind, and spirit for which the only effective remedy is abstinence from the use of alcohol. It adheres to the concepts set forth in the “Twelve Steps and Twelve Traditions” of Alcoholics Anonymous.

The overall goal of this program is to facilitate patients’ active participation in the fellowship of AA. It regards such active involvement as the primary factor responsible for sustained sobriety (“recovery”) and therefore as the desired outcome of participation in this program.

According to the AA viewpoint, alcoholism is a chronic progressive illness which, if not arrested, may lead to insanity or death. It is characterized by loss of the ability to control (limit) the use of alcohol:

We alcoholics are men and women who have lost the ability to control our drinking. We know that no real alcoholic ever recovers control. (“Alcoholics Anonymous,” p. 30)

As is true for all chronic illnesses, alcoholism has specific and predictable effects (symptoms) on the individual and a predictable course. In addition to its physical effects, alcoholism affects its victims on many levels, including the psychological, social, and spiritual.

Alcoholism is also characterized by “denial,” or resistance to accepting the reality of loss of control over drinking:

Most of us have been unwilling to admit we were real alcoholics. No person likes to think he is bodily and mentally different from

his fellows. Therefore, it is not surprising that our drinking careers have been characterized by countless vain attempts to prove we could drink like other people. (“Alcoholics Anonymous,” p. 30)

Alcoholics Anonymous is not a treatment method but a fellowship of peers, connected by their common addiction, which is guided by its 12 Steps and traditions. The only stated requirement for admission is a desire to stop drinking.

AA makes no commitment to a particular causal model of addiction; rather, it limits its schema to the concepts of loss of control and denial. Historically, AA has emphasized two themes in its program:

- Spirituality: Belief in a “Higher Power,” which is defined by the individual and which represents faith and hope for recovery.
- Pragmatism: Belief in doing “whatever works” for the individual, meaning doing whatever it takes in order to avoid taking the first drink.

Treatment Goals and Objectives

Goals

This treatment program has two major goals, which relate directly to the first three Steps of Alcoholics Anonymous.

Acceptance

- Acceptance by patients that they suffer from the chronic and progressive illness of alcoholism.
- Acceptance by patients that they have lost the ability to control their drinking.
- Acceptance by patients that, since there is no effective cure for alcoholism, the only viable alternative is complete abstinence from the use of alcohol.

Surrender

- Acknowledgment on the part of the patient that there is hope for recovery (sustained sobriety) but only through accepting the reality of loss of control and by having faith that some Higher Power can help the individual whose own willpower has been defeated by alcoholism.

- Acknowledgment by the patient that the fellowship of AA has helped millions of alcoholics to sustain their sobriety and that the patient's best chances for success are to follow the AA path.

Objectives

The two major treatment goals are reflected in a series of specific objectives that are congruent with the AA view of alcoholism.

Cognitive

- Patients need to understand some of the ways in which their thinking has been affected by alcoholism.
- Patients need to understand how their thinking may reflect denial (“stinking thinking”) and thereby contribute to continued drinking and resistance to acceptance (Step 1).
- Patients need to see the connection between their alcohol abuse and negative consequences that result from it. These consequences may be physical, social, legal, psychological, financial, or spiritual.

Emotional

- Patients need to understand the AA view of emotions and how certain emotional states (e.g., anger, loneliness) can lead to drinking.
- Patients need to be informed regarding some of the practical ways AA suggests for dealing with emotions so as to minimize the risks of drinking.

Behavioral

- Patients need to understand how the powerful and cunning illness of alcoholism has affected their whole lives and how many of their existing or old habits have supported their continued drinking.
- Patients need to turn to the fellowship of AA and to make use of its resources and practical wisdom in order to change their alcoholic behavior.
- Patients need to “get active” in AA as a means of sustaining their sobriety.

Social

- Patients need to attend and participate regularly in AA meetings of various kinds, including AA-sponsored social activities.

- Patients need to obtain and develop a relationship with an AA sponsor.
- Patients need to access AA whenever they experience the urge to drink or suffer a relapse.
- Patients need to reevaluate their relationships with “enablers” and fellow alcoholics.

Spiritual

- Patients need to experience hope that they can arrest their alcoholism.
- Patients need to develop a belief and trust in a power greater than their own willpower.
- Patients need to acknowledge character defects, including specific immoral or unethical acts, and harm done to others as a result of their alcoholism.

Treatment Overview

This facilitation program is very structured, with each session having a specific agenda and following a prescribed pattern. Patients are asked to keep a personal journal. Each session includes specific “recovery tasks”: suggestions made to patients for reading and action between sessions. Therapists will suggest reading material drawn from AA Conference-approved texts.

Central to this approach is strong encouragement of the patient to attend several AA meetings per week of different kinds and to read the “Big Book” (“Alcoholics Anonymous”) as well as other AA publications throughout the course of treatment.

Sessions

The facilitation program consists of 12 sessions, divided as follows:

- 12 individual sessions with alcoholic patients if they are single.
- 10 individual sessions plus 2 conjoint sessions with patients and their partners if they are in a stable relationship.
- A maximum of two individual emergency sessions as needed.

The above sessions are intended to be offered within a period of 12 consecutive weeks.

The goal of the conjoint sessions is to educate the partner regarding alcoholism and the AA model, to introduce the concept of enabling, and to encourage partners to make a commitment to attend six Al-Anon meetings of their choice.

Organization and Structure

The program is organized as follows:

- Four core topics
- Six elective topics
- Termination

It is intended that the four core topics plus the termination session be provided to all patients. There is more flexibility in the therapist's use of the six elective topics. Any core or elective session may be repeated if needed to complete the 12-session schedule. These can be tailored to the individual patient with supervisory consultation. The use of a combination of core and elective topics allows this program to develop individualized treatment plans within broad parameters. For example, it can be used with patients who have had no prior exposure to AA concepts, patients who have never undergone treatment of any kind for alcoholism, and patients who have had one or more inpatient treatment experiences plus extensive exposure to AA.

Journals

Patients are asked to maintain a personal journal, which is reviewed by the therapist prior to the start of each session, and which is used to record the following:

- All AA meetings attended (dateWtimeWplaces).
- Personal reactions to and thoughts about meetings.
- Reactions to suggested readings.
- "Slips" (occasions when the patient has taken one or more drinks) and what was done about them.
- Reactions to recovery tasks.
- Cravings or urges to drink, and what the patient did about them.

Emergencies

When working with patients who may be actively drinking or whose sobriety is compromised by slips, it is not uncommon for therapists to be confronted by various "emergencies." Typical examples of such emergencies include patients—

- Getting drunk.
- Getting arrested for driving while intoxicated (DWI).
- Having a family dispute as a result of drinking.
- Experiencing intense urges to drink.
- Feeling depressed about being an alcoholic (or about a slip).
- Getting into trouble on the job as a consequence of drinking.
- Needing medical detoxification as a consequence of a binge.

Emergencies of a psychiatric nature (e.g., suicidal thinking, psychosis, violence, self-injury) may require either an emergency session with the therapist or referral to an emergency mental health service for evaluation and possible intervention. In such instances, patients' continued involvement in the facilitation program may require review. In general, uncomplicated medical detoxification (up to 72 hours) should not disqualify patients as long as they are willing to continue and as long as the 12 sessions can still be provided within 12 weeks.

In addition to having to deal with emergencies of a psychiatric nature, and possibly detoxification, contact with the therapist outside of scheduled treatment hours, for example, as a method of helping patients cope with urges to drink or dealing with slips, is discouraged in this program. Instead, patients should be consistently encouraged to turn to the resources of AA as the basis for their recovery. The therapist may offer specific advice and help in this regard, such as assisting a patient in contacting the AA Hotline or the patient's sponsor.

Session Format

Session 1— Introduction

In the first session, the therapist covers topic 1. The therapist introduces this program and provides an overview of it (including its goal of active involvement in AA), helps patients evaluate their level of alcohol involvement, introduces the AA view of alcoholism, and attempts to motivate patients to stay sober.

Sessions 2-11

All four core topics need to be covered in sessions 2 through 11, plus as many elective topics as are appropriate to the individual patient. This treatment planning should be done in collaboration with a supervisor. The format for these sessions is as follows.

Part 1: Review

Beginning with session 2, each session begins with a review of the patient's experience since the last session, with special emphasis on drinking. It is important to avoid protracted discussions of collateral issues (work, relationships, children, etc.). The therapist should focus on drinking as much as possible. In addition to patients' self-reports, journal entries can be very helpful in guiding treatment and establishing future recovery tasks.

Specific mention should be made of all sober days. These are legitimate cause for sincere congratulations. Strong urges to drink should be discussed openly and nonjudgmentally. Similarly, slips need to be approached nonjudgmentally as events that can be openly acknowledged and discussed by the patient without fear of recrimination. Slips should be thought of (and interpreted) as times when the powerful and cunning illness of alcoholism overcomes the patient's willpower.

In addition to briefly reviewing sober days and slips, the review time (10-15 minutes) should be used to talk about the patient's reactions to readings and to meetings that were attended since the last session. If no meetings were attended or if the patient seems to be resisting going to meetings, the reasons for this resistance should be explored.

Part 2: New Material

Following the review, each session should move on to cover its specific focus, either a core or an elective topic. These are described in detail in this manual. Even within a topic, the material can be adjusted to a particular patient's situation, so long as the presentation remains consistent with the AA view of alcoholism.

Part 3: Recovery Tasks

Each session should end with specific suggestions—recovery tasks—for the patient to follow up on between sessions, including—

- A mutually agreed-upon list of AA meetings to be attended.
- Suggested readings from the three AA texts: "Alcoholics Anonymous," "Twelve Steps and Twelve Traditions," and "Living Sober."
- Other suggested readings, including pamphlets, meditation books, and other materials that the therapist is familiar with and would recommend as pertinent to the individual patient's recovery.

NOTE: When offering patients advice or giving them recovery tasks from the point of view of an AA-oriented program like this one, it is important to remember that AA itself prefers the word “suggestion” to the word “rule.” Specific strategies for staying sober are as varied as the number of people who make up the AA membership. The bottom line is to do what works for individual alcoholics, meaning how they have succeeded in staying sober.

In keeping with the spirit of AA, therapists using this manual are advised to avoid making “assignments,” in the sense of telling patients what they should do. The AA tradition tells us that it is better to share with a particular patient “some things that other alcoholics have found helpful in your situation” without pressing for the kind of commitment that other therapies might. This boils down to making suggestions as opposed to prescribing behavior.

Suggestions made by the 12-Step therapist should be consistent with what is found in AA-approved publications such as those that are recommended to patients. Examples of strategies for dealing with urges and slips that are consistent with AA include—

- Calling an AA friend.
- Going to a meeting (or another meeting or a different meeting).
- Going to an AA social.
- Calling your sponsor.
- Calling the AA Hotline.
- Changing a habit pattern (doing something different).
- Distracting yourself.
- Praying.

Aside from being consistent with AA traditions, recovery tasks should be specific, and the therapist should make a point of following up on them at the beginning of each session.

Needless to say, the therapist should be thoroughly familiar with the three AA texts, as well as with the locations, times, and types of meetings that may be available in the area, when giving a patient recovery tasks that involve going to meetings or reading.

**Final Core
Session:
Termination**

The final session has its own goals and follows a process somewhat different from that described above. Refer to the specific material in this manual regarding termination.

Readings

Since its inception, AA has emphasized reading, particularly the “Big Book” and the “12 x 12,” as a way of understanding the fellowship and its principles. This facilitation program incorporates reading materials to augment the material covered in sessions. It is suggested that all patients be strongly encouraged to obtain personal copies of the following books:

- “Alcoholics Anonymous.” 3rd edition. New York: Alcoholics Anonymous World Services, 1976
- “Twelve Steps and Twelve Traditions.” New York: Alcoholics Anonymous World Services, 1952.
- “Living Sober.” New York: Alcoholics Anonymous World Services, 1975.

In addition to the above, therapists using this manual should familiarize themselves with the contents of the following publications, which are relevant to one or more of the treatment topics described later:

- “Things My Sponsors Taught Me,” by Paul H., Center City, MN: Hazelden, 1987.
- “Denial,” by Melody Beattie, Center City, MN: Hazelden, 1986.
- “Releasing Anger,” by Richard S., Center City, MN: Hazelden, 1985.
- “Grieving: A Healing Process,” by Peter McDonald, Center City, MN: Hazelden, 1985.
- “Detaching With Love,” by Carolyn W., Center City, MN: Hazelden, 1984.

Contrast With Other Treatment Approaches

This treatment program differs from a social learning model and a motivational model of alcoholism treatment in several ways. Specific assumptions associated with this treatment program include the following:

- Alcoholism is a chronic progressive illness with predictable symptoms and a predictable course.
- Alcoholics have permanently lost the capacity to control their drinking.
- Alcoholism affects the alcoholic's body, mind, and spirit, and true recovery requires healing in each of these fellow.,
- The only viable alternative for the alcoholic is total and lifelong abstinence from alcohol.
- Even a single drink can trigger the alcoholic's craving for alcohol and lead to a renewed cycle of compulsive drinking.
- Individuals will have the best chance of staying sober over the long run if they—
 - Accept their loss of control.
 - Reach out to fellow, alcoholics through AA.
- Spirituality—faith in a Higher Power—plays a more powerful role in recovery than individual willpower.
- Encouraging patients to actively work the 12 Steps of Alcoholics Anonymous is the primary goal of treatment, as opposed to any skill that the therapist can teach.
- Patients will be better served if they can be taught and encouraged to utilize the fellowship of AA and its resources (meetings, Hotline, sponsorship) as opposed to relying primarily on the therapist as a means of sustaining sobriety.
- The ultimate goal for the alcoholic is to resist taking the first drink, one day (or hour) at a time.

Therapist Guidelines

Using This Manual

It is important that therapists make every effort to follow the format laid out in this manual. Therapists should decide before each session which topic will be covered (either core or elective). Therapists should be thoroughly familiar with the contents of a session prior to beginning it. Allowing for some degree of individual therapeutic style, therapists should nevertheless attempt to ask questions and cover issues in ways similar to how they are presented here. While it is recognized that the actual content of therapy will be affected by the individual patient, every effort should be made to cover as much material as possible, including all core topics and as many electives as is reasonable given the individual case.

Role of the Therapist

The primary role of the therapist is as a facilitator of patients' acceptance of their alcoholism and of a commitment to the fellowship of Alcoholics Anonymous as the preferred path to recovery. This is accomplished by the therapist serving the following functions.

Education

The therapist acts as a resource and advocate of the 12-Step approach to recovery. The 12-Step therapist—

- Explains the AA view of alcoholism and interprets slips and resistance to AA in terms of the power of alcoholism and the dynamics of denial.
- Introduces several of the 12 Steps and their related concepts and helps the patient to understand key AA themes and concepts (e.g., denial, powerlessness) by identifying personal experiences that illustrate them.
- Introduces, explains, and advocates reliance on the fellowship of AA as the foundation for recovery, which should be thought of as an ongoing process of “arrest” (as opposed to cure).
- Explains the role of a sponsor and helps patients identify what they would most benefit from in a sponsor.

- Answers questions about material found in the “Big Book,” the “12 x 12,” and other readings.

Facilitation

The therapist uses patients’ reports of their experience between sessions to actively facilitate their involvement in AA. The 12-Step therapist—

- Encourages attendance at AA meetings, monitors patient involvement in AA, and actively promotes a progression toward greater involvement in AA, for example, by going to meetings that require more personal involvement, such as “Step” meetings and “discussion” meetings.
- Clarifies the role of therapist versus sponsor and refuses to become a sponsor while helping the patient find one.
- Remains vigilant for signs of denial, particularly in patient accounts of slips, and explains slips in terms of denial.
- Suggests recovery tasks that will enhance patients’ understanding of alcoholism and AA as well as their successful integration into the fellowship of AA.

Desired Therapist Characteristics

Status With Respect to Recovery

Twelve-Step therapists, being professionals whose goal is to facilitate and encourage active participation in Alcoholics Anonymous, need not be personally in recovery. However, they must be knowledgeable of and comfortable with the foundation of 12-Step recovery as described in AA Conference-approved literature. Therapist self-disclosure of recovery status is to some extent a clinical issue (i.e., dependent on the particular case), but generally speaking, the authors encourage honesty in the therapeutic relationship.

If experienced therapists who are not in recovery contemplate using this manual, it is strongly recommended that they attend at least 10 open AA meetings and an equal number of Al-Anon or Families Anonymous meetings and be thoroughly familiar with all of the reading material that is recommended for patients. In addition, to be maximally effective as a facilitator, the therapist is advised to develop a network of AA contacts: men and women who are active in AA and who could be called on to assist in getting a shy or ambivalent patient to those first meetings, giving advice about particular meetings, providing directions, and so forth. Persons who have been sober and active in AA for a least a year are candidates for doing this type of 12-Step work as part of their own recovery. Therapists can develop working relationships with these

people by going to AA meetings on some regular basis or by talking with recovering persons they know. Firsthand knowledge of such contact people is desirable.

Active, Supportive, and Involved

In general, therapists using this approach are expected to be forthcoming and conversational, as well as appropriately self-disclosing. Twelve-Step therapists are expected to be interactionally active and nonjudgmentally confrontive during therapy sessions, as opposed to merely reflective. This does not mean that the therapist lectures the patient, does more talking than the patient, or chastises the patient for slips. Rather, the therapist utilizing this approach should be prepared to identify denial and confront the patient consistently in a frank but respectful manner regarding the patient's attitudes or behaviors, to actively encourage the patient to get involved in the fellowship of AA, and to help the patient understand key AA concepts as they are reflected in the patient's actual experience.

Therapists should recognize that while this facilitation program is structured, it is not inflexible. Patients can be expected to interpret the AA concepts presented here in light of their own experience. This is consistent with the AA approach, which allows for a great deal of individuality of interpretation within broad guidelines. For example, the 12 Steps specifically allow for individuality in conceptualizing a Higher Power ("God as we understand Him"). Similarly, what represents unmanageability (Step 1) for one patient may not be meaningful to another. What is most important is not whether patients interpret these concepts in the same way; rather, what counts is the end result: active involvement in the fellowship of Alcoholics Anonymous.

The 12-Step therapist is familiar with basic AA traditions and introduces them, along with various AA slogans, as they are appropriate in treatment. These slogans (Easy Does It, One Day at a Time, Fake It Till You Make It, Turn It Over, etc.) are most helpful when they are related to a patient's life. The successful 12-Step therapist uses slogans judiciously and gives them meaning by connecting them to the individual patient's experience.

Focused Treatment

Twelve weeks is a short time in which to facilitate lasting change. This is a structured program with much material to be covered; therefore, it becomes a therapeutic challenge to cover as many issues as possible for each patient in the time allotted. It is expected that all core topics will be covered, plus as many electives as possible.

At the beginning of each session, through the process of reviewing the previous week, issues relevant to the individual patient's life can be expected to come up. Patients should be given time to articulate their problems and concerns and to feel heard by the therapist. At the same

time, it is important to keep in mind that the focused nature of this program does not allow therapists to “follow the patient” entirely—in other words, to create therapeutic agendas that ignore the facilitation program’s content or objectives.

In light of this, it is the therapist’s responsibility to keep therapy sessions focused on sobriety-related issues and to avoid getting off the track into lengthy discussions of other matters (marital, job, or parenting problems). In such cases, therapists should invoke the First Things First slogan: Emphasize the patient’s need to focus on sobriety as the foundation for all other changes and growth. Benefits gained from establishing sobriety may very well have beneficial spillover effects into many other areas of the patient’s life. One response to a patient’s persistent efforts to divert the discussion to relationships, work, or family problems could be assurance of referral to appropriate therapy following completion of the 12-Step facilitation program, should these issues continue to be of concern.

Reliance on AA

In this program, the fellowship of AA, and not the individual therapist, is seen as the major agent of change. Involvement in AA (including regular attendance at a variety of meetings and AA social activities plus the use of a sponsor) is therefore considered preferable to reliance on the therapist (who will be unavailable after the 12th session). In general, patients should be encouraged to rely on the resources of the fellowship, more than on the therapist, in times of crisis.

When bona fide crises arise that cannot be reasonably solved by going to an AA meeting or by calling an AA friend, the AA Hotline, or a sponsor, the therapist may elect to schedule an emergency session. The goals of such sessions should be-

- To help the patient assess the nature of the crisis in terms of how it threatens sobriety.
- To establish priorities (First Things First).
- To identify courses of action that are consistent with the AA approach to recovery.
- To solve the crisis by relying on AA.

Confrontation

In the context of this program, confrontation is something that therapists can think of as helpful and honest mirroring. The most appropriate form of confrontation is to share frankly but respectfully what you see the patient doing. Most often this involves confronting the patient about some form of denial.

Confrontation that is patronizing or harsh or implies that the patient has a character problem as opposed to a powerful and cunning illness is likely to be counterproductive in the long run. The therapist needs to keep the following goal of confrontation in mind:

Confrontation is a method for helping patients see their behavior in perspective: as reflecting resistance to accepting the reality of loss of control and unmanageability (Step 1).

The following is one example of the preferred mode of confrontation:

“What you’re saying is that you can’t find the time to go to a meeting. What I hear is that lots of other things are more important to you than going to a meeting. I see that as denial, meaning some resistance on your part to accepting the fact that you’ve lost control over alcohol. It seems that way to me because if you really accepted your limitation with alcohol and your need to abstain completely from using it, then hardly anything would be more important than getting active in a program that offers you hope. I think you’d find the time to go for treatments, even every day of the week, if you had a potentially terminal illness and if treatment could mean the difference between life and death. That’s the way it is with alcoholism. It’s an illness, it’s chronic and progressive, and it can lead to a premature death. How do you feel about that?”

Alcoholics Anonymous is both a spiritual and a practical program. Both its practical wisdom and its spirituality are reflected in many of its slogans.

The 12-Step therapist should not only be familiar with many AA slogans but should actively use them in therapy to promote involvement in AA and advise patients in how to handle difficult situations. The better patients understand the meaning behind each AA slogan, the better they will be at applying it on a day-to-day basis.

Slogans

Some key AA slogans are described below.

- *One Day at a Time.* Recovery is best thought of as a journey that is undertaken one step at a time. The goal is to avoid taking the first drink and to stay sober a day at a time. Anniversaries of sobriety are important, but ultimately what is most important is whether you drink today, not whether you drank yesterday or will drink tomorrow.
- *First Things First.* If alcoholics do not stay sober, nothing else will matter, since they may end up in an institution, in jail, or prematurely dead; meanwhile, alcoholism will undermine their body, mind, spirit, and relationships, making the overall quality of life

progressively worse. Although all people, including alcoholics, have multiple commitments, obligations, and responsibilities, the *first* commitment of alcoholics must be sobriety. In this area, sponsors are especially helpful, as is active participation in meetings.

- *Fake It Till You Make It.* Not everything in the AA fellowship will appeal or make sense to the recovering person. The slogan asks the alcoholic to be humble: to follow advice on faith in the belief that it will prove beneficial in the long run. This includes going to meetings, working the Steps, and doing what one's sponsor advises.
- *Easy Does It.* The recovering person needs to avoid excess stress, which will invite relapse. The serenity prayer is relevant here, as it urges the recovering person to accept what cannot be changed. This includes alcoholism, some family problems, past transgressions, and decisions that have already been made.
- *Turn It Over.* A Statement of faith, this slogan encourages acceptance of what cannot be changed in the belief that all will work out for the best in the end.

When dealing with technical problems like those described below, the goal is to determine if the patient is still interested in and capable of participating in the facilitation program.

Technical Problems

In general, the therapist should begin by exploring the reason why the patient was late, missed, or rescheduled a therapy session. Listen for evidence of denial: "I can do this on my own," "I don't think my problem is as bad as you seem to think it is," "I don't believe I've lost control of my drinking," "I was busy and forgot about our session," and so on.

Patient Is Consistently Late for Appointments/Cancels Sessions

When denial seems to be the issue, the therapist should identify and interpret it as part of the illness of alcoholism. Remember that denial is necessarily verbalized, but may be "acted out" through behavior or through various excuses for not going to the meetings, not doing suggested readings, and so forth. One form that denials often takes is chronic lateness and cancellations. If this pattern emerges, but patients refuse to "own up to it" as resistance, try to engage them in a frank and nonjudgemental discussion of their reservations about treatment. If the pattern continues, a more open discussion about motivation for treatment may be helpful.

Keep in mind that this form of resistance does not invariably reflect denial of alcoholism. In some cases, it may be due to fear of failure, or social shyness. Help resistant patients clarify their reasons for resisting active involvement in AA and work from there.

Patient Comes to Session Drunk

Do not proceed with a session if a patient shows up under the influence. Ask the patient to call the AA Hotline, an AA friend, or his/her sponsor, if possible. If the person is not willing, have him/her call a significant other to arrange transportation home. As a last resort, rely on local resources or police for transportation. Reschedule the session.

Patient Resists Going to Meetings

This common resistance can take many forms, from making excuses to criticizing AA or its members. Interpret this respectfully as denial—as evidence of the patient’s refusal to accept loss of control and the fact that alcohol is making life progressively more unmanageable (Step 1.)

It is appropriate to coach patients regarding how to go to a meeting and what to expect. The therapist should not offer to take the patient to a meeting but may do anything reasonable short of that, such as role-playing or arranging for an escort through various AA contacts the therapist has developed.

Patiently persist in trying to get the person to make definite commitments to meetings, using the AA schedule to identify specific meetings that would be appropriate. Never terminate a patient for refusing to go to meetings, since to do so would be inconsistent with AA.

Patient Uses Other Substances

Substance substitution is one symptom of addiction and should be so interpreted if the patient appears to be using a substitute for alcohol. Addicts cannot be allowed to believe that they can safely use other substances, for two reasons. First, use of another substance will reduce resistance to use of the patient’s substance of choice. Second, there is a definite risk of cross-addiction (multiple addiction) if the patient turns to a substitute mood-altering chemical.

Patient Appears Clinically Depressed or Psychotic

Mild depression may be regarded as either a symptom of withdrawal or an appropriate response to acceptance—to admitting to loss of control over alcohol use and the personal limitation that Step 1 implies. In contrast, severe depression or other psychopathology may require assessment for referral to alternative treatment.

Project MATCH Guidelines

Several additional procedures are consistently implemented in all Project MATCH clinical research units. Key MATCH-specific procedures are summarized in the following paragraphs for the information of those interested in the details of the trial.

According to MATCH protocol, if a patient misses an appointment and cannot be contacted within the following 2 days, the therapist is responsible for notifying the project coordinator who then sends a letter to the patient.

Some patients request extra sessions with the therapist, particularly in the early weeks of treatment. The need for extra sessions should be determined by the clinical judgment of the therapist based on the seriousness of the situation. The maximum number of permissible extra sessions under the MATCH protocol is 2 (making the maximum number of sessions 14). If a patient requires more than two additional sessions with the therapist, the possibility of clinical deterioration or withdrawal from the study should be considered.

All instances of clinical deterioration must be reviewed with the project coordinator. These include development of acute psychosis, suicidal or homicidal ideation, onset of cognitive impairment, deterioration of physical health, and extensive drinking or drug use. Project MATCH has procedures for responding to these developments, and they should be reviewed with the project coordinator at the first indication of a problem.

Since the goal of Project MATCH is to determine optimal patient-treatment matches in the three therapies, the protocol seeks to avoid dilution or duplication of the dose of the intervention received by an individual during the treatment period. Project MATCH clients may not be seen by other mental health professionals for more than 6 contact hours during their 12 weeks of treatment in the study. If clients express interest in other forms of treatment, they should be urged to postpone them, if possible, until after the 12-Step treatment is completed. As a routine part of each followup, data are collected on any nonstudy therapy a patient may have received.

The final MATCH-specific procedure involves referring patients who are dissatisfied with their treatment. If all attempts to keep a patient in treatment fail, the study must provide a specific referral and help the patient make contact. Additional treatment may not be provided by the 12-Step therapist or any other therapist in the study. Referral is to be made to an outside agency or to a therapist within the same agency who has no involvement in the study. Referral must first be discussed with the project coordinator or project director, because it has implications for the patient's continuation in the study. In any event, the patient is urged to participate in followup interviews as originally planned.

Part 1: Core Topics

In order to expose patients to key AA concepts of alcoholism, therapists need to be sure to cover all of the four core topics described in part 1 and to do so thoroughly. These topics should be discussed in the order in which they are presented here:

Topic 1: Program Introduction

Topic 2: Step 1—Acceptance

Topic 3: Steps 2 and 3—Surrender

Topic 4: Getting Active

It may be necessary to refer back to one or more core topics from time to time, even when the topic for a given session is an elective (see part 2).

Topic 1: Program Introduction should be covered in the first session. It follows a unique format and may take up to 1 1/2 hours to complete.

Topic 2: Step 1—Acceptance should be presented in the second session. Sessions 2 through 11 follow a consistent format, which is described later.

After all four core topics have been covered, sessions may move on to one or more elective topics.

Topic 1: Program Introduction

Session 1, which may run as long as 1 1/2 hours, has several objectives:

- Introduce patients to the AA view of alcoholism.
- Help patients assess their level of alcohol involvement (including symptoms of dependency).
- Explain the 12-Step facilitation program.
- Attempt to engage patients in active participation in this program; in other words, to “give AA a chance.”

Opening

The therapist can begin by establishing rapport and getting basic background information:

- Therapist’s name. **NOTE: First names are appropriate.**
- “Where do you live?”
- “Do you live alone or with someone? Who?”
- “Are you working? Where? What do you do?”
- “Were you able to find the clinic okay?”
- “How does this time work out for you?”
- Why is the patient in the program?
 - “How do you feel about being here today?”
 - “What circumstances led to your being here?”
 - “How did you find out about this program?”

Previous Treatment Experience

Having briefly established the reasons for being in treatment, move on to an assessment of the patient's previous experiences, if any, with alcohol treatment programs.

- Has the patient been in an alcohol rehabilitation program or any other treatment program for drinking?
 - “Have you ever gone for help about your drinking before today?”
 - “If you have been in treatment before, give me a quick run-down of those experiences:
 - Where and when did they occur?
 - What was the orientation (philosophy) of the program(s)?
 - What did you learn about yourself and your drinking from those treatment experiences?
 - How long did you stay sober after each of those treatments?”
- What, if any, experience has the patient had with Alcoholics Anonymous?
 - “Have you ever gone to AA? How many times?”
 - “Approximately how many AA meetings have you attended in the last year?”
 - “When did you stop going to AA and why?”
 - “If you had a period of sobriety, what were the circumstances of your relapse? How did you react to your relapse? How did you feel? What did you do?”
- How has the patient attempted to stop or control alcohol use aside from formal treatment or AA?
 - “How have you tried to either control or stop your drinking on your own? What were these experiences like?”
 - “What has been the longest period of time, over the past year or so, that you've gone without having even a single drink?”
- What is the patient's interest in this program?
 - “Do you honestly believe you have a drinking problem?”
 - “Are you interested in doing something about your drinking?”
 - “Do you think you need help? If so, why?”

- “Do you believe you need to stop drinking altogether?”
- “How do you feel about being in this treatment program at this time? What are your hopes? What are your fears or concerns?”

Alcohol History

Following the introduction, proceed to the alcohol history. This is a chronological account of alcohol use, including patterns of use (increases, changes in preference) as well as life events and transitions that were associated with either the onset of drinking or some significant change in drinking habits. The therapeutic goal of an alcohol history is to facilitate acceptance (Step 1) by identifying patterns of problems associated with drinking, based on information collected through self-report. In particular, an alcohol history can help draw a connection between alcohol abuse and negative consequences (life becoming unmanageable).

The alcohol history can be introduced as follows:

“I’d like to spend some time with you doing an alcohol history together. The purpose of an alcohol history, by the way, is to help us both identify the patterns of your alcohol use over time, as well as to see how the use of alcohol as a mood-altering substance may have had an impact on your life.

“It is important that you be honest with me about this information, which will be held in confidence. Also, it will be helpful if you can identify what was going on in your life at times when your drinking increased. I’ll also be asking you about how drinking affected you, positively and negatively, at different times. Let’s start your alcohol history at the age when you first used alcohol.”

Here is an example:

<i>Age</i>	<i>Amount used/ how often</i>	<i>Positive/negative effects</i>	<i>Significant events at this time of life</i>
11	Sips from my father’s beer once or twice.	Felt grown up and high. Felt sick sometimes.	My family moved. I had to leave all my old friends.
13	Drank beer after school with friends two or three times a week.	It was exciting, kind of cool and rebellious.	My father was changing jobs a lot at the time.

NOTE: In addition to the above basic information, some therapists may want to get more detailed information on the following:

- **What type of alcohol was consumed at different ages, including preferred forms of alcohol.**
- **Amount used, including least, most, and average amounts consumed at different points in time.**
- **Changes (increases) in use, by age.**
- **What feelings were associated with significant increases in alcohol use.**

Take the history in broad strokes. Starting with the age of first use, ask what drinking was like 3 years later; then proceed in 5-year increments. Note significant life changes (marriages, divorces, job changes, births) that correlate with changes in drinking patterns.

The therapist should also inquire at some point during the alcohol history about the patient's use of other mood-altering chemicals. Inquire specifically about the patient's history of use, and current use, of each of the following:

- Marijuana
- Cocaine
- Amphetamines ("speed", "uppers")
- Barbiturates ("downers")
- Prescription drugs
- LSD (acid, mushrooms)
- Heroin

Note *any current use* of any of the above substances, since the treatment goal will change from abstinence from alcohol use to abstinence from use of *all* mood-altering chemicals.

Negative Consequences

Having established a history of alcohol use, the therapist now works with the patient to determine the nature and chronology of negative consequences that have been associated with alcohol abuse, using an introduction such as the following:

"Now let's take a look at some of the issues, problems, and conflicts that you've experienced these past several years, starting with your physical health."

Consequences can be divided into several categories.

Physical Consequences

Included here are all medical problems, as well as accidents or injuries, that have occurred while under the influence of alcohol, such as—

- Hypertension (high blood pressure).
- Gastrointestinal (digestive) problems.
- Insomnia.
- Weight loss.
- Auto, home, or job accidents / injuries.
- Blackouts.
- Passing out.
- Heart disease.
- Diabetes.

Legal Consequences

Includes DWI arrests and other legal consequences associated with alcohol use. For veterans, inquire about military history for any drinking-related incidents.

Social Consequences

The therapist should inventory all social consequences of alcohol use, including—

- Job problems.
- Marital problems.
- Loss of old friends subsequent to alcohol abuse.

Sexual Consequences

Sexual dysfunctions associated with habitual alcohol use include—

- Problems of arousal in both men and women (e.g., impotence).
- Orgasmic dysfunction (anorgasmia in women, delayed ejaculation in men).

Psychological Consequences

The therapist should ask whether the patient is experiencing any symptoms of depression:

- Insomnia or disturbed sleep (e.g., waking up consistently in the middle of the night).
- Appetite disorders, especially loss of appetite.

- Irritability or moodiness.
- Loss of motivation/drive/interest.
- Memory problems (especially “forgetfulness”).

Financial Consequences

Ask patients specifically about their current financial status and problems they may have had over the past few years, including-

- Creditor problems (revoked credit cards, etc.).
- Mortgage/rent problems.
- Delinquent loans.
- Problems “making ends meet.”
- Fines.
- Legal fees associated with alcohol-related arrests.

Summary

Summarize the completed inventory of problems or consequences. Do this partly to get concurrence and partly to elicit yet further consequences that may not have been mentioned so far.

The final step in the alcohol history is to test the patient’s willingness to draw a connection between negative consequences and drinking:

“I’m interested in knowing if you see any connection between any of these problems you’ve had and drinking. What do you think? Do you believe that any of these could have been avoided if you weren’t drinking at the time? Which ones? What consequences of alcohol use have you suffered recently?”

Tolerance

Another symptom of alcohol dependency to be assessed is tolerance—the tendency to require progressively larger amounts of a mood-altering chemical like alcohol to produce a similar physical/emotional effect. The therapist should ask questions like the following to determine if a tolerance to alcohol has been developed:

- “Does it take more alcohol now than it used to for you to get really drunk?”
- “Have you noticed that your ability to drink has gotten stronger over time; in other words, that you can hold your liquor better now than before?”

- “Have you noticed any tendency in yourself to develop a ‘reverse tolerance,’ meaning the tendency to feel drunk on just a single drink or two?”

Loss of Control Symptoms of loss of control over alcohol use include—

- Repeated failures in efforts to stop use.
- Failed efforts to control or restrict use, such as:
 - Drinking only on weekends.
 - Drinking only wine (beer, etc.).
 - Limiting amount consumed (“no more than ____”).

NOTE: The following passage from the “Big Book” may also be useful with patients:

Here are some of the methods we have tried: Drinking beer only, limiting the number of drinks, never drinking alone, never drinking in the morning, drinking only at home, never having it in the house, never drinking during business hours, drinking only at parties, switching from scotch to brandy, drinking only natural wines, agreeing to resign if ever drunk on the job, taking a trip, not taking a trip, swearing off forever (with and without a solemn oath), taking more physical exercise, reading inspirational books, going to health farms, accepting voluntary commitment to [hospitals]—we could increase the list ad infinitum. (p. 31)

- Substance substitution: substituting a second- or third-favorite form of alcohol (or another mood-altering chemical) if the preferred form is not available.
- Hiding a supply of alcohol.
- Preoccupation:
 - Thinking about having a drink while at work or anticipating the first drink on the way home from work.
 - Avoiding responsibilities and obligations in order to drink.
 - Buying extra alcohol in case your supply runs low.
- Drinking alone.
- Drinking within an hour or two of waking up.
- Guzzling drinks in order to get high faster (“chasing a high”).

- Drinking before social occasions in order to get a head start.
- Feeling upset if one's supply is low, or having a tantrum if deprived of alcohol.
- Drinking more than you intended to on a number of occasions.

Diagnosis

Using information obtained from the alcohol history as well as other information (such as negative consequences associated with use, tolerance, and loss of control), the therapist now needs to share a diagnosis with the patient. In doing so, it is vitally important to emphasize that it is based on information provided directly by the patient. One way to do this is as follows:

“It seems to me, based on the information you’ve given me so far, that you have the following symptoms:

- Tolerance (explain, using specific examples from self-report).
- Loss of control (give supportive evidence).
- Continued drinking even though you’ve experienced the following negative consequences as a result of it: (summarize consequences).

“Taken together, this information you’ve given me suggests that you cannot effectively control your use of alcohol. Basically, that inability to control your use is what it means to be an alcoholic.”

Alternatively, a diagnosis based on the very same self-report data can be correlated to a Jellinek chart. Two such charts, one for men and one for women, are included in appendix A. Based on analyses of case histories, the Jellinek charts present a visual image of the course of alcoholism in terms of symptoms. They also lay out a pathway to recovery.

If you choose to use the Jellinek charts to share a diagnosis, once again be certain that you can document your case by referencing the patient's self-reported experiences. It can be approached in this way:

“Let me give you this chart to look at. I have a copy too. It's based on research, and it shows the course of alcoholism. It shows how symptoms progress and how alcoholism eventually ends in obsessive drinking. I believe that your use of alcohol at this time places you at the _____ stage of use. Let me give you my reasons for believing that, based on what you've told me today.”

Program Overview

The therapist should now review this 12-Step facilitation program, being sure to cover each of the following points.

Sessions

There will be 12 sessions in all, 2 of which may be conjoint sessions with the patient and hiWher spouse or partner (to be determined jointly by the therapist and the patient). In addition, there can be up to two emergency sessions if needed. The therapist will decide if an emergency session is appropriate.

Objectives of Treatment

The therapist will help the patient achieve the following objectives:

- Understand the AA view of alcoholism: That alcoholism is a chronic, progressive, and fatal illness that cannot be cured but which can be arrested so long as a person who has the illness is willing to follow some suggestions based on the experience of other alcoholics.
- Understand how AA works: How to find meetings, different types of meetings, sponsorship, and so on.
- Understand some of the key AA concepts, such as “surrender,” as well as the meaning behind many of its slogans.
- Learn how to use AA as a resource for staying sober One Day At A Time.

Responsibilities of the Therapist

Make it clear that you are there to—

- Educate, support, and advise the patient.
- Act as a resource person and coach to facilitate the patient’s understanding of alcoholism, the fellowship of AA, and its 12 Steps.
- Help the patient focus on staying sober One Day At A Time with the help of AA.

Responsibilities of the Patient

Explain that you expect the patient to—

- Attend all sessions.
- Come to sessions sober.
- Keep a journal.

- Make an honest effort to follow through on recovery tasks suggested by the therapist.
- Be honest, even about slips.
- Focus on staying sober One Day At A Time.

NOTE: Ask patients to call 24 hours in advance if a session needs to be rescheduled and to call if they are going to be late or will miss a session. Also ask patients to try to arrive 5-10 minutes early for each session, beginning with session 2, so that you will have a few minutes to review the patient's journal in advance. The purpose of this request is to emphasize the importance of the journal and to allow you to plan specific recovery tasks with respect to AA meetings and suggested readings.

Recovery Tasks

Recovery tasks are specific suggestions made by the therapist at the end of each session. They should be followed up on at the beginning of the next session. Suggestions should always be made in two areas:

- How many AA meetings the patient will attend between sessions, with the goal for initial recovery being the equivalent of one meeting a day.
- What materials the therapist suggests that the patient read before the next session.

In addition to the above, the therapist may wish to make suggestions about specific AA meetings (or types of meetings) the patient should attend and about how the patient can get active in AA meetings.

Meetings

Give patients a current schedule of AA meetings that are held in their geographic area. If patients live and work in two different areas, give them a schedule for each area. Help patients select which meetings they will attend between now and the next session. Note this in writing for followup purposes, and make sure that the patients write it down in their journal as well.

NOTE: The objective is to attend the equivalent of one AA meeting a day (i.e., 90 meetings in 90 days). The therapist should start out with this suggestion and then negotiate with patients to attend as many meetings as they are willing to. In later sessions, the therapist should continue to advocate going to meetings on a daily basis as well as whenever the patient has an urge to drink.

Journal

Give the patients journals (a composition book is fine for this purpose). Ask them to make a note of all AA meetings they attend (dates and times) as well as their unedited thoughts and reactions to them. Encourage patients to be completely honest about both positive and negative feelings about meetings. Also, ask them to note any reactions to readings in the AA literature.

Reading

Provide the patient with a packet containing the following AA publications:

- “Alcoholics Anonymous” (the “Big Book”)
- “Twelve Steps and Twelve Traditions” (the “12 x 12”)
- “Living Sober”

Ask the patient to begin reading these books, and make any specific suggestions you like with respect to them, keeping in mind the patient’s reading level and the amount of time (per day) that can reasonably be devoted to reading. Chapters 1, 2, and 5 of the “Big Book” are useful for those who are completely unfamiliar with AA, as are pages 1-7 of “Living Sober.”

The therapist should end this session by checking the patients’ willingness to follow through on recovery tasks. Help patients articulate any resistance you detect, and establish empathy with them. Encourage patients to do as much as they can, with primary emphasis on attending AA meetings. Clinical judgment and therapeutic skill should be utilized to modify recovery tasks if necessary (for example, if written material clearly appears to be above the patients’ reading level, or if they have already done extensive reading).

Troubleshooting

The purpose of the first session is to engage the patient’s interest in voluntarily committing to this 12-Step facilitation program. Approaches that utilize excessive pressure, threat, or coercion toward this end are likely to elicit a false commitment at best. This false commitment is called “compliance.” The compliant patient in treatment is “talking the talk” of recovery (most likely to either please or placate the therapist) but is not “walking the walk” of recovery, in the sense of being truly motivated to give the fellowship of AA an honest try. In this program, the therapist is advised to take a direct, nonjudgmental, and educative approach to confrontation. Stick to the facts as you see them, and do not allow yourself to be talked out of your interpretation of those facts. At the same time, respect the patient’s resistance to the idea of being powerless over alcohol.

The chemical history, along with symptomatology (tolerance, etc.) and an understanding of the process of alcoholism (Jellinek charts), should

be relied on consistently as the basis for confronting patients firmly and frankly with their current situation. The therapist who is convinced that alcoholism is a disease process should have confidence that alcoholic patients have struggled to control their use and should attempt to elicit evidence of this in a direct but supportive and sympathetic way. Similarly, slips can be discussed frankly yet sympathetically as the result of a disease that is more powerful than individual willpower.

Faced with resistant patients, the therapist should attempt to consistently provide feedback to them regarding—

- How the patient's life is becoming increasingly unmanageable due to alcohol abuse.
- How individual efforts have not proven effective in stopping or controlling use over the long run.

Resist temptations to be distracted from the main subject of this program, which is the patient's alcohol use and AA. Remember that the goal here is facilitation of the patient into AA. Concurrent issues (marital problems, job problems, posttraumatic stress, depression) can be handled initially by encouraging the patient to make use of AA resources such as meetings and social events, peers, and sponsors.

For patients who have a difficult time understanding the concept of "powerlessness" as it applies to drinking, reading the following story, excerpted from the "Big Book" may be helpful:

Our behavior is as absurd and incomprehensible with respect to the first drink as that of an individual with a passion, say, for jay-walking. He gets a thrill out of skipping in front of fast-moving vehicles. He enjoys himself for a few years in spite of friendly warnings. Up to this point, you would label him as a foolish chap having queer ideas of fun. Luck then deserts him and he is slightly injured several times in succession. You would expect him, if he were normal, to cut it out. Presently he is hit again and this time has a fractured skull. Within a week after leaving the hospital a passing car breaks his arm. He tells you he has decided to stop jay-walking for good; but within a few weeks he breaks both legs.

On through the years his conduct continues, accompanied by his continual promises to be careful or to keep off the streets altogether. Finally, he can no longer work, his wife gets a divorce, and his friends laugh at him. He tries his best to get the jay-walking idea out of his head. But the day comes when he races in front of a fire engine, which breaks his back.

The fact is that alcoholics, for unknown reasons, have lost the power of choice in drinking. Their so-called willpower becomes practically

nonexistent. They are without defense against taking the first drink. (p. 37)

Follow this up by engaging the patient in a discussion of this story, asking questions like-

- “Can you relate to the idea of ‘compulsion’ that’s presented in this story?”
- “Would you say that jay-walking was ‘out of control’ in this case?”
- “Have you known anyone who had a compulsion or an obsession that they couldn’t control?”
- “Can you see how some people are as out of control of their drinking as this man was out of control of his jay-walking?”

NOTE: In approaching alcoholic patients using this program, it is important that the therapist accept alcoholism as a no-fault illness. In other words, consider alcoholism to be a disease to which individuals are genetically predisposed. It is not their fault that they have either the predisposition or the illness itself; therefore, guilt over being an alcoholic is as inappropriate as is guilt over having renal disease or diabetes. There is also no cure for alcoholism; rather, there is only a method for arresting the process, which is active participation in the 12-Step program of Alcoholics Anonymous.

While alcoholics are not responsible for their illness, they are responsible for their recovery. Alcoholics cannot blame anyone else for their illness or assign responsibility to anyone else for their recovery.

Format: Sessions 2–11

Sessions 2 through 11 follow a common format.

Review (10-15 minutes)

- Review of journal
 - All meetings attended since the last session.
 - Reactions to meetings.

NOTE: Patients should be encouraged to attend meetings on a daily basis, and the therapist should negotiate down from that expectation with reluctance. Get specific commitments in this regard, and follow up by checking journal entries. Consult with your supervisor if there is strong resistance here and also regarding what types of meetings are appropriate for a particular patient.

- Review of slips
 - What, where, and with whom?

NOTE: The goal is to find out how patients handled a slip and what they could do next time that would be consistent with AA, such as-

- **Calling the AA Hotline.**
- **Going to a meeting.**
- **Calling someone the patient met at a prior meeting (an AA peer).**

Some people prefer the word “relapse” to the word “slip.” Either may be used, though the former seems to have more severe connotations than the latter.

- Review of urges
 - When and where?

- How did the patients handle them?
- What could they do in the future that would be consistent with AA?
- Review of sober days
 - Every day of sobriety deserves recognition and praise, without going so far as to promote false confidence or complacency.

**New Material
(30 minutes)**

- The therapist introduces new concepts or material for discussion.
- Questions/reactions are elicited and discussed.

**Recovery Tasks
(10 minutes)**

- Meetings
- Readings

**Summary
(5 minutes)**

- Other suggestions
- What was the gist of today's discussion in the patient's own words?
- Does the patient understand the recovery tasks that have been suggested? Is s/he willing to follow through on them?

Topic 2: Step 1—Acceptance

Review

Journal

- Meetings attended.
- Reactions to meetings.
- Discussion of why meetings were not attended, if appropriate.
- Reactions to readings.

Slips

- Where, when, and with whom?
- What did the patient do about them?
- What could the patient do in the future that would be consistent with AA?

Urges

- When and where?
- How did the patient handle it?
- What could the patient do in the future that would be consistent with AA?

Sober Days

- How many?
- How many successive?
- Reinforce with recognition of a significant accomplishment.

New Material: Step 1 and Denial

Session 2 introduces the first Step of AA and the following key concepts:

- Powerlessness (and limitation).
- Unmanageability.
- Denial (versus acceptance).

Stages of Acceptance

Step 1 of Alcoholics Anonymous reads as follows:

WE ADMITTED WE WERE POWERLESS OVER ALCOHOL—
THAT OUR LIVES HAD BECOME UNMANAGEABLE

Step 1 is, in fact, a complex statement. Its essence is the acceptance of personal limitation, in this case, one involving the loss of control over drinking. Although some individuals apparently achieve this acceptance via a single leap of faith, it is also possible to think of acceptance as a process involving a series of stages:

- Stage 1: “I have a problem with alcohol.”
- Stage 2: “Alcohol (drinking) is gradually making my life more difficult and is causing problems for me.”
- Stage 3: “I have lost my ability to effectively control (limit) my use of alcohol, and the only alternative that makes sense is to give it up.”

When discussing Step 1, it may be helpful to keep these stages of acceptance in mind and to work with patients toward the end of helping them achieve acceptance in stages.

To begin, facilitate a discussion of Step 1, reading it aloud and then talking about it, making sure to cover the following points:

- “What does this statement mean to you? What is your initial reaction to it? Does it make you mad at all?”
- “How do you relate to the concept of powerlessness? What kinds of things are you powerless over? Can you understand how some people can be powerless over alcohol?”
- “At this point, do you believe that you can still control your use of alcohol? On what basis do you believe this?”
- “In what ways has your life become unmanageable?” Using a chalkboard or flipchart, list ways in which the patient’s life has become increasingly unmanageable.

Say to the patient something like the following:

“Step 1 represents a statement of personal *limitation*. Accepting powerlessness over alcohol is much like having to accept any other personal limitation or handicap. Some people who have a hard time relating to Step 1 as it is written relate to it better if it is framed in terms of limitation. I would like you to think of times in your life when you were confronted by a limitation of some sort. It could be physical, intellectual, economic, or whatever. Whatever it was, it stood between you and something you wanted. What was it?”

Continue as follows:

“Typically, people do not react to limitation calmly; instead, they resist or deny it.

- Can you relate to feeling mad about having to face some personal limitation in the past?
- Is limitation easy or difficult for you to accept?”

Denial

Explain to the patient that “denial” is a term used to refer to the difficulty people often have in accepting or coming to terms with a personal limitation. The roots of denial lie in how it feels to have to accept a limitation, which usually is very unpleasant.

Limitation causes pain, and it is normal for people to protect themselves from pain. Limitation arouses feelings of anxiety, anger, shame, sadness, inadequacy, or guilt. Any or all of these emotions can motivate the individual to avoid (deny) coming to terms with (accepting) a personal limitation.

- Ask the patient how it feels to think about being powerless over alcohol.
- List these feelings.

Anger, anxiety, and depression are typical reactions to limitation. Acceptance of alcoholism, like acceptance of any limitation, is a grief process. Denial has a place in this process, as do anger and sadness. One stage of grief is “bargaining.” As it applies to Step 1, bargaining is alcoholics’ secret belief that they can “safely” drink; in other words, that they can control their drinking.

Explore this idea of bargaining, which is part of our natural defense against accepting loss and limitation. In this case, the loss is the loss of control over alcohol use, and the limitation is the fact that the patient can no longer safely drink.

Describe and explain the following forms of denial:

- Refusing to face facts: Refusing to do a serious alcohol history, refusing to acknowledge negative consequences of use, rejecting clear evidence of tolerance, refusing to go to AA meetings.
- Minimizing the facts: Understating negative consequences, tolerance, and so forth.

- Avoiding: Sleeping a lot, becoming socially isolated, or becoming compulsive (addictive) in some other way, such as work or eating.
- Exaggerating others' use in an effort to "normalize" one's own use.
- Blaming someone/something else for alcohol use (a bad marriage, family conflicts, feeling depressed, etc.), as opposed to accepting the fact that cravings for alcohol are responsible for use.
- Bargaining: Trying to limit or control either the amount or type of alcohol used or when it is used.
- Rationalizing: Making up "good" reasons (usually ones that will get sympathy) for drinking.

Work with patients to list some of the ways in which they are denying their powerlessness and the limitation of alcoholism.

Alcoholics Anonymous

The therapist should now provide a brief summary of AA: It is a peer-help movement (a fellowship) that was started by a physician and a stockbroker who had tried their best to control their alcohol use over many years, only to conclude defeat. If it would be helpful, read the following excerpt:

Most of us have been unwilling to admit we were real alcoholics. No person likes to think he is bodily and mentally different from his fellows. Therefore, it is not surprising that our drinking careers have been characterized by countless vain attempts to prove we could drink like other people. The idea that somehow, someday he will control and enjoy his drinking is the great obsession of every abnormal drinker. The persistent illusion is astonishing. Many pursue it into the gates of insanity or death. ("Alcoholics Anonymous," p. 30)

Explain that the fellowship of AA was founded on this simple idea: Some people, for some reason, simply could not stop their use of alcohol by relying on individual willpower alone; instead, they had to come to terms with the need to abstain from alcohol altogether and to seek support from others in making whatever changes were necessary to do so.

Explain that AA is based on the following key ideas:

- There is no cure for alcoholism; no treatment will enable an alcoholic to drink safely.
- Abstinence—staying sober One Day At A Time—is the only viable option for alcoholics.

- Self-reliance is not enough, and the support of peers with the same problem is vital to sustained recovery.

Finally, the therapist should review the main goals of AA to make sure that the patient clearly understands the following:

- The goal of AA is to avoid that first drink.
- AA asks its members not to think about forever, but rather to focus on each day of sobriety.
- AA is not looking for perfection. Slips are less important than what one does about them. Progress is more important than perfection.

Recovery Tasks

Meetings

Which meetings will be attended this week? Review the results of the previous week and make specific suggestions, keeping in mind the goal of 90 meetings in 90 days.

Reading

Suggested readings relative to Step 1:

- “12 x 12”: pages 21-24.
- “Big Book”: “The Doctors Opinion,” “Bill’s Story,” “More About Alcoholism.”
- “Living Sober,” pages 7-10.

Make additional suggestions as seem appropriate to the individual patient.

Journal

The patient should continue to note meetings attended and write down frank reactions to meetings as well as to readings.

Unmanageability

Ask patients to describe in their journal, in chronological order, experiences and events that illustrate how their life has become gradually and increasingly unmanageable as a consequence of drinking.

Troubleshooting

Once the concept of denial is presented, slips and resistance to getting involved in AA can be interpreted in this light. These interpretations should be made frankly and repeatedly, though nonjudgmentally. One approach to denial regards it as a normal part of the grief process.

People seem to be naturally predisposed to deny losses and limitations, and alcoholism represents both. Here are some examples of interpretations that reflect this point of view:

- “I think that part of your unwillingness to go to meetings is denial. I think there’s a part of you that does not want to accept this limitation—that you are an alcoholic and that you have to give up drinking. That part of you wants you to avoid going to an AA meeting.”
- “You slipped because you fooled yourself into thinking you were safe. So you went to the bar to meet your old friends, thinking that you could do that and not drink.”
- “The part of you that wants to deny your addiction tells you that you can control your use, that it was okay for you to have those cocktails at _____’s party. You fooled yourself into believing that you could limit your use, because you wanted to believe that.”
- “I know you don’t like to hear this, but I see your denial at work again. The part of you that still wants to drink—that doesn’t want to let go of alcohol—was telling you that you could have that beer, and that you’d be able to stop there, even though experience proves you can’t.”

A second way of conceptualizing denial is to think of it as “insanity” as that word is used in AA. Alcoholism as a form of insanity is implied in Step 2 (“Came to believe that a Power greater than ourselves could restore us to sanity”). The form of insanity involved in alcoholism is alcoholics’ delusional belief (delusional because it flies in the face of experience) that they can safely drink.

Alcoholism has been described as an illness of the mind as much as an illness of the body. The alcoholic rationalizes drinking and creates an illusion of choice when in fact drinking is an obsession that leaves no room for free will or conscious (rational) choice. From this perspective, resistance to accepting a diagnosis of alcoholism or of continuing to think and act in ways that promote drinking are aspects of alcoholism itself, just as much as physical tolerance is. The therapist can interpret resistance in these terms as follows:

- “Alcoholism is in fact an illness—an illness of the mind and of the body. It affects you physically—for example, you’ve had blackouts. It also affects you mentally—in the way you think, even when you’re sober. When you went to that party last weekend, you convinced yourself that it would be okay to drink so long as you only drank wine with dinner. Then you went home and got drunk on bourbon. That’s the illness at work. It’s called ‘stinking thinking’ in AA.”

- “From the AA point of view, the fact that you don’t want to go to meetings is just another symptom of the illness. You know from experience that once you start drinking you can’t stop until you’re drunk, but you continue to convince yourself that you really don’t have this obsession or that you can control it in some way when the facts speak to the contrary.”

Finally, some therapists may find it helpful to approach denial by viewing it as an internal conflict. The alcoholic can be thought of as someone who has a “dual personality”: the part of the self that wants to stay sober and enjoys sober consciousness and sober living (the recovering personality) versus the part that resists the idea of limitation, craves alcohol, and will do anything to get it (the alcoholic personality). Recovery represents an ongoing struggle between these two forces within the alcoholic patient. The therapist needs to ally with the recovering personality and assist the patient in strengthening it, while confronting the alcoholic personality consistently but with respect and compassion. Keep this phrase in mind throughout treatment: *Denial never sleeps*. Recovery demands eternal vigilance, which is what active involvement in the AA program can provide.

In order to align effectively with the recovering personality within the patient, the therapist must recognize the following facts:

- Alcoholism is more powerful than the patient’s individual willpower alone, so the alcoholic personality and denial will inevitably win out if the patient chooses to fight them without help in the form of AA.
- It is a normal human tendency to resist accepting limitation and to test limitation. This is deadly to the alcoholic in the long run.
- The alcoholic personality is cunning and clever and will make every effort to lower the defenses of the recovering personality by trying to convince the alcoholic that s/he is safe (no longer needs AA or can drink safely). Some have compared being in recovery to walking up a down escalator: As soon as alcoholics stop working a recovery program, the illness will begin bringing them down. Alternatively, it could be said that recovery requires eternal vigilance.

Topic 3: Steps 2 and 3—Surrender

Review

- Review the patients' journal, if they have kept one, and follow up on commitments that were made at the end of the previous session:
 - AA meetings: What meetings were attended, and what were the patients' reactions to them?
 - Reading: What did the patients read, and what were their reactions?

NOTE: Explore failures to keep commitments by meeting patients on their own ground, in other words, by engaging patients in an open discussion of their reasons for not doing what they agreed to do. How might this be a reflection of denial? What attitudes lie behind the resistance? For example, do patients make excuses, ridicule AA, or believe that they are not really alcoholics?

One of the most common forms of denial is expressed in feeling different from people who go to AA meetings—"I'm not like those people." Of course, every patient can be expected to be different in some ways from other alcoholics, and this can be readily acknowledged. The point behind AA is how the members of the fellowship are all the same, that is, in being unable to stop drinking. Does it make patients uncomfortable to think that they may be the same as "those other people" in this way? Discuss these issues as they arise, exploring the patient's attitudes and then countering them by getting back to facts as established by the alcohol history and other information that has come to light. Continue to confront the patient by respectfully and frankly stating the facts as you see them. Ask patients to think about making an honest commitment to stop drinking and to give the fellowship of AA an honest try as a means of doing that. Emphasize the importance of keeping an open mind and ask patients to give AA a try without necessarily making a long-term commitment to it. Ask them to think of ways in which they are similar to others who go to meetings, especially with respect to drinking. If others are worse off, can the patient imagine ending up that way?

- Review slips
 - When, where, with whom?
 - What specific strategies could be used next time:
 - Call the AA Hotline.
 - Go to a meeting—any meeting.
 - Call an AA peer.

NOTE: Because the goal of this program is to facilitate the patient’s entry to the fellowship of AA, it is important to de-emphasize reliance on the therapist as a means of staying sober, of coping with urges to drink, or of dealing with a slip. The material found in the book “Thing My Sponsors Taught Me,” published by Hazelden, provides a wealth of practical advice that you may want to share from time to time with patients relative to specific problems they encounter. In doing so, however, be careful to avoid becoming a surrogate sponsor for patients, who need to find their own sponsors through AA. It may be important in some cases to clarify from time to time your role as a therapist in this facilitation program. (Refer to “Therapist Guidelines.”)

- Review urges to drink
 - When and where?
 - What did the patient do?
 - How could the patient use AA to help with urges in the future?
- Review sober days
 - How many since the last session?

NOTE: It is more consistent with the AA view to congratulate patients for staying sober today than to get involved in counting sober days too much. The goal in AA is to stay sober today and not worry too much about yesterday or tomorrow. Accordingly, it is appropriate to congratulate patients on staying sober for a certain number of days, so long as you do not lose sight of the fact that a slip can happen at any time and what is most important is what patients are doing today about their drinking.

New Material: Steps 2 and 3

NOTE: If Step 1 can be compared to admitting the problem, then Steps 2 and 3 are equivalent to accepting the solution. The two go hand in hand and together form the foundation for recovery through involvement in AA.

Introduce the new material by referring the patient to the chapters on Steps 2 and 3 in the “Twelve Steps and Twelve Traditions,” explaining that this should be a recovery task for the coming week.

Read Steps 2 and 3 aloud to the patient:

CAME TO BELIEVE THAT A POWER GREATER THAN OURSELVES
COULD RESTORE US TO SANITY.

MADE A DECISION TO TURN OUR WILL AND OUR LIVES OVER
TO THE CARE OF GOD AS WE UNDERSTOOD HIM.

Elicit reactions to Step 2:

- What does the patient believe in? Who are his/her heroes? What are his/her most cherished values?
- Does the patient have an open mind about what can help him/her abstain from alcohol?
- What kind of Higher Power does the patient believe in? What are the qualities of this Higher Power?
- Of what religious background is the patient? Does s/he still practice? If not, when and why did s/he stop?
- In what ways has alcohol abuse caused insanity? One way to interpret “insanity” is that it is manifested in a tendency to repeat harmful, ineffective behaviors despite clear evidence of their harmfulness or ineffectuality. Another way to define it is that insanity is a failure of good judgment and clear thinking.
- How has alcohol abuse led the patient to make poor decisions/choices or to stay “stuck” with harmful or ineffectual behaviors?
- Defiance and arrogance are common personality traits of addicts, whether or not they were this way before they became addicted.
 - In what ways is the patient defiant or arrogant?
 - How is this a reflection of denial—of the patient resisting his/her limitation?

Elicit reactions to Step 3:

- Step 3 is the “opening of a locked door”—the move away from denial and toward acceptance of addiction.
- What does the idea of “turning over” your will mean to patients? Have they ever trusted another person enough to follow their advice blindly?
- What are the patient’s attitudes regarding trusting others in general and the therapist in particular and accepting common wisdom such as that found in the AA program?
- Discuss the “cult of self-reliance”—the contemporary popular notion that one can be totally responsible for one’s self as opposed to needing to rely on others to achieve personal goals. AA is based on the idea of interdependence as opposed to self-reliance.
 - How much has the patient bought into the cult of self-reliance?
 - Has the patient ever followed someone else’s advice, simply on the basis of trust and faith? If so, who and when? What about trusting the wisdom of AA based on faith?
 - What resistance does the patient have to Turning It Over as opposed to “going it alone”?

Summarize:

- What concerns or reservations does the patient have about the concepts presented in steps 2 and 3? Take the time to elicit these, to define them, and then to interpret them using whatever approach is most comfortable for you (see discussion on “Denial”).

Recovery Tasks

Meetings

Which meetings will the patient attend? Is the patient ready to try out different kinds of meetings, such as Step meetings and discussion meetings, in addition to speaker meetings? If there is resistance to going to meetings, how might this reflect denial at work?

Reading

Suggested readings are as follows:

- “Big Book”: “Bills’ Story,” “There Is a Solution,” “We Agnostics.”
- “12x12”: pages 25-41.
- “Living Sober”: pages 77-87.

Troubleshooting Again, when presenting material on steps 1, 2, and 3, the best therapeutic stance is frank but nonjudgmental. The therapist must believe in the illness model of alcoholism: that alcoholism is an illness affecting the body, mind, and spirit. The therapist must be prepared, however, for the patient to resist these ideas, as the “Big Book” makes amply clear. Patients may criticize or demean AA and the 12 Steps or may attempt to draw the therapist into a discussion (or argument or debate) about whether alcoholism is really an illness or whether controlled drinking is possible. They may attempt to change the agenda of this program, for example, to make into marital therapy or psychodynamic psychotherapy. The therapist is advised not to enter into such debates, not to react defensively to criticism, and not to get off the track of the program. Keep the following in mind:

- The objective of this program is facilitation of the patient’s active involvement with AA.
- The therapist does not need to defend AA—it does very well on its own and will continue whether or not this particular patient believes in it.
- Believing in the 12 Steps or in a Higher Power may be less important than simply going to meetings, which should be the first goal.
- Alcoholism is a powerful and cunning illness, and patients may just insist on doing it their way for now.
- Every sober day (and sometimes every sober hour) is important and should be recognized. Whenever you are confronted with a slip, think about how many sober days (hours) the patient has had since seeing you last.
- Alcoholism is an illness that defeats the will and causes alcoholics to regress, becoming more and more infantile (impulsive, self-centered) and difficult to deal with over time. This is their illness at work. It is important to separate the illness from the person it affects.
- A patient who shows up drunk is a patient who needs social support. The therapist cannot be a support network or even a sponsor. Get the patient to use AA whenever possible. For example, encourage the patient to call the Hotline.

Topic 4: Getting Active

Review

- Review the patient's journal, if s/he has kept one, and follow up on commitments that were made at the end of the previous session:
 - AA meetings: What meetings were attended, and what were the patient's reactions to them?
 - Reading: What did the patient read, and what was his/her reaction?
- Review sober days
 - How many?
 - Recognize *each day* of sobriety.
 - Is the patient getting a feeling for the AA saying, One Day At A Time? If not, then take a few minutes to talk about the AA philosophy of living and staying sober *now*, without worrying too much about what happened yesterday or what might happen tomorrow. Encourage the patient to focus efforts on not drinking for the rest of today and then dealing with tomorrow when it comes.
- Review urges to drink
 - When and where?
 - What did the patient do?
 - How could the patient use AA to help with urges in the future?
- Review slips
 - When, where, with whom?
 - What can the patient do differently? Emphasize three critical AA concepts:
 - *People, Places, and Things*.—Things that need to change, including familiar drinking places, drinking buddies,

enablers, and old habits. AA wisdom says to “avoid slippery people, slippery places, and slippery things” if you do not want to slip. What are some of the slippery people, places, and things in the patient’s life? How could they be avoided? How could they be replaced with nonslippery people, places, and things?

- *Easy Does It.*—The need to avoid trying to solve too many problems at once and thereby feeling overwhelmed. Patients may need to express their concerns and frustrations and to communicate their other problems of living. On the other hand, the therapist can support sobriety by helping patients monitor their level of overall stress and by encouraging patients to decompress through meditation, prayer, exercise, affirmation, or whatever works for them. The key insight to provide is the message behind the slogan, which advises us to “not bite off more than we can chew.”
- *First Things First.*—The need to stay sober is the first priority, since nothing else will matter if the alcoholic continues drinking. Given the fact that all patients can be expected to enter treatment with a multitude of problems, some of which are at least partly consequences of drinking, it is easy for both the patient and the therapist to either get off the track (of the goals of this program) or to feel overwhelmed and confused. When other issues arise, no matter how legitimate, both the patient and the therapist are advised to think of this slogan and to get back on track, since as this AA slogan points out, sobriety is the foundation for dealing with everything else. AA suggests that those who stay sober are those who are willing to go to any length to do so. Recovery is not a passive process, but one that requires effort and action.

NOTE: Once more it will be important at the outset of each session to “meet the patient where s/he is,” that is, to get a sense of how the patient is reacting to this program. Resistances that take the form of not going to meetings, not reading, or having reactions to both that are unbalanced in the negative direction should be explored. Using a formulation of denial that is most comfortable for you—see discussion on “Denial”—confront resistance in a straightforward but nonjudgmental manner.

New Material: Getting Involved

“Getting active” refers to the idea that recovery comes only through working the program, by active involvement in the 12-Step program (as opposed to trying to not drink through solitary, white-knuckle determination or by simply attending but not participating in meetings).

Present this material, adjusting it as necessary to the individual patient so as to make it understandable:

“Addiction is an illness that affects, among other things, the individual’s will. As alcoholism progresses into the illness of the mind that is characterized by obsession and delusion, it becomes stronger than the will. Some individuals may be able to stay sober when they are feeling good, but they will be vulnerable to slipping as soon as they are in situations that evoke particular emotions such as anger or loneliness or which leave them feeling tired—in other words, in any situation where willpower may be weakened. Each time the will is defeated, the alcoholic becomes more hopeless and alienated. Not a few alcoholics have committed suicide while in such a state of despair. Becoming active in AA, including doing things like getting phone numbers or helping make coffee, may seem pointless to patients when they are feeling good and in control, but it can save their lives in the long run since it will connect the patient to a fellowship—to a ‘Power greater than themselves.’ Similarly, the spiritual aspect of AA provides comfort and support to the individual whose willpower has been eroded by alcoholism. Steps 2 and 3 challenge the alienated and defeated alcoholic to find faith, again in a Power greater than the self.’ Together, getting active and finding faith are vital to recovery.”

After checking to see that the patient understands the gist of the above, move on to a discussion of getting active:

“Following on these ideas, we need to discuss this matter of ‘getting active.’ The ‘Big Book’ tells us, ‘Faith without works is dead’ (p. 76). Beyond merely attending AA meetings—sitting there passively—getting active involves ‘working the program’ in each of three areas. Let’s look at each of them.”

Participation

Attending meetings marks the start of establishing a new network of friends that will be critical to recovery. However, merely going to meetings without participating in them is not the same thing as working the 12-Step program and is not likely to be helpful to recovering patients when they have strong urges to drink or have a slip. At those times, the patient needs to know what to do (whom to call and where to go) and to feel comfortable doing so without hesitation. That is why getting active is so vital.

There are many different kinds of meetings (speaker meetings, Step meetings, discussion meetings, women’s/men’s meetings). The therapist should work with the supervisor to select appropriate meetings for each patient. Some patients may be comfortable going to speaker and discussion meetings from the start of treatment (e.g., patients

who have gone through an AA-oriented inpatient program); others may need to be eased into discussion meetings by attending some speaker meetings first.

The book “Living Sober” has many practical ideas for getting active. The therapist should be familiar with these and work with the individual patient to develop a program for getting active.

NOTE: Be as concrete as possible in this effort, developing an actual list of things to do that patients can take with them and that the therapist can use for followup purposes.

Examples of getting active include volunteering to make coffee or clean up after meetings, attending AA social events, and participating in discussion meetings. Another way of getting active is to make use of telephone therapy.

Using the Telephone

Patients will definitely not like everyone they meet at AA meetings, and the therapist should expect and respect this. On the other hand, the more meetings (and different ones) patients attend, the more likely it is that they will connect with at least a few people.

One goal of this facilitation program is to get patients not only to attend and participate in meetings, but to get phone numbers of people whom they can call. When should a recovering person use the telephone? Here are some examples:

- Whenever they have an urge to drink.
- After they have had a slip (as soon as possible).
- When they are feeling lonely, angry, or tired.
- When they feel overwhelmed by life’s problems.
- When they feel good (and perhaps complacent) about their sobriety.

The more people they meet and talk to, the more phone numbers patients can get, and therefore, the more people they will have to call at those critical times.

Telephone therapy has long been a tradition in AA. Along with going to meetings and getting a sponsor, using the telephone is one of the cornerstones of recovery. Assure the patient that AA members expect to give out their phone numbers and expect to get calls. Often there is no need to even explain the reason for calling.

NOTE: Prepare patients to be asked for their phone numbers.

Explore the patients' resistances or anxieties about asking for phone numbers or using them:

- When would they hesitate to make a call: The middle of the night? On a weekend? From work?
- Why would they hesitate to make a call: When feeling angry? Depressed? Lonely? These are exactly the right times to call!

Work through patients' resistances to using the telephone as much as possible, using role-playing (practice) if necessary to facilitate their willingness to try it as a recovery task for the next week.

Getting a Sponsor

Explain to the patient that the use of sponsors is perhaps the oldest tradition in AA. Originally, sponsors were people who were willing to take responsibility for visiting alcoholics in the hospital and for taking them to an AA meeting when they were discharged. Also, sponsors were used as resources for questions about material in the "Big Book." Today, sponsors are obtained through meetings, and their role is not to visit inpatients or to explain the "Big Book" so much as it is to serve as a source of practical advice from someone who has been in recovery longer to someone who is less experienced. Even people who have been in recovery for years are apt to still have a sponsor, though in their cases the sponsor may be a peer in terms of recovery.

What a Sponsor Is

It is a privilege and a responsibility to be a sponsor. The sponsor is someone the patient can call (in addition, hopefully, to other AA friends) who can provide basic information about AA and its traditions, who can help to answer questions about the Steps, who can steer the patient toward meetings that might be helpful, and who can facilitate getting active.

What a Sponsor Is Not

A sponsor is not a therapist, a judge, or a parent. A good sponsor will not tell you what to do (but will give you suggestions if you ask) and cannot help you solve personal or marital problems, judge you, or take care of you. A sponsor cares about you, understands from personal experience the issues in recovery that you face, and is an ally. However, there is plenty of room for therapy in recovery, and having both a therapist and a sponsor should not present any conflict, so long as the therapist respects the patient's 12-Step recovery program.

How To Get a Sponsor

First, explore patients' resistances to getting a sponsor. What concerns or reservations do they have? What qualities would they be looking for in a sponsor (age, background, etc.). AA suggests these ground rules:

- Sponsors should be of the same sex as the patient.

- Sponsors should be of the same age or older than the patient.
- Sponsors should have at least a full year of sobriety and should be actively working the 12-Step program, including going to meetings, using the telephone, and having their own sponsor.

Next, explain the process for asking for a sponsor, which is simple: Go to a meeting, wait for announcements, and say that you need a sponsor. Alternatively, patients can just go to meetings, arrive early or stay late, and casually let people know that they are looking for a sponsor.

NOTE: Role-playing (practicing) the process of asking for a sponsor and discussing what characteristics to look for can be very helpful to many patients. In addition, it can be useful to discuss likely candidates that the patient has met. “Living Sober” contains some good material on sponsorship, as does “Things My Sponsors Taught Me.” The therapist may want to refer to both and also suggest to patients that they look for a copy of the AA pamphlet on sponsorship at a meeting.

Recovery Tasks

Meetings

- Which meetings will be attended this week?

Reading

- “Living Sober”: pages 13-18 and 24-30.
- “Big Book”:
 - How much has the patient read?
 - What has been the patient’s reaction so far? What questions have arisen?
 - What if any stories can the therapist recommend to this particular patient?

Participating

- Ask patients to do *two* specific things toward getting active. Write these down and give them a copy.

Getting a Sponsor

- Remind patients that one goal of the program is to get a sponsor. Patients need to keep this goal in mind when talking to people at meetings.
- Help patients identify *three* key things they will be looking for in a sponsor.

Using the Telephone

- Ask the patient to get *three* names and phone numbers of people, at least *two* of which have to be from members of the same sex.
- Ask the patient to call *one* person whose phone number they get, just to establish contact. This call can be as brief as 5 minutes.

Summary

- What did the patient understand this session to be about?
- What did the patient learn from this session?

Troubleshooting

The therapist should be thoroughly familiar with the material in all readings: the “Big Book,” the “12 x 12,” and “Living Sober” and should make efforts to integrate readings from all three into each session. These books are filled with practical advice and wisdom and should be resources to therapist and patient alike. Do not hesitate to read a relevant passage together and discuss its relevance to any issue at hand.

Part 2: Elective Topics

Topics in this section (topics 5 through 10) should be incorporated into the individual patient's treatment as appropriate and as time permits. The primary factor that influences which of these electives are pursued is the patient's overall progress in getting active. For many patients, the main work of this program can be expected to be focused on the four core topics. However, as progress permits, one or more of these elective topics may be covered:

Topic 5: Genograms

Topic 6: Enabling

Topic 7: People, Places, and Things

Topic 8: HALT (Hungry, Angry, Lonely, and Tired) Topic 9: Steps 4 and 5—Moral Inventories

Topic 10: Sober Living

NOTE: This facilitation program focuses primarily on three objectives:

- **Going to AA meetings.**
- **Getting active in AA.**
- **Getting and using a sponsor.**

Even when the agenda for a session involves an elective topic, do not lose sight of the importance of these objectives. Take whatever time is necessary to explore resistances, to make suggestions, and to elicit a commitment to any reasonable progress in these areas.

Topic 5: The Genogram

Review

Continue to begin each session, including those that cover elective topics, with the following basic review, taking 10-15 minutes to do so.

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce *each day* of sobriety.
- How is the patient doing with living One Day At A Time?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have?

Getting a Sponsor

- What progress is being made?
- What is the basis of any resistance?
- What suggestions can the therapist make, and what commitments will the Patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: The Genogram

The purpose of doing a genogram is to reinforce the concept of alcoholism as a disease that can usually be traced across generations (in other words, as a family illness) and to motivate the patient to break the cycle of addiction by working the AA 12-Step program. While it is important to complete the genogram itself, the exercise is primarily intended to serve as a catalyst for a discussion of how alcoholism has harmed not only the patient, but how it may have harmed others in the family and in previous generations. This should be encouraged so long as the focus of discussion is on alcohol and its consequences and not on tangential issues. Remember: First Things First.

NOTE: Therapists who are unfamiliar with the use of genograms in therapy are advised to seek consultation prior to using this technique. Genograms have the potential to evoke intense emotional reactions, often after the session is over. It can also be difficult for an inexperienced therapist to keep the focus of the genogram as it is used here on the issue of alcoholism as a family illness. Practice using role-playing, as well as doing a personal genogram with a supervisor, can be good preparation for using this technique. Finally, refer to the “Troubleshooting” section for this session before going ahead with it.

The Genogram

A chalkboard or flipchart is helpful when doing a genogram. If these are not available, use as large a piece of paper as you can find.

Include at least three generations in the genogram, starting with the patient’s own generation. List the patient and all siblings. Then fill in the following information on the genogram itself for each sibling:

- History of alcohol or drug abuse. Ask questions like:
 - Do any of your siblings have what you would consider to be a drinking or drug problem?

- Which one(s)?
- What do they use?
- What negative consequences have they suffered?
 - Legal (DWI, etc.)
 - Social (divorce, etc.)
 - Occupational (losing jobs, poor reviews, etc.)
 - Physical (health problems)
 - Emotional/psychological (depression, suicide, etc.)
 - Financial (bankruptcy, etc.)

Next, fill in the genogram for the previous generation (the patient's parents, uncles, and aunts). Collect similar information as for the siblings.

Next, obtain as much information as possible about the generation twice removed (grandparents).

Finally, if the patient has children, obtain information about them relative to alcohol or drug abuse.

Discussion

Discuss the genogram and its implications:

- How many people in the patient's family, past and present, have been affected by alcohol or drugs?
- What consequences did they suffer? Did anyone die or commit suicide either wholly or partly as a result of alcoholism?
- Does the patient see any pattern(s) in the genogram?
- What choices does the patient want to make about his/her life and that of his/her children? Where will the chain of addiction be broken?

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kind of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor? If not, what specific steps will be taken between now and the next session.

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example meditation books, but should discuss their appropriateness in advance with a supervisor.

Genogram

- Ask patients to use their journals to write down reactions or thoughts following this session.
- Make a point of asking patients to call (not normally encouraged in this program) in the event that they are experiencing distress as a result of the genogram exercise.

Troubleshooting Any genogram exercise has the potential to stir up many emotions that may have been dormant, sometimes for years. Painful recollections of growing up in an alcoholic home, of abuse, abandonment, or neglect, can evoke intense anger, anxiety, and shame. The therapist may not be in a position to adequately work through such emotions but should be sensitive to them and prepared to offer helpful guidance:

- Validate emotional reactions as appropriate to their context (“I can understand how you must have felt ashamed to bring friends home with your mother drunk most of the time.” “I can understand that it must have been frightening not knowing when your father might get drunk and become violent”).
- Direct the patient to AA as a source of comfort from people who have no doubt had similar experiences. For example, you could suggest that the patient speak to an AA peer or sponsor about this exercise and reactions to it.
- Encourage the patient to write down feelings and thoughts about the genogram and the issues it raised.

- Suggest that the patient might experience an urge to drink as a result of this exercise and what should be done about it (for example, going to a meeting or calling an AA peer).

If a patient shows signs of extreme distress or discomfort during the genogram, it may be necessary to stop, to focus on those feelings and comfort the patient, and then to discontinue the exercise. It is also advisable to create some balance in the genogram by asking patients to give themselves or others credit for accomplishments and successes; in other words, to honor one's self and others, as well as to acknowledge harm done through drinking. The point is that the people in the patient's family are good people who had an illness that led them to behave in ways that were hurtful to themselves and others. This simple act of providing some brightness now and then in an otherwise grim picture can help to offset a patient's tendency to fly into rage or to sink into shame and despair.

Topic 6: Enabling

NOTE: For patients who are in a relationship with a partner who is willing to participate in treatment, Conjoint Session 1 may be substituted for this session.

Review

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What commitment is the patient willing to make?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce *each day* of sobriety.
- How is the patient doing with living One Day At A Time?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have?

Getting a Sponsor

- What progress is being made?
- What is the basis of any resistance to getting a sponsor?
- What suggestions can the therapist make, and what commitments will the Patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Enabling

Definition

Define enabling for the patient:

- Enabling is defined as any and all behaviors by others that allow or have allowed the patient to continue drinking or avoid or minimize negative consequences related to drinking.

Check that the patient has a clear understanding of enabling, using a few examples:

- Friends who buy you drinks when you are already drunk.
- Friends who make sure they have enough liquor for you when you visit them.
- Friends who joke with you about getting drunk, or drinking as much as you do.
- Spouses who go to the store to buy liquor for you.
- Spouses who make excuses for you when you are intoxicated (e.g., calling in sick for you when you are hung over).

Enabling Inventory

Have the patient construct an “Enabling Inventory.”

NOTE: A chalkboard or flipchart is helpful for this. Have patient record personal examples in their journal.

- List significant others who have enabled the patient.
- List how they have enabled the patient (be specific).

Motivation of Enablers

Discuss the motivations for enabling.

- People enable not because they want the alcoholic to be an addict, but out of a desire to protect the alcoholic. The motives for enabling are usually benign and loving, but they end up being mutually destructive to the alcoholic and the enabler alike.
- How do enablers feel?
 - *Guilty* because they sometimes fear that they either caused or contribute to the problem.
 - *Frustrated and angry* because the alcoholic either will not change, will not listen to advice, or continues to relapse.
 - *Hopeless and depressed* as a result of continued drinking and the progressive unmanageability of their own lives as a result of being in a relationship with an alcoholic.
 - *Alienated*, meaning that they eventually give up and write off the alcoholic.
 - *Fearful and anxious* because they are afraid that the alcoholic will abandon them.

Resisting Enabling

Explain to the patient that a vital part of recovery involves acknowledging enabling and actively resisting it on a day-to-day basis.

- Patients need to be *honest* about their addiction with their primary enablers. By the same token, significant others need to become knowledgeable about denial so as to become less vulnerable to denial and enabling.
- Al-Anon is the best resource for partners of alcoholics who want to help themselves. Patients cannot “treat” their enablers.
- Patients should begin and end every day with a personal acknowledgement of being an alcoholic. This is also reinforced by daily attendance at AA meetings.

NOTE: You may want to suggest that the patient purchase and use a daily meditation book, such as “Twenty-Four Hours a Day.”

- Addicts need to own up to their methods for encouraging enabling in others, since the alcoholic typically uses many methods, such as guilt or fear, to promote enabling. For example, alcoholics may attempt to blame a binge on an argument with their partner or may arouse anxiety by claiming that their job will be in jeopardy unless a spouse covers up for them.
- Ask patients to give a few examples of how they encouraged or coerced others into enabling.

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kinds of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor?
- If yes, how is the patient making constructive use of the sponsor?
- If not, what specific steps is the patient willing to take toward getting a sponsor between now and the next session?

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example, affirmation books, but should discuss their appropriateness in advance with a supervisor.

Enabling

Ask patients to make *three* specific commitments regarding what they are willing to do with respect to reducing enabling. This does *not* mean trying to reform significant enablers so much as avoiding them or not encouraging or reinforcing them. There should be some discussion about enabling on the part of those who are closest to the patient, especially spouses.

Troubleshooting It is very important when discussing the concept of enabling to not encourage patients to blame others in any way for their drinking. Enablers are typically motivated out of concern, anxiety, or confusion about what to do. Wives of alcoholics, for example, may fear the loss of income or even spouse abuse if they do not somehow help their husbands. Husbands may fear humiliation if they do not cover up for their wives.

Alcoholics need to understand how enabling contributes to their drinking and also the role they play in encouraging that enabling. The key insight for alcoholics here is how they helped to create the enabling system that supports them. The first way to break out of this is to embrace Step 1 and openly acknowledge unmanageability and loss of control, not just once but on a daily basis. Second, enablers cannot be cured by the alcoholics they support; rather, enablers can get support for themselves through Al-Anon. Alcoholism as a family illness leads to life becoming unmanageable not only for alcoholics, but for those who are closest to them.

The goal in discussing enabling is to help patients make specific commitments to dismantling their enabling system by either avoiding enablers or by being honest with them about being an alcoholic.

Topic 7: People, Places, and Things

Review

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What commitment is the patient willing to make?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce *each day* of sobriety.
- How is the patient doing with living One Day At A Time?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have about readings?

Getting a Sponsor

- What progress is being made?
- What is the basis of any resistance to getting a sponsor?
- What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: People, Places, and Things

Lifestyles and Recovery

Alcoholics Anonymous has a long history of being very pragmatic about what it takes to stay sober: whatever works for the individual is fine. Bill W., cofounder of AA, devoted time over many years to answering letters in which recovering alcoholics asked many practical questions about staying sober. His strategy, which has become an integral part of the AA tradition, was to share suggestions about what others had found helpful in different problem situations.

This session is intended to review and address some of the practicalities of staying sober: what the patient should do about spending time with friends who drink, about going to parties, about changing habits that were intimately associated with drinking, and so on. Following the model of Bill W., the therapist should be prepared to be pragmatic, flexible, and nondogmatic. The objective is to brainstorm ideas with patients for how they can stay sober in different problem situations. The assumption is that it is not realistic for patients to expect the world to change in response to their efforts to stay sober; rather, patients must learn to change their lifestyle in order to stay sober. Moreover, any tendency to think that recovery can occur without fundamental changes in attitudes and behaviors is unrealistic.

Convey the following information to the patient:

“An adage within the AA movement goes something like this: ‘Avoid slippery people, slippery places, and slippery things, unless you want to slip.’ The wisdom in this slogan refers to the need to change many aspects of one’s lifestyle in the interest of recovery. In many ways, the word ‘routine’ (those things we tend to do day in and day out) could be added to this list of slippery things.”

The starting point for the session can be the fact that the alcoholic's lifestyle has drifted toward people and situations that facilitate and support drinking, and that s/he has developed a range of habits and rituals associated with drinking. Some of these may have to do with daily routines such as cooking meals, ironing, cleaning the house, coming home from work, or watching the 6 o'clock news on television. Other drinking rituals may involve certain people or even certain places. This process of connecting drinking with people, places, things, and routines happens naturally as drinking becomes habitual. The alcoholic is someone who is increasingly preoccupied with maintaining a certain level of alcohol in the body and whose drinking in turn becomes connected to habits and rituals. In time, many of the alcoholic's old habits and interests give way to new ones that support drinking.

In order to stay sober, alcoholics need to change many patterns associated with habitual use; otherwise, their willpower will be no match for the power of ritual and habits combined with their obsession with alcohol.

- Can the patient identify any rituals associated with drinking? Is there a certain sequence of events that s/he follows? (Most alcoholics readily own up to their ritualistic behavior around drinking, and the therapist who has a feeling for this concept of ritual can usually elicit these patterns. This will be very helpful in this session).
- Can the patient identify certain routines that are associated with drinking? For one woman, it was ironing; for a man, it was the ride home on the commuter train.
- Can the patient identify a list of drinking partners?
- Can the patient appreciate the power of habit; in other words, how powerful these rituals can be and how they can actually be stronger than willpower?
- Can the patient see how preoccupation with drinking will be no match for personal willpower in one of these slippery situations?

Explain to the patient that, given the above, it follows that recovering alcoholics need first to identify and second to change, people, places, things, and routines associated with drinking if they hope to sustain sobriety. To help the patient in this effort, the following exercise can be useful.

Lifestyle Contract

Purpose: To help the patient do a "people, places, and things" inventory to identify *what needs to be given up and what needs to be substituted*.

Without *both* parts of the exercise, the patient is apt to fail. In other words, giving up old, drinking-associated habits will not work in the long run unless they are replaced with new, sobriety-associated habits. That is the purpose of this exercise.

NOTE: A chalkboard or flipchart is helpful for this exercise. Have patients make notes in their journal.

- People
 - Who did the patients spend time drinking with in the past? Who, in other words, are the drinking buddies they need to give up?
 - How will the patient develop a new social network—a new group of (sober) friends?
- Places
 - Where did the patients spend most of their time drinking?
 - Where will the patients spend their time in the future? Included here should be places that are associated with a variety of activities:
 - Going to meetings.
 - Exercise/recreation.
 - Hobbies/interests.
- Things
 - Where did the patient keep the main supply of liquor, as well as hidden supplies?
 - What might need to be changed regarding these caches?
- Routines
 - What day-to-day routines have been associated with drinking?
 - How will the patient change these routines?

The therapist should keep notes of the people, places, things, and routines that the patient has decided to change, as well as their replacements. If the patient has not kept notes, then a copy of the therapist's notes should be given to the patient. It is important to help the patient make small but specific commitments to change and to follow up on these commitments.

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kind of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor?
- If yes, how is the patient making use of the sponsor?
- If not, how can the therapist facilitate this objective?

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example meditation books, but should discuss their appropriateness in advance with a supervisor.

People, Places, Things, and Routines

- How will the patient make a start on this? What specific commitments is the patient willing to make relative to the recovery contract? Write these down and have the patient write them in his/her journal.

Troubleshooting

Much of the material in “Things My Sponsors Taught Me” (a Hazelden publication) may be useful to the therapist in this session, particularly the following sections:

- “About the Old and the New You in Alcoholics Anonymous,” page 39.
- “About Cocktail Parties,” page 51.

The therapist should review these prior to session 7 and pick out one or two points that may be especially relevant to the particular patient. Go over these points and brainstorm with the patient about how they apply to his/her life. This can provide the initial focus for the “Lifestyle Contract” exercise.

Topic 8: HALT (Hungry, Angry, Lonely, Tired)

Review

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What commitment is the patient willing to make?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce each day of sobriety.
- How is the patient doing with living One Day At A Time?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have about readings?

Getting a Sponsor

- What progress is being made?
- What is the basis of any resistance to getting a sponsor?
- What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Hunger, Anger, Loneliness, and Fatigue

The purpose is to help the patient identify emotions which, according to AA lore, are most often associated with slips. These are the emotions that most often lead to taking that first drink, which in turn sets off the alcoholic's craving and leads to compulsive drinking.

Present the idea to patients that they need to be able to identify the following feeling states and do something about them before they are induced to drink them away:

- LONELINESS
- ANGER
- GRIEF
- ANXIETY
- RESENTMENT
- SELF-PITY

It is also a maxim in AA that alcoholics are most vulnerable to the above emotions—most apt to drink them away—when they are either hungry or tired. Therefore, AA puts a strong emphasis on getting rest and eating well.

After going through the general material below, the therapist should be flexible so as to work with those emotions that are most relevant to the individual patient.

Many AA sayings and slogans—Easy Does It, Let Go and Let God, One Day at a Time, First Things First, Turn It Over—relate to one or more of the above feelings. They reflect common wisdom for handling difficult emotions. Their value lies in their simplicity. Through these saying and slogans, the fellowship teaches alcoholics how they can live sober. The therapist should therefore be familiar with these slogans (see references below) and use them in treatment. In addition, teaching patients to connect particular slogans to situations in their lives that trigger risky emotions can be extremely helpful.

Hungry and Tired

- Reference: “Living Sober,” pages 22, 30

Recovering alcoholics need to develop a lifestyle that allows them to get adequate rest. A state of exhaustion is an invitation to drink. Related to this is physical conditioning—a body in poor physical condition will get tired more quickly than one that is being taken care of.

- How much sleep does the patient get, on average? Is this adequate? What changes, if any, could be suggested with regard to rest?
- Has the patient ever experienced drinking, or having a strong desire to drink, when feeling especially tired?
- What is the patient’s state of health? Is s/he capable of some form of regular exercise in the interest of gaining energy?

Along with the need to avoid exhaustion, AA emphasizes the need for the recovering alcoholic to avoid excessive hunger. Regular meals are encouraged and, beyond that, the alcoholic is encouraged to snack so as to avoid getting too hungry. The use of small amounts of sweets now and then may help to satiate the alcoholic’s taste for the sugar that is in the alcohol they used to drink.

- Does the patient sometimes experience cravings for something sweet?
- How can the patient satisfy this need? (Point out that whatever sweets they eat in recovery probably will not have as many calories as the alcohol they drank).

Anxious

- Reference: “Living Sober,” pages 18, 32, 41, 44.

Anxiety has many sources, but one form of anxiety that runs as a theme through AA writings concerns making decisions—knowing what to do and feeling right about it. Much of the spirituality of AA is directed at relieving the sense of confusion and anxiety associated with being alone, of having no one (or no faith) to rely on. The “serenity prayer” addresses feelings of isolation and confusion:

GOD GRANT ME THE SERENITY
TO ACCEPT THE THINGS I CANNOT CHANGE,
COURAGE TO CHANGE THE THINGS I CAN,
AND THE WISDOM TO KNOW THE DIFFERENCE

Read the serenity prayer aloud and ask patients for their reactions to it.

- Do patients relate to experiencing “existential anxiety”: the feeling of being isolated, of facing difficult decisions and choices but feeling totally alone in making them?
- Have they (do they) ever pray, or meditate, or otherwise turn to a Higher Power in times of stress, despair, confusion, or anxiety?
- Do patients relate to having difficulty deciding at times what they cannot change versus what they can (and should) change?
- How would patients feel about saying the serenity prayer at these times, of otherwise praying, or about talking to other AA friends about the dilemmas they face?

Other methods of dealing with anxiety are found in the following AA slogans.

First Things First

The first priority for alcoholics is to not take that first drink. At times, alcoholics, like everyone else, will be in conflict—will have to choose taking care of themselves versus taking care of someone else. At times, the choice may be please yourself or please someone else; make yourself happy or make someone else happy. Patients need to be encouraged to make their ongoing sobriety their first priority, even if that means frustrating or disappointing someone else.

The therapist might elicit examples from patients of situations in which they felt conflicted about taking care of themselves versus taking care of others:

- What could be the price of pleasing or satisfying others at your own expense?
- What did you do in that situation? Was it consistent with putting your sobriety first?

Easy Does It

The pressures of deadlines and overcommitment create stresses that invite drinking as a means of coping. The AA adage, “easy does it,” speaks to this particular issue.

- Does the patient identify with the stresses created by having to meet deadlines or competing commitments?
- What in the patient’s life contributes to stress, to time pressure, or to overcommitment?

Strategies for dealing with this form of stress are built around developing a system of realistic priorities.

- Make a list of things to do today, then discard half of it.
- Schedule things twice as far in advance as you usually would.
- Sit quietly for 15 minutes a day.
- Talk to someone else (preferably a recovering person) about your feelings of being overextended.

- References: “Living Sober,” pages 10, 37, 47.
“Releasing Anger” (Hazelden pamphlet).

Anger/ Resentment

Anger and resentment are pivotal emotions for most recovering alcoholics. Anger that evokes anxiety drives the alcoholic to drink in order to anesthetize it. Resentment, which comes from unexpressed (denied) anger, represents a constant threat to sobriety for the same reason.

The therapist should talk to the patient about anger and resentment:

“Resentments, reflecting as they do unexpressed anger, represent past issues. The recovering alcoholic cannot afford to live in the past but must live in the present (One Day At A Time). Therefore, resentments must be confronted and let go in favor of more effective ways of dealing with anger in the present.”

- What situations are patients resentful over?
 - How did they handle these at the time they happened?
 - Can they see how these issues cannot be resolved now, but that, on the other hand, they can learn how to express anger better, so as to avoid building up stores of resentments in the future?

The materials found in the references are useful in working with patients on resentment and anger. Use the following guidelines when working on these issues:

- Identify sources of resentment: What experiences is the patient resentful over?
- What did they do in those situations versus what they think they should have done?

- Can the patient make the connection between unexpressed anger (at the moment) and resentment (holding on to anger)?
- What can the patient learn from those experiences so as to not avoid being honestly angry in the future?
- What would stop the patient from expressing anger in the future?
- Can patients Turn It Over (meaning their anger) to a Higher Power—have the faith to express their anger and trust that their honesty will prove to be the better course in the long run?
- What makes patients angry in the here and now? Are they willing to make a commitment to expressing their anger honestly and to having faith that it will be better if they do that?

Grief

- Reference: “Grieving: A Healing Process” (Hazelden pamphlet).

Grief is as important a subject as anger and resentment in the AA literature. In the course of addiction (and often before alcohol abuse begins), the alcoholic typically experiences many losses that have gone ungrieved. The therapist should be familiar with the stages of grief:

- *Denial*. Minimizing the importance of what was lost, including denying its importance.
- *Bargaining*. Attempting to replace the lost thing with something else without acknowledging its loss.
- *Anger*. The breakdown of denial and the natural reaction to loss.
- *Sadness*. The true expression of undenied loss.
- *Acceptance*. This comes slowly, only as denial breaks down and the individual feels able to come to terms with the reality of loss (or limitation) and is ready to move on.

Ask patients to go through the above process, identifying one loss in their lives that they have worked through in this way. Then ask them to identify one loss that they have not worked through, that they may be in denial about. Alcoholics need to come to terms with the “loss” of alcohol as a means of coping and as a “friend” of sorts. Another way to look at it is that they need to accept their limitation, which is that they cannot control their use of alcohol and have to give it up.

The recovery task for this session aims at facilitating the grief process with respect to alcohol. It asks patients to write a “goodbye letter” to alcohol, as if they were writing a goodbye letter to a lover. Dependency

on alcohol needs to be conceptualized as a relationship that must be broken and grieved in the interest of recovery. This requires sensitivity and respect on the part of the therapist, along with an appreciation for the grief process and an ability to work with patients in a sympathetic manner through their grief over the loss of alcohol.

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kind of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor?
- If so, how is the patient making use of the sponsor?
- If not, what specific steps is the patient willing to take between now and the next session?

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example, meditation books, but should discuss their appropriateness in advance with a supervisor.

Grieving

- Write a goodbye letter to alcohol as if it were a relationship that you have decided to end.
- Write in your journal about losses that you have not adequately acknowledged and grieved, including losses in each of these areas:
 - Relationships (people).
 - Self-esteem.
 - People, pets, or things.
 - Goals.

Troubleshooting Troubleshooting The importance of going to meetings, getting involved in them, and developing relationships with other recovering alcoholics cannot be overstated. The patient can use the fellowship of recovering alcoholics as a source of support, advice, and comfort. By now, going to meetings should be a part of the patient's lifestyle; if it is not, the therapist should spend more time uncovering and working through the patient's resistance to this. A contracting approach can be a useful technique wherein the therapist and patient agree that the patient will try out a certain number of AA meetings or experiment with some form of participation. Patients' experiences at meetings, like their reactions to the "Big Book," need to be processed at each session.

Role-playing can be another effective technique to help the shy or shameful patient overcome internal barriers to going to meetings or participating in them. Have patients practice, for example, saying their names out loud, as if they were doing so at a meeting. Assure the patients that they will not be pressured at meetings to say more than they feel comfortable with.

Once patients have become regular in their attendance, the next step is to encourage them to talk. Meetings and subsequent contacts with fellow AA members can be used as opportunities to talk about ongoing sources of resentment and grief. Patients who merely attend AA meetings and do not participate or develop communicative relationships with other recovering men and women are handicapped in their ability to resist denial and are apt to slip into alcohol use as a means of drowning those emotions.

Topic 9: Steps 4 and 5—Moral Inventories

Review

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What commitment is the patient willing to make?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce each day of sobriety.
- How is the patient doing with living One Day At A Time?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have about readings?

Getting a Sponsor

- Does the patient have a sponsor yet?
- If yes, how is the patient making use of the sponsor?
- If no, then what suggestions can the therapist make in this regard, and what commitments will the patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Steps 4 and 5 The Moral Inventory

Alcoholism is described in AA literature as a physical and a spiritual illness. It is an illness of the spirit in the sense that alcoholics are driven by their disease to behave in ways that compromise their personal ethics and values. Alcoholics commit crimes and misdeeds in the process of satisfying their obsession with alcohol or as a result of impaired judgment while under the influence. This undermines their self-esteem, promotes alienation, and makes finding faith and reaching out to others more difficult. Steps 4 and 5 implicitly recognize the fact that alcoholics suffer feelings of guilt and shame related to their behavior and also that acknowledging and sharing these feelings has value.

This session has three goals:

- To further work through resistance to Step 1 by asking patients to think and talk about some of the “wrongs” and “errors” they have committed as a result of alcohol abuse.
- To explore the extent to which patients experience guilt that has not been shared and that can therefore threaten their recovery.
- To balance recognition of wrongs done with equal recognition of positives.

NOTE: The goal of this session is *not* to conduct a complete—searching or fearless—moral inventory, in the truest sense of Steps 4 and 5. In general, such a moral inventory is best attempted by an alcoholic who has been actively working a 12-Step program for at least 6 months. It needs to be shared with a trusted person such as a sponsor or a member of the clergy. It is more often a process than an event. The goals of Steps 4 and 5 in the context of this facilitation program are more limited: to accept some degree of responsibility for consequences of drinking and to release some guilt. The therapist needs to keep these limited goals in mind while at the same time acknowledging to the patients that they will need to do more work on Steps 4, 5, 6, and 7 in the future.

The therapist should be thoroughly familiar with pages 42-54 (Step 4) and 55-62 (Step 5) of “Twelve Steps and Twelve Traditions” and should review these chapters as necessary prior to conducting this session. Therapists who have not conducted such a moral inventory of themselves are advised to do so, and to share it with an appropriate other, prior to attempting this technique with patients.

Facilitating a Moral Inventory

There are two key issues to keep in mind when talking with patients about their moral (ethical) history. These need to be communicated to patients in a way that is understandable to them. They are, respectively, honesty and balance.

- *Honesty.*—To be of real value, a moral inventory must be honest. Patients must be carefully guided—without being judged or censured—to own up to ways in which they have hurt others, either willfully or accidentally, or have compromised their ethics as a result of alcohol abuse. In this regard, patients need to be encouraged to admit their contributions to strained marriages or friendships, problems with children, and so on. Obviously, this is sensitive therapeutic work. The practiced therapist who is secure in the belief that alcoholism is an illness that is ultimately stronger than individual willpower will be most successful in guiding the patient through these treacherous waters, encouraging frankness without promoting needless guilt. The goal of a successful moral inventory is not guilt but commitment to recovery.
- *Balance.*—A moral inventory should also be balanced, meaning that it should not lose sight of the patient’s positive qualities, right choices, and heroic efforts. Even the most severe alcoholics are capable of doing things right now and then. It will not jeopardize the goals of this work if the therapist encourages patients to think about and share positive things about their character and actions; on the contrary, discussing the positives can help minimize excessive guilt and form the basis for renewed self-esteem in recovery.

Begin the moral inventory by reading aloud Steps 4 and 5 from the “12 x 12”:

STEP 4: MADE A SEARCHING AND FEARLESS MORAL INVENTORY OF OURSELVES

STEP 5: ADMITTED TO GOD, TO OURSELVES, AND TO ANOTHER HUMAN BEING THE EXACT NATURE OF OUR WRONGS

Explore the meaning of these steps with the patient. Explain that they are concerned with character defects: those negative qualities and

tendencies that each and every person (not just alcoholics) possesses. In the case of alcoholics, character defects tend to be exacerbated due to their illness, which takes over the will and leads them to make ethical and moral compromises.

Character defects include qualities such as:

- Jealousy
- Greed
- Selfishness
- Impulsiveness
- Grandiosity
- Arrogance
- Self-pity
- Meanness
- Resentment

Assets

Alcohol abuse and alcoholism have predictable effects on personality, one of which is that character defects that were evident before the illness will get worse. Still others may emerge as a consequence of becoming obsessed with alcohol. Most alcoholics, for example, become more infantile (demanding, selfish) over time.

- Which character defects have emerged in this patient as a result of alcohol abuse?
- Elicit *specific* examples of these character defects and how others have been hurt by them. Take time to explore one or two key incidents in which the patient, under the influence of alcohol, has done something that hurt someone else and which s/he now regrets.

After exploring the negative, finish this part of the session by taking some time to explore some of the patient's better qualities, supported by specific examples of behavior that reflect them. Look for *specific* examples of qualities such as the following:

- Generosity
- Heroism
- Charity
- Altruism
- Kindness
- Humility
- Love
- Sharing
- Compassion

Document examples of these qualities.

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kind of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor? If not, what specific steps will be taken between now and the next session?

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example meditation books, but should discuss their appropriateness in advance with a supervisor.

Troubleshooting

Patients may occasionally experience periods of intense guilt or shame associated with Step 4. This may occur during the course of the session, but it is even more likely to occur after the session, when the patient has time to reflect on this material. It can be helpful to prepare patients for this eventuality as well as giving them specific suggestions for what to do in that event. Some key points to keep in mind include the following:

- The concept of amends: The idea that alcoholics who have the courage to face their moral mistakes may be able to at least acknowledge them and, in some cases, to do something to make up for them. This gives them an advantage over those who refuse to even acknowledge their defects. The question then becomes: When are amends appropriate, and what constitutes appropriate amends?
- The alcoholic should not be allowed to assume that nonalcoholics do not make moral mistakes. In fact, alcoholics who keep an ongoing moral inventory may very well lead more spiritual lives than many nonalcoholics.
- Patients should be encouraged to keep their positive qualities in mind, without avoiding or minimizing character defects. Helping patients to design one or more personal affirmations—statements that assert positive qualities and which the patient can be encouraged to repeat several times a day—can help counter unreasonable guilt and depression. Many affirmation books are available.
- Sponsors and AA friends, as well as clergy, can be key sources of support during a time of guilt and shame. Patients should be

encouraged to identify specific sources of support: people they could talk to who they think could understand their feelings.

- The therapist should not minimize, rationalize, or avoid patients' feelings of guilt and shame. Experiencing these feelings can help undermine resistance to acceptance. It can also have the effect of making patients feel all the more isolated with their feelings. It can help to remind patients that they *are not* responsible for their illness, though they *are* responsible for their recovery. Reinforcing this idea can be especially helpful at this time, since it offers hope at the same time that it acknowledges responsibility for harm done.
- Be prepared to talk about the patients' need to grieve the loss of self-esteem associated with the mistakes made under the influence of alcohol.
- Advise patients that it would be appropriate in this case to contact you between sessions if they are experiencing an intense emotional reaction to the moral inventory work. An emergency session can be appropriate here, much as is the case when doing a genogram (topic 5).

Topic 10: Sober Living

Review

Meetings

- Meetings attended and reactions.
- What is the plan for future meetings?
- What resistance is there at this point to going to meetings?
- What commitment is the patient willing to make?
- What is the patient's level of participation at meetings?

Sober Days

- How many?
- Reinforce each day of sobriety.
- How is the patient doing with living "one day at a time"?

Urges to Drink

- When and where?
- What did the patient do?
- How could the patient use AA to help with urges in the future?

Slips

- When, where, with whom?
- How is the patient doing at coming to terms with Step 1?
- What can the patient do differently next time: People, places, and things to change.

Readings

- What is being read?
- What are the patient's reactions?
- What questions does the patient have about readings?

Getting a Sponsor

- What progress is being made?
- What is the basis of any resistance to getting a sponsor?
- What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

- How is the patient doing at telephone therapy?
- What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Living Recovery

Books such as “Living Sober” devote a good deal of attention to the matter of changing habits (lifestyle) in the interest of recovery. The following areas are most relevant to recovery:

- Nutrition
- Exercise
- Hobbies

In this session, the therapist should feel relatively free to explore different aspects of the patient’s lifestyle. The expectation is that alcoholism “shrinks” the lifestyle. Over the course of the illness, the patient loses or abandons old friends, old hobbies and interests, activities, and so on. Life becomes progressively more centered around alcohol—obtaining it, hiding it, using it. In early sobriety, the relative emptiness of alcoholics’ lives drives them back toward drinking out of sheer boredom.

A good way to approach the issue of sober living is to help the patient explore what life was like before alcoholism and from that discussion to set some specific (and realistic) goals for the short-term future.

Nutrition

- How was the patient’s diet affected by alcohol abuse?
- What did s/he typically eat during the course of a day?
- What kind of changes need to be made in order to correct for nutritional deficiencies or to create a more balanced diet?

NOTE: Depending on the patient’s physical condition, it may be appropriate to suggest a consultation with a nutritionist.

- Has the patient gained or lost a good deal of weight (more than 15 pounds) in the last year? Does s/he need to gain/lose weight in the interest of health?

NOTE: Avoid supporting diet fads that appeal to the need to look good as opposed to enhancing health.

- In discussion with the patient, establish several nutrition goals.

Exercise

- What is the patient's state of health?
- What major medical conditions or illnesses does the patient have? How are they being cared for or treated?
- Does the patient have any medical conditions that would restrict ability to exercise regularly?
- What kind of exercise can the patient begin to do on a regular basis (3 times/week)? (Caution: Keep it simple. Walking a mile, using a stationary bike or rowing machine, and similar activities are more likely to last than are overly ambitious plans.)
- Set several specific exercise goals.

Hobbies

- What did the patient do for fun before alcohol came along and replaced it?
- What activities interest the patient? (Keep it simple!)
- Set several specific goals for sober recreation and fun.

Recovery Tasks

Meetings

- Make a list of meetings to attend.
- What kinds of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

- How many phone numbers will the patient be willing to get this week?
- How many phone calls is the patient willing to make this week?

Sponsor

- Has the patient gotten a sponsor? If not, what specific steps will be taken between now and the next session?

Reading

- Encourage the patient to continue reading the “Big Book,” the “12 x 12,” and “Living Sober,” making suggestions as to readings that might be particularly relevant to the individual patient.

NOTE: The therapist may recommend supplemental readings, for example, meditation books, but should discuss their appropriateness in advance with a supervisor.

Living Recovery

- Ask patients to make one specific commitment to improve their lifestyle in each of these areas: nutrition, exercise, and hobbies.

Troubleshooting

This session can be fairly free ranging, though it is advisable to touch on each of the above areas. Keep in mind that, when making commitments to change, “less is often more.” Resist any attempts by the patient to make commitments that are clearly too ambitious. It can take a lot of time to whittle down excessive optimism to a level closer to reality. Setting goals too high, like trying to make too many changes at once, will likely lead either to failure or to avoidance of getting started.

Part 3: Termination

The termination session, like the introductory session, has its own unique format. The review part of this last session should be brief, to allow for adequate time for the therapist and patient together to process the patient's experience with the 12-Step facilitation program.

Final Core Session: Termination

- Review Briefly**
- Meetings
 - Sober Days
 - Urges
 - Slips
 - Readings

**New Material:
Termination**

The 12th and final session should focus on helping the patient honestly evaluate the treatment experience and establish goals for the future. The following questions can be used as guides in this process:

- What were the patients' views of alcoholism prior to treatment, and what are they now?
 - Do they view alcoholism as a character defect or an illness? What kind of illness is alcoholism?
 - Do they now believe that alcoholics can control their use or are they out of control of use?
 - How would the patients describe the alcoholic part of their personality? How does it work to defeat the recovering part of the personality?
 - Do patients understand that one way to look at denial is as the natural human tendency to resist accepting personal limitation, in this case the limitation of not being able to control drinking?
 - Do patients understand that alcoholism is an illness of the mind characterized by being obsessed with drinking?
- What were the patients' views of Alcoholics Anonymous prior to treatment, and what are they now?
 - What has been their experience with—

- Going to meetings?
 - Getting a sponsor?
 - Getting active?
 - Calling AA friends?
-
- What were the patients' views of their own alcohol use prior to treatment, and what are they now?
 - Do the patients regard themselves as alcoholics?
 - What were the most useful parts of this treatment program to the patient?
 - What were the least useful parts of this program to the patient?
 - What information was most useful to the patient, and why?
 - Would the patient recommend this treatment program to someone else who wanted help with an alcohol problem? If so, why? If not, why not?
 - What are the patient's plans regarding AA for the 90 days after the treatment program?
 - How many meetings will the patient make a commitment to attend in those 90 days?
 - Is the patient willing to continue keeping a journal?

The Twelve Steps

Though this facilitation program focuses at most on the first 5 Steps of the AA program (and even then on limited aspects of them), the full AA program includes 12 Steps. Truly working a recovery program means working all 12 Steps, with the help of a sponsor and AA friends. Patients who have begun this work should be commended and at the same time advised that their work so far represents only the start of recovery. There is no room for complacency in recovery.

It might be appropriate to end this facilitation program with a quote from the "Big Book":

If you still think you are strong enough to beat the game alone, that is your affair. But if you really and truly want to quit drinking liquor for good and all, and sincerely feel that you must have some help, we know that we have an answer for you. It never fails, if you go about it with one half of the zeal you have been in the habit of showing when you were getting another drink (p. 181)

Troubleshooting In helping patients evaluate their experience in this facilitation program, the therapist needs to encourage honesty. Most likely, different patients will have found different parts of the program more or less helpful. Encouraging honesty in terms of feedback will help to facilitate honesty in making meaningful commitments for how many meetings the patient will attend afterward. Therapists may find it helpful to take notes regarding patient feedback for use in consultation with a supervisor.

Regardless of the patient's degree of objective success in the program (sober days versus slips), treatment should end on a respectful note. Keep in mind that even patients with many slips and those who are intensely in denial may someday "see the light." Perhaps it will come after the next negative consequence or maybe not until many consequences have taken their toll. The information provided to them through the treatment program could be what they need at some point down the road, when they are ready to absorb and act on it.

End the final session with a handshake and a reminder that the AA Hotline is listed in every phone book under Alcoholics Anonymous, and that AA is there 24 hours a day, 365 days a year.

Part 4: Conjoint Sessions

This 12-Step facilitation program includes two sessions intended for use with patients who are in relationships. Any individual whom patients consider their partner, regardless of their marital status or how long they have been in a relationship, is eligible to participate in these conjoint sessions. The conjoint sessions, however, are not intended to be in addition to the basic 12 sessions; rather, they should be included as part of the 12-session program. They should be scheduled only after the four core topics have been covered.

The objectives of the two conjoint sessions are—

- To estimate the level of partner involvement in alcohol or other substance abuse.
- To describe the 12-Step facilitation program.
- To encourage the partner to attend Al-Anon, Family Groups, or AA, as appropriate.

Partners who are judged to have no harmful involvement with alcohol will be educated regarding-

- The facilitation program.
- The concept of enabling.
- The concept of detaching.
- Al-Anon.

Partners who are suspected of being harmfully involved with alcohol or other mood-altering chemicals will be informed about the facilitation to seek an independent assessment of their own use and possible need for treatment.

NOTE: For their own reference, it is recommended that therapists using this manual familiarize themselves with the material in the pamphlet, “Detaching With Love,” by Carolyn W., published by Hazelden Educational Materials.

Conjoint Session 1: Enabling

Conjoint session 1, which may take as long as 1 1/2 hours, should be prepared for in advance by the therapist, who should contact the partner by phone (and who should also have informed the patient in advance that there will be two such sessions).

Begin the first conjoint session by explaining that its purpose is to outline this 12-Step facilitation program that the identified patient is enrolled in, to answer questions, and to explain the concept of enabling.

Program Outline (10 minutes)

In outlining the 12-Step facilitation program, try to cover the following essential points before fielding questions from the partner:

“The program is grounded in the principles of Alcoholics Anonymous.

- We view alcoholism as an illness of the body, mind, and spirit that is characterized by loss of control and obsession with drinking. Alcoholism has predictable symptoms and a predictable course which, if untreated, may lead to premature death or insanity.
- While there is no cure at present for alcoholism, it can be arrested. The best method for this is active involvement in AA.
- Alcoholics resist the idea that they are actually addicted to alcohol (cannot effectively control or limit drinking). This is called “denial.” There are many forms of denial, but its essence is that alcoholics try to convince themselves and others that it is safe for them to have a drink.
- AA is based on the idea that the alcoholic needs to resist taking *the first drink* that will trigger the compulsion to drink, and needs to do this *one day at a time*.
- Having a “slip” means drinking after a period of sobriety. Slips are unfortunate, but given the fact that alcoholism is a cunning, powerful, and baffling illness, what is most important is how the alcoholic responds to a slip. A slip is not an excuse to drink more. AA believes that going to meetings, calling an AA friend or sponsor, or calling

the AA Hotline are the best ways to deal with urges to drink as well as with slips.

- This program is based on the idea that alcoholics are responsible for their own recovery. While many factors may lead a person to use alcohol as a way of coping, addiction is ultimately a personal problem and recovery a personal challenge. Alcoholism cannot be blamed on anyone else, nor can anyone else take responsibility (credit or blame) for the alcoholic's slips or, for that matter, for the sober days."

NOTE: A popular Al-Anon adage goes like this: "You didn't Cause the illness of alcoholism, you can't Control it, and you can't Cure it."

Following the above introduction, solicit questions and answer them frankly, but limit the time for this to 10 minutes by explaining that important material is still to be covered.

It can be helpful even at this point to refer the partner who has many questions (or who exhibits strong reactions or who has a long laundry list of complaints) to Al-Anon as a resource for further information, advice, and support.

NOTE: The book "Al-Anon Faces Alcoholism" is especially helpful. Some partners may want to get this book, which is available through Al-Anon and in some bookstores. Therapists should be familiar with it and should also have an Al-Anon Family Group meeting schedule on hand and available for patients to use.

Partner Substance Use (15 minutes)

It is important to ask partners (with the patient present) about their use of alcohol and other mood-altering chemicals. Again, since time is limited, general questions such as the following may be most useful:

- "How often do you drink alcohol or use any other mood-altering chemicals (marijuana, etc.)?"
- "Have you (or your partner) ever felt that you had a problem related to alcohol or other substances?"
- "Do you know where you could go if you ever wanted to get an honest evaluation of your own alcohol/substance use?"

Enabling

Explain to both partners that enabling and detachment represent dysfunctional and functional responses, respectively, to addiction. This session focuses on enabling and the next one on detaching.

Enabling refers to any behaviors that mitigate the natural consequences of alcohol or drug abuse or support it. Enabling has the effect—often unintended—of allowing alcohol abuse to continue (and get worse) by cushioning the alcoholic. Examples of enabling include-

- Making excuses (covering up) for individuals when they are drunk and would otherwise get into trouble.
- Calling in sick for the person who's hung over.
- Excusing or justifying hostility or abuse that results from drinking.
- Accepting guilt-ridden apologies after the fact for harm done while drunk.
- Lending the alcoholic money for liquor, forgiving bad debts, or buying liquor as a gift.
- Making beer runs to liquor stores in order to keep an alcoholic off the street (to avoid a DWI arrest, an accident, or an injury).
- Defending alcoholics to their accusers for inappropriate behavior.
- Giving spouses liquor in order to calm or quiet them.

The common theme in all of these examples is that enabling is any behavior or attitude that has the effect of avoiding the real issue, which is alcohol abuse or alcohol addiction.

The above examples should provide a springboard for a discussion of how the partner has enabled the patient in treatment. To be certain that both partners clearly understand the concept of enabling, elicit several examples of enabling in their relationship.

NOTE: If there appears to be any doubt about the partner's understanding of enabling, review it briefly and try to get the patient to give some examples. The partner's capacity to understand detachment is partly dependent on being able to understand enabling and how it has been operative in the relationship.

Motives for Enabling

If enabling has the effect of making the problem worse, then why do people enable? Do they, either consciously or unconsciously, want the alcoholic to continue drinking?

NOTE: Some people argue that enablers do indeed derive some form of secondary gain from enabling—usually some control over

the relationship. Yet when you interview enablers, the impression you most often get is one of great frustration and a sense of impotence, combined with anger and resentment—in other words, just the opposite of feelings of power and control.

Ask the partner what motivated the enabling. Typical responses will be something like the following:

- “I did it because I didn’t want him to get into trouble.”
- “I was afraid that I’d lose the relationship.”
- “I was scared and didn’t know what else to do.”
- “Not helping seemed like a cruel thing to do.”

Acknowledge any or all of the above motives for enabling and the fundamental intent behind them. Doing that will help reduce any stigma associated with enabling, which in turn will enhance motivation for detaching. If the partner has trouble attributing any motivation at all to enabling, solicit some feedback from the patient and reinforce the above types of motivations. Alternatively, the therapist can suggest such motives and ask the partner to think about them.

Make the point to both partners that enabling is usually encouraged by alcoholics, since it promotes their need to continue drinking and avoid facing their limitation.

Engage the couple in a discussion of how the patient has either encouraged or coerced enabling in the past. The most common methods for this are to appeal to anxiety or guilt:

- *Anxiety*: “If you don’t help out (cover up), something terrible will happen that will affect us both (loss of a job, etc.).”
- *Guilt*: “Either it’s your fault that I have this problem (therefore you owe it to me to cover up for me) or else you should cover up for me out of loyalty.”

List ways in which the patient promoted enabling.

Reactions to Enabling

Typically, enabling (not unlike addiction) follows a predictable course. In most cases, enablers initially react with concern and a desire to help. As time goes on, however, and the problem gets worse instead of better, concern and anxiety usually give way to anger, resentment, and finally, alienation.

NOTE: Do not be surprised to encounter alienation, frustration, and resentment in the partner of the alcoholic patient.

They may have been the route, meaning treatment, before. They may resent not only the patient, but also the therapist or a treatment program that purports to be able to do what they could not—get the patient to stop drinking.

After suggesting that the foregoing responses to enabling are common and normal, try to elicit the partner's own feelings at this time. Validate feelings of frustration and resentment, and even alienation, suggesting that the couple may wish to pursue marital therapy at some point in the future.

NOTE: Do not attempt to dissuade partners who imply that they may divorce a patient who fails to stay sober or who state that they are considering divorce. After all, this may be another natural consequence of alcoholism. Do not attempt to resolve marital conflicts or to explore sources of resentment in any detail in this session. Instead, if any of these situations arise, suggest that the couple may wish to seek marital therapy, but that they may want to wait until (1) the patient has completed this facilitation program and (2) the partner has attended at least six Al-Anon meetings.

Wrap Up

Finish the first conjoint session by—

- Thanking partners for coming in, indicating your sympathy with the fact that they may have felt resentful about it.
- Encouraging partners to try out Al-Anon as a source of support in letting go of the alcoholic and beginning to pay attention to their own growth and needs. Emphasize that giving it a try does not imply making a long-term commitment to attending Al-Anon meetings.

The most likely problems to arise as a result of the two conjoint sessions are—

- Partner resistance (anger, resentment).
- Partner substance abuse.
- Emergency calls from partners.

Resistance

In this treatment program, partners can only be invited and encouraged to participate in the two conjoint sessions, which are primarily psychoeducational (as opposed to psychotherapeutic) in structure and purpose. The partner who initially refuses to attend, or who fails to show up, should be contacted by phone at least once. The therapist should make a reasonable effort to get partners to commit to coming in for the first session. They can be assured that they do not have to like

it and will be welcome to express their honest opinions and reactions. They will then be free to decide either to drop out or to attend the second session. Reassure the angry or anxious spouse that the conjoint sessions are not therapy nor are they intended to diagnose the partner.

Partner Substance Abuse

Partner substance abuse is at the same time a delicate issue and one that needs to be addressed. If the therapist has reason to believe that the partner is abusing alcohol or other chemicals, the agenda for session 2 may be dropped in favor of pursuing an assessment of substance use and referring the partner to an appropriate treatment program.

Emergency Calls

Partners are most likely to call the therapist if their partner has a slip or if a conjoint session evokes strong reactions (anger, depression). Consistent with what is done elsewhere in this facilitation program, the strategy to pursue in such cases is to encourage the partner to contact Al-Anon or to seek individual counseling independent of the treatment program. If an emergency session seems essential, it should be held with the patient and the partner conjointly. This may mean waiting a day—for example, to give a patient who has had a slip time to get sober. The therapeutic goal in responding to any emergency is to give advice consistent with 12-Step Al-Anon. For example, do not encourage a partner to bring a drunk patient to an AA meeting or to call the patient's sponsor. Discourage partners from arguing with (or otherwise trying to communicate with) a drunk patient. Help the partner see to it that the patient who has slipped is physically and medically safe but to detach from taking further responsibility.

Conjoint Session 2: Detaching

The goals of this session are—

- To define and illustrate “detaching” using examples drawn from the couple’s own experience together.
- To define “detaching with love” and help the partner discriminate detachment from enabling.
- To describe Al-Anon and encourage partners to attend six Al-Anon meetings of their choice.

Review

Briefly inquire about questions the partner may have about the material covered in the first conjoint session, making every reasonable effort to limit this discussion to approximately 15 minutes. Questions that seem directed at wanting to know what to do can be postponed with an explanation that the material presented in this session may help to answer that question and provide partners with some direction.

Al-Anon

Introduce Al-Anon as a fellowship of men and women who are in relationships with alcoholics and who gather in order to take care of themselves and seek support for their own growth process. Going to an Al-Anon meeting does *not* imply any blame for the alcoholic’s problem drinking; on the contrary, Al-Anon was originally formed by spouses of alcoholics in order to help them learn to detach from any feelings of shame or guilt associated with their partners’ illness. Meetings are anonymous, there are no fees, and the only condition for membership is being in a relationship with an alcoholic.

Ask the patient’s partner if s/he would be willing to attend six Al-Anon meetings. If the answer is yes, provide an Al-Anon Family Group meeting schedule and take a minute to identify two or three meetings that might be convenient to where s/he lives or works.

If the partner expresses reservations about Al-Anon, explore these by asking what questions s/he has or concerns that would stop him/her from trying Al-Anon. Typical concerns are—

- “What kinds of people will I find there?”

Answer: All kinds of people, some like you and some not like you. What you all have in common is being in a relationship with an alcoholic.

- “What will I be expected to do?”

Answer: You are not required to do anything. You can just go and listen and see if listening to others who are in or have been in the same boat as you is helpful to you in any way. If you want to, you can talk to some of the other people who are there after the meeting is over.

- “What is the benefit of Al-Anon?”

Answer: Living with an alcoholic is like living with anyone who has a chronic illness—it affects not only the person with the illness, but those around him/her. Over time, their lives get out of control too, and they often experience stress or depression, not to mention frustration. They often do not know the right thing to do. The best source of help for these people is others who have had to deal with similar situations. Al-Anon offers a program for starting to take care of yourself instead of everyone else.

- “What will I be committing myself to?”

Answer: Nothing. We are asking you to try out Al-Anon, not to commit to it. If you do not think it is helpful after six meetings, just stop going.

NOTE: Some patients may resist making a commitment to Al-Anon even after all of their questions have been answered. Others may simply refuse to consider it. Do not pursue the issue beyond eliciting concerns and questions and answering them as best you can.

Detaching

Explain to patients and their partners that detachment is the opposite of enabling. Whereas enabling protects alcoholics, detachment means allowing alcoholics to deal with the natural consequences of their abuse.

Detaching makes sense to most people, yet on a practical level, I daily of these same people find it hard to adopt a detached attitude and to allow alcoholics to experience and deal with whatever consequences come their way. Having made this point, ask the partner, “Why is this so?”

The most common barrier to effective detachment is guilt, which usually has one (or both) of two sources:

- Guilt due to believing that allowing the alcoholic to suffer negative consequences is somehow unloving or disloyal.
- Guilt over anger and resentment that leads to a vindictive (“you deserve it”) attitude that the partner is secretly ashamed of.

Guilt that stems from feeling disloyal can be worked through by acknowledging the positive motives for enabling while also pointing out how enabling is self-defeating in the long run and how it unwittingly allows a drinking problem to get worse.

Guilt over feeling angry and resentful can be uncovered and worked through by acknowledging such feelings as normal consequences of enabling and then by clarifying detachment as not being vindictive but benign. Detachment comes from letting go of as opposed to holding on to anger and resentment, whereas enabling builds both. Reinforce this idea of detaching as being the more functional response to problem drinking. Give the partner permission to be angry and resentful while suggesting that it is in fact loving to let the alcoholic go.

Ask the partner and the patient to think of two specific situations that might arise and to identify enabling versus detached partner responses in each one.

Wrap-Up

Example: The alcoholic wakes up hung over and leaves for work more than an hour late.

- Enabling response: The partner calls in with an excuse.
- Detached response: The partner lets the alcoholic deal with the employer and refuses to act as a middle man.

Wrap up this second conjoint session by encouraging the partner to make use of any or all of the following resources:

- *Al-Anon*, including Al-Anon sponsors and friends.
- *Individual counseling*, preferably with a professional trained in addictions treatment.
- *Marital counseling* after the patient completes the 12-Step facilitation program.

Troubleshooting Probably the most common therapeutic complication of this session will be the alcoholics' reactions to their partners becoming involved in Al-Anon. This is where detaching needs to be conceptualized as a reciprocal process. Not only must partners detach from alcoholics and allow them to be responsible for their own recovery, but alcoholics must also allow their partners to take care of their needs and issues, including how alcoholism has affected them and how they should act in the future. The therapist should try to be an advocate of both partners' right to take responsibility for their own issues and to seek the support and guidance of peers.

The second possible complication is that strong emotions will be aroused, especially anger and resentment on the part of the partner. Here again, the therapist must be cautious to avoid being drawn into marital therapy. With only two conjoint sessions, there is little chance of healing longstanding resentments. Rather, the couple can be encouraged to look into marital counseling after the patient has completed the program and after the partner has attended at least six Al-Anon meetings. Recognize that problems exist and that the future of the relationship may be in doubt. On the other hand, both partners may stand to gain by putting off any decisions until both have had a chance to work a recovery program.

Appendix A—Jellinek Charts for Men and Women

Symptoms and phases of alcoholism in men

Have you ever experienced—	YES?
Prodromal phase	
1. Increased tolerance (need to drink more to get the same effect)?	_____
2. Temporary loss of memory (blackouts, times you couldn't remember what you did)?	_____
3. Sneaking a drink when no one was looking?	_____
4. Preoccupation with drinking (thinking about drinking while working, etc.)?	_____
5. Hurried drinking ("chasing a high")?	_____
6. Avoided talking about your drinking because it made you uncomfortable?	_____
7. Loss of memory (can't remember things you said, what you were supposed to do)?	_____
Crucial (basic) phase	
8. Loss of control (unable to predict how much you'll drink)?	_____
9. Justifying (making excuses for drinking)?	_____
10. Disapproval from others about your drinking?	_____
11. Being extravagant with money?	_____
12. Aggression (verbal or physical)?	_____
13. Remorse (or guilt or depression about drinking)?	_____
14. Periods of abstinence (times when you tried to stop drinking)?	_____
15. Changes in your pattern of use (switching types or brands of alcohol)?	_____
16. Losing friends (or having fights with them) on account of your drinking?	_____
17. Losing a job or getting into trouble at work on account of drinking?	_____
18. Giving up old hobbies or activities in order to spend time drinking?	_____
19. Having to get treatment of some form for your drinking?	_____
20. Feeling resentful a lot toward others?	_____
21. Escape (moving or changing friends in an effort to get a "fresh start")?	_____
22. Protecting your supply (hiding a stash of alcohol)?	_____
23. Drinking in the morning (or before work)?	_____

	YES?
Chronic phase	
24. Drinking more or less continuously for at least 18 hours (a “binge”)?	_____
25. Doing things that violate your own ethical or moral standards?	_____
26. Inappropriate (or confused) thinking, such as hearing voices or not knowing where you are?	_____
27. Decreased tolerance (feeling and acting drunk after just one drink)?	_____
28. Vague fears or anxiety?	_____
29. Tremors (shaky hands)?	_____
30. Feeling hopeless or suicidal?	_____

Source: Adapted from Jellinek, E.M. A chart of alcohol addiction and recovery. *Journal of Iowa Medical Society* Mar. 1964.

Symptoms and phases of alcoholism in women

Have you ever experienced—	YES?
Prodromal phase	
1. Increased tolerance (need to drink more to get the same effect)?	_____
2. Unwillingness to discuss drinking?	_____
3. Feelings that women who drink excessively are worse than men?	_____
4. Personality changes when drinking?	_____
5. Drinking more just before your menstrual period?	_____
6. Feeling more intelligent and capable when drinking?	_____
7. Being “supersensitive”?	_____
Early stage	
8. Periods of abstinence (times when you’ve tried to stop drinking)?	_____
9. Disapproval from others about your drinking?	_____
10. Rationalizing (making excuses for) drinking?	_____
11. Temporary losses of memory (blackouts, times you couldn’t remember what you did) when drinking?	_____
12. Unexplained bruises or injuries?	_____
13. Drinking before facing a new situation?	_____
Middle stage	
14. Neglecting eating?	_____
15. Protecting your supply (hiding a “stash” of alcohol)?	_____
16. Self-pity (feeling sorry for yourself)?	_____
17. Feeling resentful toward others?	_____
18. Being permissive or lax with your children because of guilty feelings about drinking?	_____
19. Drinking to feel happier but finding yourself feeling more depressed?	_____
20. Being told by others that you “couldn’t be an alcoholic”?	_____
21. “Predrinking”—drinking before a drinking occasion; or “postdrinking”—continuing to drink after a drinking occasion?	_____

	YES?
22. Feeling guilty about drinking?	_____
23. Drinking more or less continuously for a period of at least 18 hours?	_____
Late stage	
24. Starting the day with a drink?	_____
25. Tremors (shaky hands)?	_____
26. Decreased tolerance (feeling and acting drunk after just one drink)?	_____
27. Sneaking drinks?	_____
28. Gulping drinks?	_____
29. Persistent remorse?	_____
30. Devaluing personal relationships?	_____
31. Carrying liquor in your purse?	_____

Source: Adapted from James, J.E. Symptoms of alcoholism in women: A preliminary survey of AA members. *Journal of Studies on Alcohol* 36(11):1564-1569, 1975. © by Journal of Studies on Alcohol, Inc., Rutgers Center of Alcohol Studies, New Brunswick, NJ 08903. Used with permission.

Appendix B—Therapist Selection, Training, and Supervision in Project MATCH

Specifications of treatment in manuals is intended to define and differentiate psychotherapies, to standardize therapist technique, and to permit replication by other investigators. However, it is essential that manual-guided therapies be implemented by qualified therapists who are trained to perform them effectively. Project MATCH uses extensive procedures to select, train, and monitor therapists in order to promote delivery of study treatments that are specific, discriminable, and delivered at a consistently high level of quality. These include (1) selection of experienced therapists committed to the type of therapy they would be performing, (2) extensive training to help therapists modify their repertoire to meet manual guidelines and to standardize performance across therapists and across sites, and (3) ongoing monitoring and supervision of each therapist's delivery of treatment during the main phase of the study to assure implementation of study treatments at a high and consistent level.

Therapist Selection

All MATCH therapist candidates are required to meet the following selection criteria: (1) completion of a master's degree or above in counseling, psychology, social work, or a closely related field, (2) at least 2 years of clinical experience after completion of degree or certification, (3) appropriate therapist technique, based on a videotaped example of a therapy session with an actual client submitted to the primary investigator at each site and to the Yale Coordinating Center, and (4) experience in conducting a type of treatment consistent with the MATCH treatment they would be conducting and experience treating alcoholics or a closely related clinical population.

These criteria are intended to facilitate (1) selection of appropriate therapists for the training program, as training is *not* intended to train novice therapists, but to familiarize experienced therapists with manual-guided therapy, and (2) implementation of MATCH treatments by experienced and credible therapists. For example, therapists selected

Therapist Training

for the Cognitive-Behavioral Coping Skills Therapy (CB) are experienced in cognitive and behavioral techniques; thus, the CB therapists are predominantly doctoral or masters-level psychologists. Therapists for the Twelve-Step Facilitation Program are predominantly individuals who have gone through 12-Step recovery themselves, have been abstinent for several years, and are typically masters-level or certified alcoholism counselors. Therapists selected for the recently developed Motivation Enhancement Therapy (MET) have worked extensively with alcoholics and typically have experience in systems theory, family therapy, and motivational counseling.

Training, supervision, and certification of therapists was centralized at the Yale Coordinating Center to facilitate consistency of treatment delivery across sites. Each therapist came to New Haven for a 3-day intensive training seminar, which included background and rationale for Project MATCH, extensive review of the treatment manual, review of taped examples of MATCH sessions, and practice exercises. Each therapist then returned to their clinical site and was assigned a minimum of two training cases, which were conducted following the MATCH protocol (e.g., weekly individual sessions, a maximum of two emergency and two conjoint sessions, truncated sessions for patients who arrived for a treatment session intoxicated).

All sessions from training cases were videotaped and sent to the Coordinating Center for review of the therapists' (1) adherence to manual guidelines, (2) level of skillfulness in treatment delivery, (3) appropriate structure and focus, (4) empathy and facilitation of the therapeutic alliance, and (5) nonverbal behavior. Yale Coordinating Center supervisors review all training sessions and provide weekly individual supervision to each therapist via telephone. Supplemental onsite supervision is delivered weekly by the project coordinator at each Clinical Research Unit.

Therapists were certified by the Yale Coordinating Center supervisors following successful completion of training cases. Therapists whose performance on initial cases was inadequate were assigned additional training cases until their performance improved. The average number of training cases was three, and therapists completed an average of 26 supervised sessions before certification.

Ongoing Monitoring

To monitor implementation of Project MATCH treatments, facilitate consistency of treatment quality and delivery across sites, and prevent therapist "drift" during the main phase of the study, all sessions are videotaped and sent to the Coordinating Center, where a proportion of each subject's sessions (one-third of all sessions for Cognitive-Behavioral and Twelve-Step Facilitation, one half of all MET sessions) are reviewed by the supervisors. Telephone supervision is provided on a monthly basis by the Coordinating Center supervisors and supplemented with weekly onsite group supervision at each Clinical Research Unit.

All sessions viewed are rated for therapist skillfulness, adherence to manual guidelines, and delivery of manual-specified active ingredients unique to each approach. These ratings are sent monthly to the project coordinators at each site to alert local supervisors to therapist drift. Therapists whose performance deviates in quality or adherence to the manual are “redlined” by the Coordinating Center, and the frequency of sessions monitored and supervision is increased until the therapist’s performance returns to acceptable levels.

