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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 1½ hours to complete.

Topic 2: Step 1–Acceptance should be presented in the second session. Sessions 2 through 11 follow a consistant 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 1½ 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:

Age	Amount used/ how often	Positive/negative effects	Significant events at this time of life
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 his/her 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
- Other suggestions

Summary (5 minutes)

- 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 strenghthening 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 that 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 resistances 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": "Bill's Story," "There Is a Solution," "We Agnostics."
- "12 x 12": 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 really is an illness or whether controlled drinking is possible. They may attempt to change the agenda of this program, for example, to make it 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 to 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.