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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 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: 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 patients 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 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 acknowledgment 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
- ANXIETY
- ANGER
- RESENTMENT
- GRIEF
- 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.

Anger/ Resentment

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

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

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

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.

Assets

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

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- What kinds of meetings are being attended?
- What is the patient doing to get active?

Telephone Therapy

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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.