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Therapist Guidelines

Using This Manual

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

Role of the Therapist

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

Education

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

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

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

Facilitation

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

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

Desired Therapist Characteristics

Status With Respect to Recovery

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

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

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

Active, Supportive, and Involved

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

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

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

Focused Treatment

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

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

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

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

Reliance on AA

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

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

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

Confrontation

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

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

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

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

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

Slogans

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

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

Some key AA slogans are described below.

- *One Day at a Time.* Recovery is best thought of as a journey that is undertaken one step at a time. The goal is to avoid taking the *first* drink and to stay sober a day at a time. Anniversaries of sobriety are important, but ultimately what is most important is whether you drink today, not whether you drank yesterday or will drink tomorrow.

- *First Things First.* If alcoholics do not stay sober, nothing else will matter, since they may end up in an institution, in jail, or prematurely dead; meanwhile, alcoholism will undermine their body, mind, spirit, and relationships, making the overall quality

of life progressively worse. Although all people, including alcoholics, have multiple commitments, obligations, and responsibilities, the *first* commitment of alcoholics must be sobriety. They must be prepared to make whatever hard decisions are necessary in order to stay sober. In this area, sponsors are especially helpful, as is active participation in meetings.

- *Fake It Till You Make It.* Not everything in the AA fellowship will appeal or make sense to the recovering person. This slogan asks the alcoholic to be humble: to follow advice on faith in the belief that it will prove beneficial in the long run. This includes going to meetings, working the Steps, and doing what one's sponsor advises.

- *Easy Does It.* The recovering person needs to avoid excess stress, which will invite relapse. The serenity prayer is relevant here, as it urges the recovering person to accept what cannot be changed. This includes alcoholism, some family problems, past transgressions, and decisions that have already been made.

- *Turn It Over.* A statement of faith, this slogan encourages acceptance of what cannot be changed in the belief that all will work out for the best in the end.

Technical Problems

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

Patient Is Consistently Late for Appointments / Cancels Sessions

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

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

Keep in mind that this form of resistance does not invariably reflect denial of alcoholism. In some cases, it may due to a fear of failure or

social shyness. Help resistant patients clarify their reasons for resisting active involvement in AA and work from there.

Patient Comes to Session Drunk

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

Patient Resists Going to Meetings

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

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

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

Patient Uses Other Substances

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

Patient Appears Clinically Depressed or Psychotic

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

Project MATCH Guidelines

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

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

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

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

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

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