Facilitating 12-Step Recovery from Substance Abuse

This chapter presents a model for facilitating recovery from alcohol or drug abuse or addiction. The model is intended for use by practitioners who do not necessarily have extensive knowledge of or experience with 12-step fellowships such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) but who wish to actively facilitate their patients' use of such programs as a means of not drinking or not using drugs. Patients need not be dependent either on alcohol or drugs in order to benefit from the model presented here; rather, they need merely to meet the primary criterion for becoming members of AA (or NA), namely, having "a desire to stop drinking" (Alcoholics Anonymous, 1952, p. 139) or to stop using drugs. However, the reader should be aware that these fellowships have as their overall goal abstinence from (as opposed to controlled use of) alcohol or drugs. By definition, these fellowships were founded and exist for the benefit of those who have failed to control their use of alcohol and/or drugs (Alcoholics Anonymous, 1976, pp. 21, 24, 30–31).

Goals and Overview

Twelve-Step Facilitation (TSF; Nowinski & Baker, 2003; Nowinski, Baker, & Carroll, 1992) includes a range of interventions that are organized into a "core," or basic, program; an "elective," or advanced, program; and a conjoint program. Interventions in the core program are most appropriate for what could be termed the "early" or initial stage of recovery from alcohol or drug dependence. By "early recovery," we generally mean that stage of change in

which an individual takes his or her initial steps from active substance abuse toward abstinence. The interventions included in the TSF core program could also be said to be directed primarily at the first four stages of change as described by the transtheoretical model of change (Prochaska, DiClemente, & Norcross, 1992; Saunders, Wilkinson, & Towers, 1996). These include *precontemplation*, referring to a relative unawareness of any need to change one's behavior at all; *contemplation*, meaning the process of coming to a decision to change; *preparation*, or marshaling resources for change; and *action*. This entire stage of the change process is typically marked by ambivalence, or what is commonly referred to as *denial* in the recovery field. The primary focus of this chapter will be on the TSF core program.

TSF also includes a set of interventions that can be brought to bear when working with patients who have moved to the *maintenance* stage of change (Prochaska et al., 1992, p. 1101). In recovery terms, these are men and women who have shown some sustained sobriety as well as some evidence of having bonded to a 12-step fellowship. Some of the topics included in the advanced program of TSF may also be useful with patients who have relapsed after some period of sobriety.

The conjoint program, which is the third component of TSF, may be used with patients at any stage of change. It is intended to enlist the help of significant others in the change process by teaching them the Al-Anon concepts of *enabling* and *caring detachment* (Al-Anon Family Group Headquarters, 1986a).

Finally, TSF includes a structured termination session. The goals of this session are to assess progress to date and to develop a posttreatment follow-up plan of action.

TSF was intended to be utilized as a time-limited (12- to 15-session) intervention. Initially developed as an individual treatment, it has been adapted for use with groups (Mande-Griffin et al., 1998; Seraganian, Brown, Tremblay, & Annies, 1998). In either format TSF is a highly structured intervention whose sessions follow a prescribed format. Each begins with a review of the patient's *recovery week*, including any 12-step meetings attended and reactions to them, episodes of drinking or drug use versus sober days, urges to drink or use drugs, reactions to any readings completed, and any journaling that the patient has done.

The second part of each session consists of presenting new material, consisting of material drawn from the core, elective, or conjoint programs. Each session ends with a wrapup that includes the assigning of *recovery tasks*: readings, meetings to be attended, and other pro-recovery behavioral work that the patient agrees to undertake between sessions.

The various TSF interventions are grouped as follows:

Core (basic) program

- Introduction and assessment
- Acceptance

- People, places, and routines
- Surrender
- Getting active

Elective (advanced) program

- Genograms
- Enabling
- Emotions
- Moral inventories
- Relationships

Conjoint program

- Enabling
- Detaching

Early Recovery

Broadly speaking, early recovery can be broken down into two phases: *acceptance* and *surrender.* "Acceptance" refers to the process in which the individual overcomes denial. "Denial" refers to the personal belief that one either does not have a substance abuse problem, and/or that one can effectively and reliably control one's drinking or drug use. In motivational terms, acceptance represents a vital insight: that the patient has in fact lost the ability to effectively control his or her use. Acceptance is marked by a realization that the patient's life has become progressively more unmanageable as a consequence of his or her alcohol or drug use, and furthermore that individual willpower alone is an insufficient force for creating sustained sobriety and restoring manageability to one's life. Given that realization, the only sane alternative to continued chaos and personal failure is to admit defeat (of one's efforts to control use), and to accept the need for abstinence as an alternative to controlled use.

As important as insight is, insight alone is not sufficient for recovery. That is where the concept of *surrender* comes in. "Surrender" basically means a willingness to take action, and specifically to embrace the 12 steps as a guide for recovery and spiritual renewal. AA and NA are programs of action as much as they are programs of insight and personal growth. Surrender follows acceptance and represents the individual's commitment to making whatever changes in lifestyle are necessary in order to sustain recovery. Surrender requires action, including frequent attendance at AA and/or NA meetings, becoming active in meetings, reading AA/NA literature, getting a sponsor, making AA/NA friends, and giving up people, places, and routines that have become associated with substance abuse and which therefore represent a threat to recovery. In TSF the action and commitment that are the hallmarks of surrender are guided to some extent by the facilitator; but they are also heavily influenced by

the individuals whom the patient encounters and begins to form relationships with within 12-step fellowships. One especially significant relationship that TSF actively advocates for in early recovery is that of the *sponsor.*

Involvement in 12-step fellowships will inevitably expose both the patient and the therapist to a number of key 12-step traditions and concepts, such as the concept of a *higher power* (Alcoholics Anonymous, 1976, p. 50), the advocacy of fellowship over professionalism (Alcoholics Anonymous, 1952, p. 166), and the concepts of *group conscience* and *spiritual awakening* (Alcoholics Anonymous, 1952, pp. 106, 132). Because these concepts and traditions are so central to 12-step fellowships and their philosophy of recovery, the practitioner must not only be familiar with them but must be prepared to discuss them and their implications for action. Effective assignment of recovery tasks does not require that the therapist be in recovery, but it does demand familiarity with the culture and traditions of 12-step fellowships. For this reason therapists who have no personal knowledge of 12-step fellowships are encouraged to familiarize themselves with the basic AA texts, such as *Alcoholics Anonymous* (Alcoholics Anonymous, 1976), *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous, 1952), and *Living Sober* (Alcoholics Anonymous, 1975). When working with drug abusers the basic NA text (Narcotics Anonymous, 1982) is very useful. Finally, therapists who are naive concerning 12-step fellowships are encouraged to attend several open AA, NA, and/or Al-Anon meetings prior to implementing TSF.

Principles of Twelve-Step Facilitation

TSF, as a model of intervention, seeks to be both philosophically and pragmatically compatible with the 12 steps of AA. Accordingly, TSF is based on certain principles that follow from the 12 traditions of AA, and that should be understood if the intervention is to achieve this desired compatibility. Potential facilitators might do well to reflect on these principles and to "work through" any reactions they may have to them prior to embarking on an intervention.

Locus of Change

TSF considers the primary locus of change with respect to patients' drinking or using behavior to lie less in the hands of the therapist and more in the hands of 12-step fellowships such as AA and NA. In other words, our goal is the patient's active participation and involvement in 12-step fellowships, for we rely on that involvement to support the patient's recovery. That is the main reason why we prefer the word "facilitation" to words such as "therapy" or "treatment." The facilitator is obviously a highly skilled professional who must possess not only good psychotherapy skills but also a working knowledge of 12-

step fellowships. However, the therapist must also be able to resist becoming a patient's recovery program, as opposed to AA and/or NA becoming that program. In order to accomplish this, the facilitator must develop considerable skill in knowing when to provide advice and support personally versus when to encourage the patient to seek these things through AA or NA. As skilled as the facilitator may be, he or she must accept the idea that the patient's recovery is not dependent solely on the skills he or she acquires through therapy or on the support of the therapist; rather, therapists who employ TSF believe that sustained recovery relies heavily on skills the patient acquires through active fellowship with other recovering persons and on their ongoing support. Such a therapeutic stance places the responsibility for recovery squarely on the shoulders of the patient and defines the therapist–patient role as one of collaboration to achieve the goal of involvement in AA and/or NA.

Motivation

From its inception AA has characterized itself as a fellowship that is "based on attraction rather than promotion" (Alcoholics Anonymous, 1952, p. 180). Through this statement AA established a tradition of not seeking to attract members through overt advertising or promotion, much less through coercive techniques of any kind. AA's historic rate of growth is such that it has been likened to a "social movement" (Room, 1993). This growth, in turn, has relied in great part on the notion of identification and attraction, and also on the 12-step, which states: "*Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs*" (Alcoholics Anonymous, 1952, p. 106).

AA assumed from the outset that if an alcoholic attended meetings, listened to the stories of other alcoholics, and identified with them, then sooner or later he or she would naturally be motivated to try the program laid out in the 12 steps. The 12th step, meanwhile, supported the institution of sponsorship, in which individuals who have succeeded in sustaining recovery through AA or NA over a period of years, and who have remained active in it, will take newcomers under their wing for a period of time. They do so in order to support the newcomer and to teach him or her the traditions, etiquette, and other "rules of the road" that have evolved over the years in 12-step fellowships.

The AA/NA philosophy of attraction has implications for the therapist who wishes to use TSF. TSF eschews a heavily confrontational approach in favor of what could be called "carefrontation." This latter approach is more similar to what a newcomer to AA or NA will likely encounter at meetings. Typically, newcomers are greeted heartily; but there is no "hard sell," but instead a low-key approach that is welcoming and emphasizes "giving it a try" and "keeping an open mind."

The effectiveness of more coercive approaches at achieving sustained

sobriety has not been thoroughly tested. Although some have argued cogently that most people who seek help are pressured to do so in some way or another (Anderson, 1991), it remains our conviction that involvement in AA or NA is most effectively accomplished through a shaping approach, emphasizing positive reinforcement of any and all progress made—in other words, through an approach that is compatible with the traditions of these fellowships.

Spirituality

One aspect of 12-step recovery that clearly separates it from other models of intervention lies in its active promotion of spirituality. The guiding books of AA—*Alcoholics Anonymous* (1976) and *Twelve Steps and Twelve Traditions* (1952)—are replete with references to the importance of spirituality to recovery, and the 12th step, already cited here, asserts that following the program of personal growth as outlined in the 12 steps will lead in the end to a spiritual "awakening."

Here are some examples of the way that 12-step fellowships speak of spirituality:

> We have learned that whatever the human frailties of various faiths, those faiths have given purpose and direction to millions. People of faith have a logical idea of what life is all about. Actually, we used to have no reasonable conception whatever. (Alcoholics Anonymous, 1976, p. 49).

> On one proposition, however, these men and women [alcoholics] are strikingly agreed. Every one of them has gained access to, and believes in, a Power greater than himself. (Alcoholics Anonymous, 1976, p. 50)

> . . . as a result of practicing all the Steps, we have each found something called a spiritual awakening. (Alcoholics Anonymous, 1976, p. 106)

Twelve-step fellowships regard spirituality as a force that provides direction and meaning to one's life, and they equate spiritual awakening with a realignment of personal goals, specifically, with a movement away from radical individualism and the pursuit of the material toward community and the pursuit of serenity as core values.

When conducting TSF, the clinician should be prepared to discuss the issue of spirituality. At several different points in treatment (Nowinski & Baker, 2003, pp. 73–81; Nowinski et al., 1992, pp. 2, 4, 47–48) the facilitator is asked to engage the patient in a specific discussion of his or her spiritual beliefs. Guidelines are provided for these discussions, which generally focus around the issues of willpower, powerlessness, and faith, as well as on the issues of personal values and goals.

Pragmatism

Interestingly, although many people think of AA and its sister fellowships as primarily spiritual programs (and sometimes confuse them with religions), historically pragmatism has been as central to AA as spirituality. One official AA publication, *Living Sober* (Alcoholics Anonymous, 1975), is subtitled *Some Methods AA Members Have Used for Not Drinking.* This book contains a wealth of practical advice—much of it very compatible with cognitive-behavioral therapies—for avoiding "taking the first drink." Consider the following sampling from its Table of Contents:

- Using the 24-hour plan
- Changing old routines
- Making use of "telephone therapy"
- Getting plenty of rest
- Fending off loneliness
- Letting go of old ideas

In TSF the facilitator attempts to educate the patient with respect to some practical methods for staying sober. The facilitator consistently admonishes the patient to focus on "one day at a time" (another very pragmatic approach), and encourages the patient to solicit and follow practical advice from fellow AA members and his or her sponsor on issues ranging from the best ways to deal with difficult situations, to how to cope with cravings, to what to do after a slip, and so on. Of course the most basic advice given to all alcoholics and addicts is simple: don't drink (or use) and always go to meetings. In TSF each facilitation session ends with the facilitator assigning one or more *recovery tasks*, which are specific and pragmatic suggestions for action, including meetings, readings, journaling, and the like. In this way TSF mirrors the pragmatism of AA itself.

A Collaborative Approach

In setting a tone for the intervention, the 12-step facilitator takes an approach that is best described as "collaborative." He or she consistently strives to engage the patient in a constructive collaboration with the goal of achieving sobriety. The facilitator relies on the third tradition of AA as a foundation for this collaboration: *the only requirement for AA membership is a desire to stop drinking* (Alcoholics Anonymous, 1952, p. 139). This tradition is deliberate in its wording. It means that it is not essential for the patient to embrace each and every tenet of AA, or to adopt a particular spiritual philosophy. This attitude is supported by the following statement: "Alcoholics Anonymous does not demand that

you believe anything. All of its Twelve Steps are but suggestions" (Alcoholics Anonymous, 1952, p. 26).

Following on the above, TSF encourages therapists to be flexible within the broad guideline of establishing a collaborative relationship with the patient toward the end of helping him or her stopping drinking or using. Confrontation in TSF is common, but it never takes the form of threat. For example, the 12-step facilitator will never terminate treatment because a patient drinks between sessions (or even shows up intoxicated).[1] On the other hand, the facilitator will consistently confront the patient about drinking or drug use and its connection to denial, and will consistently attempt to move the patient through the process of acceptance and surrender. The facilitator, committed to the idea that "90 meetings in 90 days" is the best strategy for the person in early recovery, will continue to ask for and encourage frequent attendance at meetings, but she or he will never make compliance with this suggestion a condition of treatment. Similarly, the 12-step facilitator will identify and point out denial to the patient, and will talk frankly with the patient about any "slips" that he or she has. But the facilitator always accepts addiction as a "cunning and clever" illness, and therefore expects both denial and relapse (at least in early recovery) as natural parts of the overall recovery process. Again, the 12-step facilitator seeks to be a shaper of behavior, relying heavily on rapport and reinforcement.

Focus

The focus of TSF is on helping the patient *begin* the process of recovery. The primary goal of TSF is to help the patient begin the process of bonding to a 12-step fellowship by understanding its key concepts and learning how to utilize its resources for support and advice.

Although collateral issues may (and frequently are) raised by patients in the course of treatment, facilitators are advised to avoid "drift," that is, a loss of focus on drinking or drug use and on becoming active in AA or NA, in favor of some other issue. Facilitators make every effort to validate patients' legitimate concerns—for example, about work, marriage, or family issues. But they also should be alert to patients' use of collateral issues as a means of avoiding either the subject of alcohol or drug use or the facilitator's expectations concerning them. While concurrent therapies may be necessary at times (e.g., for the acutely depressed patient, or for the patient with a co-occurring chronic

[1] TSF has specific guidelines for therapists to follow in the event that patients show up for meetings intoxicated, if they binge, or if their overall mental status deteriorates. The general guideline is that sessions are terminated if the patient is intoxicated although the therapist's first task is to ensure the patient's safety and make suggestions regarding contacting the AA. Hotline, getting to a meeting, or the like. TSF may be temporarily suspended if a patient requires detoxification.

mental illness), in general the TSF model advocates prioritizing problems, with early recovery from alcohol or drug abuse at the top of the list. At the very least, treatment of substance abuse should be coequal with treatment of mental illness in any comprehensive treatment plan, since a failure to address it independently (e.g., to assume that it may spontaneously remit once another problem is addressed) is always a serious mistake.

Objectives

The primary goals of early recovery, namely, acceptance and surrender, are achieved not only through dialogue with the facilitator but also through action on the part of the patient. Toward this end TSF seeks to achieve a number of specific objectives that can be broken down broadly into two related categories: (1) active involvement and (2) identification and bonding.

Active Involvement

To be sure, active involvement in 12-step fellowships such as AA and NA means going to meetings. But merely attending meetings does not qualify as *active* involvement. Very often practitioners who are unfamiliar with the 12-step model may stop their intervention at this point, or even short of it. "I suggested that my patient go to an AA meeting," a clinician might say, "but she told me that she tried that once and didn't like it."

Much as any psychotherapy involves helping patients work through resistances to change, facilitating active involvement means helping the patient to examine and work through resistances to active involvement in AA and/or NA. Working within a 12-step frame of reference, one is apt to encounter the word "denial" used instead of "resistance," though the two are in fact conceptually equivalent.

"Getting active" begins with going to meetings. For the individual who is just beginning to give up alcohol or drugs, 12-step fellowships have traditionally advocated attending 90 meetings in 90 days (i.e., a meeting a day, if not more, as a minimum goal). The exact origins of this common wisdom are vague, as are the origins of much of the "culture" of AA and the advice that is commonly offered to newcomers. However, such advice squares well with research on relapse (Marlatt & Gordon, 1985), which shows consistently, across addictions, that the majority of relapses occur within 90 days of initial abstinence.

AA and NA meetings vary a great deal with respect to membership, tone, and format. Because AA is by tradition deliberately decentralized (Alcoholics Anonymous, 1952, pp. 160, 172), no two meetings will be exactly alike. The result is a fellowship that is eclectic in form and open to continual change. The

facilitator should understand that there are not only discernable regional differences in the overall tone of meetings, say between those held in Connecticut and those held in California, but that there is a growing trend toward various "specialty" meetings. It is common, for example, to find men's, women's, Latino, and gay AA/NA meetings listed, not to mention nonsmoking meetings. In larger communities, one can typically also locate meetings for professionals, for clergy, and so on. The San Francisco Bay Area lists special AA meetings for atheists, for agnostics, and for meditators. Not all meetings, moreover, will be officially registered with AA's central office. Many are started by AA and NA members and grow by word of mouth.

Though AA as an organization purposefully exerts no effort to assure that meetings are organized or run in a prescribed way, there are a number of AA and NA traditions, as well as discernable types of meetings. Traditions include, of course, anonymity. They also include a rule against *cross-talk*, meaning interrupting a speaker to question him or her. So-called *service work*, such as making coffee, setting up and taking down chairs, and passing the hat for voluntary contributions to pay for any costs associated with supporting the meeting are other traditions likely to be seen across groups. Finally, most groups will establish a series of rituals and rites, such as ways of starting and ending meetings; ways of recognizing the achievement of certain landmarks, such as one, two, five, and 10 years of sobriety; and so on.

There are also, by tradition, several different types of meetings, starting with *speaker meetings*, in which an individual tells his or her story of addiction and recovery, generally following this format: "How it was then, what happened, and how it is now." Invariably the theme of these stories is that of the phoenix: the capacity of the human spirit to rise from the ashes of defeat. The key to this dramatic change in each case is the individual's courage to admit that alcohol or drugs has made life unmanageable (acceptance), and to replace individual willpower with fellowship and the 12 steps as a pathway to recovery and spiritual renewal (surrender).

Another type of meeting is the *open discussion* meeting. Here a designated member or members raises an issue (e.g., resentment, loneliness, spirituality) that members respond to in turn, sharing their thoughts or experiences relative to the subject.

A third type of meeting is called a *step meeting*. Usually a group will focus on one of the 12 steps for a month at a time. At the beginning of the meeting the step is read aloud. Members then respond to the step, explaining how they are "working" it in their daily lives. Some groups go through the entire 12 steps in this way; other groups may limit themselves to certain steps only—for example, the first three—and cycle through them repeatedly.

Some AA and NA meetings are *open*, meaning that one need not necessarily admit to having a problem with alcohol or drugs in order to attend. Such meetings are good to recommend to patients who are not yet sure that they

have a problem, or who want to stop drinking or using. They are also useful for therapists who want to learn more about 12-step fellowships before implementing TSF in their practices. Other meetings are *closed*. These meetings should be attended only by persons who are ready to admit to alcoholism or addiction, and who say they want to stop.

In facilitating early recovery, the facilitator should monitor not only *how many* meetings a patient attends, but also *what kinds* of meetings he or she attends. This can be done conveniently by asking patients to maintain a personal "recovery journal" in which they record meetings attended, what type they are, and their own reactions to them. By exploring these entries at the outset of each session (the review of the patient's "recovery week"), the therapist can help to create momentum in treatment and greatly enhance the overall facilitation effort.

Facilitators should make an effort to encourage patients to try out several different types of meetings, including open discussion, step, and speaker meetings. They should also encourage patients to attend one or two specialized meetings (e.g., a men's or a women's meeting). After the patient has attended a number of different meetings, she or he can be encouraged to begin thinking about making one of them his or her *home group*. This means making a commitment to attending that meeting regularly and to accepting some service work responsibility at the meeting. The secretary of the meeting is the individual who generally assigns service work responsibilities, which are typically rotated after a period of time.

Choosing a home group and accepting some responsibility for service to it moves the newly recovering patient to a deeper level of active involvement. Another level is achieved as the patient begins to utilize *telephone therapy*. This is another long-standing AA/NA tradition, attributed to one of AA's founders, Bill Wilson, who is reported to have once decided to call someone instead of taking a drink.

Giving and getting phone numbers is another normal part of the AA/NA culture, and patients should be prepared for it. Of course, they should feel free to decline to give out their phone number initially, if this idea makes them feel uncomfortable. However, the therapist should normalize this tradition and explain its purpose, which is to build a support network of fellow AA/NA members who are sympathetic to the goal of not drinking or using drugs, and who can be called on in times of need. In this regard it is important to explain to patients who are not experiencing any immediate urges to drink or use (and who may therefore be inclined to see no immediate need for such contacts) that it is important to establish a network of AA friends *before* one needs them.

On another level, getting and using phone numbers, like becoming more active in meetings, serves to gradually reconstruct the patient's social circle. Over time it can lead to less contact with old, drinking or using friends and more contact with new, sober friends. Since research suggests that social sup-

port is a significant factor in recovery (Sobell, Cunningham, Sobell, & Toneatto, 1993), this process of progressively establishing a new social network can be thought of as a core objective of TSF.

The last objective with regard to facilitating active involvement in AA or NA concerns *sponsorship*. A sponsor is by tradition a sort of mentor: an individual who has traveled the road before you and who can serve as your guide. AA succinctly describes the role and significance of the sponsor in early recovery in this way: "Not every A.A. member has a sponsor. But thousands of us say we would not be alive were it not for the special friendship of one recovering alcoholic in the first months and years of our sobriety" (Alcoholics Anonymous, 1975, p. 26).

Sponsors by tradition are of the same sex as the newcomers, for the obvious reason of minimizing the possibility of dual agendas. For gay and lesbian patients, the same caveat applies: a sponsor ought not to be someone with whom a romantic attraction is likely to become established.

The sponsor–sponsee relationship is usually a close one. For newcomers especially, sponsors will often establish a pattern of daily telephone (and sometimes face-to-face) contact. They may meet the newcomer at meetings and facilitate his or her meeting new people. The sponsor may suggest meetings that would be particularly good for the newcomer to attend. Sponsors may also introduce newcomers to AA social events and may try to the best of their ability to answer questions about the 12 steps or the fellowship itself. Because of the need to maintain clear boundaries, the facilitator (even if she or he is personally in recovery) cannot become a patient's sponsor. Nevertheless, the facilitator needs to take a proactive role in helping the patient to find a sponsor very early in the recovery process. Often this issue will be brought up directly in meetings: the meeting chairperson will ask, first, if there are any newcomers present, and second, if there is anyone in need of a sponsor. Alternatively, the patient can be coached in how to ask for a sponsor at that point in a meeting when it is open to requests.

Taken together, the above set of objectives serve to establish a broad basis of social support for sobriety while simultaneously breaking the patient away from people, places, and routines that have long been associated with alcohol or drug use. Along with identification, it is a core aspect of the TSF program. Obviously it is an active therapeutic process, and one that goes well beyond the simple (and passive) suggestion that a patient "try going to AA."

Identification and Bonding

It is axiomatic within AA that it is the similarities among alcoholics, not the differences, that are important. What is being referred to, of course, is the "similarity" of not being able to control drinking. Bill Wilson expressed it this way:

> We are average Americans.[2] All sections of this country and many of its occupations are represented, as well as many political, economic, social, and religious backgrounds. We are people who normally would not mix. But there exists among us a fellowship, a friendliness, and an understanding which is indescribably wonderful. (Alcoholics Anonymous, 1952, p. 17)

It is common, indeed natural, for the newcomer to AA and NA to experience discomfort. After all, alcoholism and addiction still carry with them a significant social stigma. In addition, people who have little or no direct knowledge of 12-step fellowships are apt to hold many stereotyped attitudes and beliefs. For example, they may have the idea that AA and NA are religions or that their members are obsessed with God. Many worry that they will be asked to commit themselves to a cult, or that they will find themselves surrounded by skid-row bums. In all of these ways and more, patients' anxieties may cause them to persist in seeing themselves as different, while ignoring the essential similarity between their own experiences with substance abuse and those of everyone else in the room.

The first thing the facilitator needs to do is to normalize and empathize with patient's initial reticence to identify with those attending a meeting, or even to walk into a meeting. Reading the above quote can initiate a productive discussion of this issue, as can having the patient share entries that were written in his or her recovery journal after going to a meeting. The facilitator needs to remain alert for resistance to identification and to help the patient work it through. The first strategy for doing so is education. Solicit and discuss any stereotypes the patient has about AA/NA, their members, or what happens at meetings. Then ask the patient to go to some open speaker and discussion meetings and to simply listen. Ask the patient to recount what she or he heard, being vigilant for stereotypes versus realities.

The facilitator should routinely ask the patient who is new to AA or NA if there was a person, or a particular part of a story or discussion, that she or he could relate to (i.e., *identify with*). Building on this foundation, the facilitator can gradually promote the patient's capacity for identification. Naturally this calls for no small amount of judgment and skill—for example, in knowing just how much identification to press for. Sometimes identification is simply too threatening to the patient to be accepted in whole.

Others methods for facilitating identification are keeping a journal (already mentioned) or reading AA and NA material. Especially useful for purposes of promoting identification are the many personal stories of addiction

[2] AA has grown considerably since these words were written. According to the AA General Services Office, as of December 31, 1998, there were 101,000 AA groups spread out over 145 countries. Total membership at that time exceeded 4 million.

and recovery that appear in *Alcoholics Anonymous* (1976) and *Narcotics Anonymous* (1982). For patients with a great deal of social anxiety, attempting to identify through reading at home may be easier at first than identifying through listening at meetings.

However identification is achieved, it is a highly desirable outcome of 12-step facilitation for it has the effect of *bonding* the patient to the fellowship. Often, in the very early stages of recovery, it is getting active per se that is most crucial. In order to sustain involvement and ensure sobriety over the long run, though, a deeper sense of identification and connection—of bonding—may be crucial. Furthermore, in general, it is in the context of this bonding that many AA members begin to pursue more advanced work such as creating moral inventories (Steps 4 and 5) and to experience firsthand some of the spiritual renewal that has long been associated with AA. Indeed, it may be impossible for an individual to experience the "spiritual awakening" that the 12th step speaks of in the absence of this bonding process.

Taken together, active involvement and identification form a solid basis for recovery. The more effective the facilitator, in collaboration with the patient, is in establishing these dimensions of recovery, the more likely, we think, it is that the patient will sustain his or her sobriety.

Assessment

Facilitating recovery using a 12-step model begins much as any good treatment for substance abuse should begin: with a thorough assessment. The specific approach to assessment employed in TSF has been described in detail elsewhere (Nowinski & Baker, 2003; Nowinski et al., 1992) and for reasons of space will be described only briefly here.

Assessment is important for two reasons. The first and most obvious reason is that we want to determine if the prospective patient is indeed addicted to alcohol or drugs. In reality, however, research has established that "problem drinkers" just as much as true alcoholics can benefit from TSF (Project MATCH Research Group, 1997). Therefore, the use of TSF need not be limited to "severe" or "end-stage" alcoholics or addicts.

A second and perhaps less obvious objective underlying assessment has to do with the issue of motivation. Part of the purpose of taking a thorough alcohol and drug history, as well as a careful inventory of consequences, is to establish a collaborative therapeutic relationship with the patient and, ideally, to reach a *consensus* regarding diagnosis and treatment. This may require the facilitator to refer back frequently in subsequent sessions to data collected during the assessment. Therefore, it is important that the clinician keep good records of information he or she has gathered. Toward this end, it is recommended that

the patient be given a copy of the assessment and be asked to review it as one of his or her first *recovery tasks* between sessions.

An alcohol–drug history is a graphical representation of chronological changes in the type and amount of mood-altering substances used by the patient, along with correlated events and effects. Creating an alcohol–drug history is best done using a chart such like that shown in Table 2.1.

In this hypothetical example, the patient reported first use of alcohol at age 11. At that time he sipped from his father's supply of beer, primarily on weekends. Drinking made him feel "silly," but sometimes it made him feel sick. He reported that his mother and father fought often at about the same time. By age 13 his use of alcohol had increased to two or three beers, two or three times a week. This made him feel "high," suggesting that he was experiencing some pleasurable affect as a consequence of his drinking, and was using alcohol primarily for its euphoric effects. At about this same time, his father left the home.

By the time he was 14 our hypothetical patient was drinking beer as well as smoking marijuana three to four times a week. He reports that this made him feel "mellow," which suggests that he was at that point using substances to control his mood and to create a sense of relaxation and calm. He also reports getting into trouble at school and having much conflict at home at this point in time.

Although Table 2.1 is necessarily brief for purposes of illustration, the clinician should take care to fill in a similar chart as completely as possible, adding as much detail as the patient will offer. Again, the objective is to engage the patient in a collaborative effort in the creation of this autobiography, most especially to document the *progression* of substance use over time and all significant events correlated with it. If this takes more than a single session, so be it.

After the alcohol–drug history is completed, the patient should be given a copy and asked to study it between sessions. At the next session the facilitator should review it again with the patient, filling in any additional details that the patient recalled as a result of this recovery task.

TABLE 2.1. Alcohol–Drug History

Substance/age	Type/amount	Frequency	Effects	Significant events
Alcohol/11	Beer: sips from Dad's supply	Weekends	"Silly" "Sick"	Mom and Dad fighting.
Alcohol/13	Beer: 2–3 ×	2–3/wk	"High"	Dad left.
Alcohol	Beer: 2–3 ×	3–4/wk	"Mellow"	Doing poorly in school/ fighting at home.
Marijuana/14	1–2 joints ×	3–4/wk		

The second major part of the assessment is an inventory of *consequences* of alcohol and drug use. Again, both for purposes of clarity and to enhance motivation, this is best done chronologically. The facilitator can introduce this part of the assessment with an opening statement similar to the following:

> "Let's take some time to examine some of the issues, conflicts, and problems that you've experienced over your life, and let's see if any of them are connected in any way to your use of alcohol or drugs."

Negative consequences of alcohol or drug use should be explored both chronologically and categorically. Be sure not to leave out (or allow the patient to avoid) examining each of the following areas.

Physical Consequences

Included here (especially for older patients) are the physical consequences of long-term substance abuse, including

hypertension, gastrointestinal problems, sleep disorders, weight loss, alcohol- or drug-related injuries and accidents, emergency room visits, blackouts, heart problems, liver disease, and kidney disease. Keep in mind that it is estimated that approximately 50% of all general hospital beds in the United States are occupied by patients whose medical illnesses are alcohol- or drug-related (National Institute on Alcohol Abuse and Alcoholism, 1990).

Legal Consequences

Alcohol and drug use often lead to legal troubles such as DWI (driving while intoxicated) arrests, arrests for possession or sale of illegal substances, arrests for disorderly conduct, and the like. Also include alcohol- or drug-related illegal activities (e.g., sale, theft, prostitution) that the patient was either not arrested or convicted for.

Social Consequences

Social consequences of alcohol or drug use include relationship, family, or job conflicts. Substance abusers often alienate their partners, perform progressively more poorly at work, and are dysfunctional as parents. They may destroy their marriages, lose their jobs, and alienate their friends. It is important to do a thorough inventory of such losses, in chronological order, and to connect them to the patient's alcohol–drug history as appropriate.

Psychological Consequences

Habitual use of alcohol and drugs, even in the absence of clear dependency, typically leads to negative psychological consequences such as anxiety and depression. Other consequences include poor anger control, sleep and eating disorders, irritability, amotivational syndrome, and confused thinking. As habitual use gives way to dependency, and as negative consequences accrue, suicidal thinking and suicide attempts are not uncommon.

Sexual Consequences

Not only is alcohol and other substance abuse associated with sexual dysfunction in both males and females (Powell, 1984), but alcohol and drug use and dependency are often correlated with sexual victimization and exploitation. The facilitator should explore the patient's sexual history to determine if sexual dysfunction, victimization, or exploitation are present, and if so whether they are correlated with substance abuse. Frank discussion of sexuality is often omitted from assessment even though it is often a potential motivator for recovery. Guidelines for conducting substance-abuse-related sexual histories have been published elsewhere (Nowinski & Baker, 2003).

Financial Consequences

It is a good idea to have the patient estimate how much money she or he has spent on alcohol or drugs in the 2 years prior to the assessment. Expenses should include both the cost of the substances themselves and the costs of any consequences. The latter include such costs as traffic tickets, legal defense or representation, and lost income. For example, a cocaine addict may have spent $50,000 on cocaine over 2 years; but may also have lost a job worth $40,000 per year; had to hire one lawyer to represent him in court, and another to represent him in divorce action; and had a bank foreclose on his house. These financial consequences are all justifiably included as costs of addiction.

* * *

Once both the alcohol–drug history and the inventory of consequences have been completed, the assessment itself ends with the facilitator sharing a diagnosis and treatment plan. Obviously, this should come as no surprise to the patient if the assessment process has truly been a collaborative venture. Still, the patient and the clinician may disagree, especially if the clinician thinks the patient is addicted, but the patient still does not believe that he or she is addicted. What is important for the clinician to note is that it is not essential for the pa-

tient to acknowledge alcoholism or addiction in order to proceed with TSF. The sole criteria for making use of AA, and therefore using TSF, is a *desire to stop drinking.* Addiction is not a prerequisite.

Treatment

It is to be hoped that a successful assessment has not only confirmed a clinical diagnosis for both the clinician and the patient, but has also motivated the patient to want to stop drinking or using drugs. In some cases this motivation will mean that the patient will be willing to follow the therapist's advice—for example, to begin attending meetings, doing some reading, keeping a journal, and so on.

Many patients may acknowledge that drugs and/or alcohol have indeed caused serious consequences, and may even express a desire to stop drinking; nonetheless, their behavior may reveal a resistance to taking any of the actions that recovery requires. Others may produce a history replete with consequences, and appear to be leading an unmanageable life, yet still deny addiction. In each of these situations successful treatment demands that the therapist be able to establish a collaborative relationship with the patient. Within AA and other 12-step fellowships the transition from outright denial, to passive acknowledgment of a problem, to active participation in a 12-step fellowship as a means of achieving recovery is known as "working the steps." This is also the crux of early recovery. It is a process wherein the patient could be said to move from *denial*, to *acceptance*, to *surrender.*

Acceptance

The first step of AA and NA as it appears in their respective "Big Books" read as follows:

> We admitted we were powerless over alcohol—that our lives had become unmanageable. (Alcoholics Anonymous, 1976, p. 59)

> We admitted we were powerless over our addiction—that our lives had become unmanageable. (Narcotics Anonymous, 1982, p. 8)

Although many individuals take issue with the word "powerless" in these statements, it is important for clinicians who wish to use TSF to understand exactly how that concept is used within the fellowships of AA and NA, which is *contextual.* In other words, 12-step fellowships speak of powerlessness only in the context of alcohol or drug use. Step 1 refers specifically to *powerlessness over alcohol or drug use*; it does not imply any kind of generalized powerlessness.

The powerlessness that is spoken of in Step 1 does have to do with acknowledging the limitations of individual willpower. Twelve-step fellowships were and are built on acceptance of a simple yet profound recognition: that individual willpower can be overwhelmed by the addiction process. Once addicted, efforts to control use will only lead to failure and frustration, and eventually to hopelessness. Furthermore, once addicted, individuals are not as likely to sustain sobriety alone as they are through mutual support. In order to stay sober, AA admonishes the alcoholic to "quit playing God" (Alcoholics Anonymous, 1976, p. 62), and to accept the notion that "any life run on self-will can hardly be a success" (Alcoholics Anonymous, 1976, p. 60).

In essence, then, the first step represents a statement of humility. It reflects an acceptance of personal limitation: that life has become *unmanageable*, that this unmanageability is the result of substance abuse, and that willpower alone has not been enough to change that. Philosophically, the first step (and AA itself) has been characterized as a challenge to the radical individualism that has long been a core theme in U.S. culture (Room, 1993).

In discussing Step 1 with patients, the therapist will find it extremely useful to have the alcohol–drug history and the chronology of consequences at hand. The focus of therapist–patient dialogue should be on the *progressive pattern of unmanageability in the patient's life and the limitations of personal willpower.* If the patient's history and chronology do not make a case for total loss of control, it should at least show a pattern of growing unmanageability that can be pointed out—repeatedly, if necessary—to the patient. The patient can also be encouraged to describe some of the methods that she or he has used in the past in order to limit or stop her or his use of alcohol or drugs. In this regard the facilitator would do well to share the following excerpt with the patient:

> 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, swearing off forever (with or without a solemn oath), taking more physical exercise, reading inspirational books, going to health farms and sanitariums, accepting voluntary commitment to asylums—we could increase the list ad infinitum. (Alcoholics Anonymous, 1976, p. 31)

In the face of evidence of growing unmangeability and failure to control use, the patient who continues to resist suggestions that she or he needs to admit defeat (of willpower) and therefore needs to give up alcohol or drugs altogether could be said to be in *denial.*

Any discussion of Step 1 should proceed toward acceptance of the need for abstinence in a series of steps, as follows:

1. The patient acknowledges that he or she has a "problem" with alcohol or drugs—that life has become, or is becoming, progressively more unmanageable.
2. The patient acknowledges that individual efforts to limit or stop drinking or using have failed (i.e., accepting powerlessness in the context of substance use).
3. The patient acknowledges the need to give up alcohol and/or drugs as opposed to trying to limit or their control use.

As simple and straightforward as the above sounds, clinicians find that moving a patient from denial to acceptance usually is more of a *process* than an *event*—and a painful one at that. For many individuals with alcohol or drug problems, acceptance represents an insight that is achieved gradually and only reluctantly. It is also an awareness that is frequently accompanied by intense emotional reactions (to acceptance of personal limitation and the loss of alcohol or the drug of choice as a "friend" and coping mechanism), such as anger, that the facilitator must be able to empathize with. As a rule, acceptance without emotion is suspect. More typically, patients will experience most or all of the emotional stages associated with grief and loss as they move through the stages of acceptance. The clinician does well to raise this issue of emotional responses to Step 1, to normalize it, and then to explore it with the patient.

People, Places, and Routines

From acceptance, which roughly corresponds to the *contemplation* stage of change (Prochaska et al., 1992), TSF moves on to help the patient *prepare* for change. The vehicle for this preparation is the Lifestyle Contract, an example of which is shown in Table 2.2.

The Lifestyle Contract is based on the notion that addiction evolves into a virtual lifestyle that is supported by a range of "people, places, and routines." In order to support his or her recovery, once the decision has been made to pursue abstinence as a long-term goal, the substance abuser must be prepared to make changes in each of these areas. The Lifestyle Contract, which is devel-

TABLE 2.2. Lifestyle Contract

	Dangerous to recovery	Supportive of recovery
People	Drinking friends	AA members Nondrinking friends
Places	Bars, casinos	AA meetings Nondrinking friends' homes
Routines	Drinks after work	Meeting AA friends Exercise

oped collaboratively by the patient and the therapist, becomes a blueprint for this life change.

The Lifestyle Contract also assumes that simply "giving things up" will not be a successful strategy for change in the long run. To truly support recovery, people, places, and routines that are supportive of recovery must be substituted for those that pose a threat to recovery. Viewed another way, the Lifestyle Contract is an inventory of the lifestyle that supports drinking or drug use versus an alternative lifestyle that supports sobriety.

It is recommended that the therapist work with the patient to develop a Lifestyle Contract early in treatment, but only after the patient has achieved at least some degree of acceptance of the need to give up alcohol or drugs.

Surrender

Surrender follows acceptance and the development of the Lifestyle Contract. It represents the patient's decision to seek outside help and abandon personal willpower as a means of controlling or stopping use of alcohol or drugs. Like acceptance, surrender is more typically a process than an event. Again, it is a process that evokes intense emotion. It is reflected in Steps 2 and 3 of Alcoholics Anonymous:

> We came to believe that a Power greater than ourselves could restore us to sanity. We made a decision to turn our will and our lives over to the care of God *as we understood Him*. (Alcoholics Anonymous, 1976, p. 59)

The italics at the end of the third step appear in the original text and are emphasized in order to point out that the AA view of God or a higher power is a pluralistic one. There is neither an organized priesthood nor a specific dogma within AA or NA; rather, these are deliberately decentralized fellowships. The closest thing to a dogma are the 12 steps themselves, which are framed not as dogma but as suggestions.

AA does have a long spiritual tradition, to the extent that the 12 steps challenge us to believe in a center of power that is greater than our individual wills. Substituting faith in the group (or some other higher power) for faith in personal willpower has been construed as a form of spiritual conversion or awakening:

> Faith is a dynamic process of construal and commitment in which persons find and give meaning to their lives through trust in and loyalty to shared centers of value, images and realities of power, and core stories. Conversion in AA perspective begins when one reaches and acknowledges a state of helpless desperation in the effort to maintain the false self and the illusion that one can manage one's drinking. Gradually it comes to mean making a commitment to enter into the 12

steps and become part of the 12 traditions of Alcoholics Anonymous. (Fowler, 1993)

If Step 1 involves *accepting the problem* (i.e., alcoholism or drug addiction), then Steps 2 and 3 can be thought of as *accepting the solution*, which requires the addict to reach out. Within 12-step fellowships this is commonly referred to as "turning it over"—that is, moving away from self-centeredness and an excessive belief in the power of individual willpower toward a willingness to reach out to and accept the strength of fellowship. This is more than an abstract notion: it will be directly reflected in patients' *hope for recovery*, in their *willingness to become active in the fellowship*, and in their *openness to receiving advice*. When an individual begins to "surrender" in this fashion, she or he begins to appreciate that accepting powerlessness over alcohol or drugs does not in any way imply helplessness over addiction.

AA and NA are fellowships that were established by and for the "hopeless," in other words, by and for people whose personal struggles to control addiction had led to personal defeat and desperation. Individuals whose problems with alcohol and drugs are less severe than that may have a harder time identifying with some of the shared images, values, and stories that form the spiritual foundation of these fellowships. Nevertheless, so long as life has become increasingly unmanageable as a result of drinking or drug use, the individual may become motivated to give it up. Furthermore, as stated earlier, even "problem drinkers" (as opposed to true alcoholics) have benefited from TSF.

The clinician should engage the patient in a specific and ongoing dialogue about willpower, faith, and surrender. It is suggested that at least one entire session be devoted to reading Steps 2 and 3 and discussing the patient's reactions to them. Questions like the following can be used as a guideline for this discussion:

- "As a youth, who were your heroes, and who are they now?"
- "What are your most cherished values? In other words, what personal qualities in others do you admire most?"
- "How do you feel about people who ask others for help when they feel stuck, and why?"
- "Are you open to the idea that people struggling with similar problems can help each other more than each of those people can help themselves?"
- "Whose advice are you most likely to follow?"
- "Do you ever pray? When, and why?"
- "Are you open to the idea that there are some personal problems that a person can solve only by reaching out for help and support from others?"

- "Do you believe that others could help you stay clean or sober?"
- "What is your idea of God?"
- "Who in the world do you trust the most, and why?"
- "Are you willing to do what someone else who has overcome alcoholism or drug addiction tells you to do? When would you, and when wouldn't you, follow his or her advice?"
- "How do you feel about using the support of people in AA or NA to help you stay clean and sober?"

This sort of dialogue is more than an intellectual adventure. It is central to introducing the patient to the spiritual foundation of 12-step fellowships. Not all therapists will be comfortable engaging patients in this sort of dialogue. All therapists would be wise to ponder such questions themselves before entering into this kind of dialogue. In the end it can be very productive to venture down this road, since it represents a highly effective route to working through patients' resistances to becoming active in AA or NA and making full use of their social and spiritual resources. An all-too-common alternative to this kind of dialogue is for the therapist to merely accuse the patient of being in denial, which only encourages further resistance. Rather than pursuing that course, it is generally more productive to explore issues related to letting go of the illusion of personal omnipotence and to overcoming reluctance to reach out to others.

Getting Active

The fifth and final component of early treatment centers around facilitating the patient's active participation in AA and/or NA. "Getting active," in 12-step parlance, means "working the steps." AA puts it this way: "Just stopping drinking is not enough. Just not drinking is a negative, sterile thing. That is clearly demonstrated by our experience. To stay stopped, we've found we need to put in place of the drinking a positive program of action" (Alcoholics Anonymous, 1975).

A popular meditation book expresses similar sentiments in this way: "Work and prayer are the two forces which are gradually making a better world. We must work for the betterment of ourselves and other people. Faith without works is dead" (Anonymous, 1975, p. 83).

The message here is clear: recovery requires faith, but it also requires action. Steps 1 and 2 in particular can be thought of as necessary but not sufficient conditions for staying clean or sober. To facilitate recovery, the clinician must be prepared to continually work with the patient toward the goal of his or her active involvement in a 12-step fellowship, namely, going to meetings frequently and listening well, getting phone numbers and building a support network, seeking a home group and taking on a responsibility, seeking out a sponsor, and reading AA/NA material.

Two useful vehicles for pursuing the goal of getting active are keeping a *recovery journal* (described earlier) and doing *recovery tasks*. The latter are not unlike "homework" that is often employed in cognitive-behavioral therapies which, like TSF, also involve patient–therapist collaboration and active work on the part of the patient. It is recommended that the clinician end each session with a series of specific recovery tasks, and begin each session with a review of the patient's "recovery week," including progress made on recovery tasks.

Recovery tasks and the subsequent review should cover each of the following areas:

- Readings from AA and/or NA literature.
- Suggestions about specific meetings to attend.
- Progress made on the use of telephone therapy, selecting a home group, taking on responsibility, and getting a sponsor.

Clinicians may wish to employ techniques like role playing in order to facilitate reaching specific objectives (e.g., using the telephone, speaking up at meetings) that are difficult for patients suffering from high social anxiety. Therapists must also be prepared to shape behavior—in this case, active participation—through positive reinforcement of the patient's efforts. It is not uncommon, for example, for patients to make several false starts when first "testing the waters" of AA or NA. They may get as far as the door of a meeting, for example, only to turn around at the last second. They may come to a meeting late and leave early. Or they may attend only one meeting after promising to attend three.

Obviously, to be able to shape behavior, the facilitator must first know about it. A blaming or unreceptive attitude on the part of the facilitator is likely to cloud communication when what is needed is openness. The patient should be made to feel safe disclosing what he or she actually did between sessions. This is not inconsistent with his or her also knowing what the clinician would *like* him or her to have done. Rather than scolding or punishing the patient in any way, the therapist should recognize and reinforce all the patient's positive efforts to change, and then work collaboratively with the patient to identify the causes of any resistance. If the cause is something like social anxiety, then techniques like role playing may help. If the cause is linked to resistance to ideas like powerlessness, as discussed earlier, then a different approach may be in order.

READINGS

Here are some suggestions for readings that might be assigned relative to the subjects of acceptance, the Lifestyle Contract, surrender, and getting active:

Acceptance

Twelve Steps and Twelve Traditions: pp. 21–24.
Alcoholics Anonymous: "The Doctor's Opinion," "Bill's Story," "More About Alcoholism."
Narcotics Anonymous: "Who Is An Addict," "Why Are We Here?" "How It Works."
Living Sober: pp. 7–10.

Surrender

Alcoholics Anonymous: "There Is a Solution," "More About Alcoholism," "How It Works."
Narcotics Anonymous, pp. 22–26.
Twelve Steps and Twelve Traditions, pp. 25–41.
Living Sober, pp. 77–87.

Lifestyle Contract/Getting Active

Alcoholics Anonymous: Personal stories (to be selected by facilitator).
Living Sober: Chapters 3, 6, 8, 10, 11, 13, 14, 15, 18, 22, 26, 27, 29.

Therapists should be familiar with any readings assigned and be prepared to discuss them during the review period at the outset of each TSF session. Consideration should be given to the patient's reading level and available time when making reading assignments. For patients who cannot read, audiotapes of AA publications are available through Alcoholics Anonymous World Services, PO Box 1980, New York, NY, 10163-1980. Similarly, most AA and NA texts are available in various translations.

Readings should not be limited to the above. Rather, these are offered as appropriate suggestions. With experience, the facilitator will develop personal preferences as well as a sense for "what fits who" with respect to readings.

MEETINGS

In order to make meaningful recommendations about which meetings to suggest to a patient, the facilitator must obtain current official AA and NA meeting schedules. These are available through regional AA or NA offices. Local numbers for AA and NA groups are listed in the white pages of many telephone books. They may also be obtained at AA and NA meetings. This brings up an important point: clinicians wishing to utilize TSF are strongly encouraged to occasionally attend open AA, NA, and/or Al-Anon meetings, to maintain current meeting schedules, and, if possible, to develop their own small network of AA and NA contacts who may be useful resources for getting shy newcomers to meetings, explaining the AA/NA "rules of the road," and so on.

Many recovering persons express a great deal of gratitude to those first "friendly faces" encountered at meetings. The facilitator should not assume this responsibility personally; instead, she or he is better off developing relationships with recovering men and women who are at a point in their own recovery process where they are ready to do this sort of "12th step" work. Therapists should not hesitate to reach out for such help, since it is an integral part of the AA culture to help those who need help.

Conjoint Program

It is not uncommon for interventions based on a 12-step model to include a family and/or marital component. Such an inclusion recognizes the reality that substance abuse effects not only the abuser but also his or her significant others. A detailed intervention for significant others of substance abusers has been described elsewhere (Nowinski, 1998).

TSF incorporates an abbreviated conjoint program into its model. The TSF conjoint program is consistent with the philosophy of Al-Anon, which is a 12-step fellowship for significant others of substance abusers (Al-Anon Family Group Headquarters, 1986a).

The objectives of the TSF conjoint program, which generally spans no more than two or three sessions, is to provide a spouse or significant other with an overview of the facilitation program that the patient is undergoing, to do an initial assessment of possible partner substance abuse, and to introduce the significant other to Al-Anon and two of its key concepts: enabling and detaching.

TSF recognizes that relationships, including marriages and parent–child relationships, are often rendered deeply dysfunctional and wounded as a result of addiction. It recognizes also that marital and/or family therapy are often much needed by alcoholics and addicts in recovery. At the same time, TSF is based on the idea that *early* recovery is best served by focusing on acceptance, surrender, and getting active. In a similar vein, TSF seeks to help significant others get a *start* on recovering from the effects of addiction, and believes that programs like Al-Anon offer the best resources for that start. Accordingly, before a patient who is just beginning recovery and his or her partner or family are referred for marital or family therapy, TSF attempts to engage them in fellowships that can offer understanding, support, and advice.

Partner Substance Abuse

The issue of partner substance abuse cannot be ignored by the practitioner working with persons on early recovery for the obvious reason that it represents a threat to the early recovery of the primary patient. But TSF does not

insist on total abstinence from partners who are merely social drinkers. However, basic questions such as those listed below should be asked in order to determine whether a partner is best referred for treatment as well:

- "Do you drink or use drugs at all? If so, what do you drink [use] and how often?"
- "Have you ever felt [or has anyone else ever suggested] that you have a problem with alcohol or drugs?"
- "Have you ever suffered any consequences of any kind related to alcohol or drug use?"
- "Has drinking or drug use ever interfered with your day-to-day life or made it 'unmanageable' in any way?"

Based on a simple and brief inquiry such as this, along with any information that the clinician has gathered from the patient, a decision can be made about whether it should be suggested to a partner that he or she should also seek further help. At the same time the facilitator will know whether partner substance abuse should be taken into account when constructing the primary patient's Lifestyle Contract.

Introducing Al-Anon and/or Nar-Anon

Al-Anon and Nar-Anon are fellowships that parallel AA and NA. However, these fellowships were formed not to support recovering addicts or alcoholics, but rather to support those who are in relationships with alcoholics or addicts. As do AA and NA, both Al-Anon and Nar-Anon begin with statements of "powerlessness." In this case, however, it is the behavior of the alcoholic or addict that the individual is powerless over. Coming to terms with this personal limitation (Step 1 of Al-Anon) is a process that parallels the alcoholic's or addict's coming to terms with his or her powerlessness over alcohol or drugs. Many of the same psychodynamics (e.g., denial) must be acknowledged and worked through. Similarly, the decision to reach out to others (Al-Anon) for support and guidance has its parallels in Steps 2 and 3 of AA.

Learning to stop doing things that either purposefully or inadvertently allow the alcoholic or the addict to continue drinking or using (*enabling*), and to let go of any illusion of being able to control the alcoholic or addict (*detaching*), are central to Al-Anon and Nar-Anon. It is only through learning detachment, it is believed, that partners and family members can begin to recover their own mental health. Al-Anon and Nar-Anon provide both the social and the spiritual support for this process. Al-Anon expresses the overall goal this way:

> "Detach!" we are told in Al-Anon. This does not mean detaching ourselves, and our love and compassion, from the alcoholic. Detachment, in the Al-Anon

> sense, means to realize we are individuals. We are not bound morally to shoulder the alcoholic's responsibilities. (Al-Anon Family Group Headquarters, 1986, p. 54)

After giving partners an overview of TSF and inquiring into their own use of alcohol or drugs, the facilitator devotes the bulk of the conjoint program to discussing the issues of enabling and detaching and encouraging the partner to get active in Al-Anon or Nar-Anon. In this way the conjoint program, however brief, parallels the facilitation program itself. *Enabling* is defined as any behavior that has the effect of allowing the alcoholic or addict to ignore facing the reality that drinking or drug use is making his or her life unmanageable. Examples are given, such as those listed below:

- Making excuses to cover up for the patient when she or he would otherwise get into trouble as a consequence of alcohol or drug use.
- Providing money or other support for acquiring alcohol or drugs.
- Justifying (rationalizing) inappropriate or illegal behavior while under the influence of alcohol or drugs.

The significant other is asked to give specific examples of how she or he has enabled the patient to continue to drink or use. The motivations behind these actions are also explored. Typically, it is concern for the well-being of the patient, or fear of the consequences (e.g., to the family) of not enabling, that motivates enabling. For example, a spouse might fear the loss of income if she refused to call in "sick" for a drunk spouse. Others might fear physical abuse if they say no to a demand for money that they know will be spent on alcohol or drugs. Less often, enabling is motivated by a desire to avoid facing one's own alcohol or drug problem.

Detaching can be thought of as a process of learning not to enable, but it also can be conceptualized more positively as learning what to do *instead of* enabling. The facilitator engages the partner in some discussion of this change, using examples of enabling as a springboard. To follow on the above example, instead of calling in "sick" for the alcoholic who in fact is hungover, the partner could sympathize with the drinker's dilemma but still refuse to make the call for him or her.

Learning to detach takes courage. It can be supported by the therapist, to be sure, but it is through the fellowships of Al-Anon and Nar-Anon that partners will find the greatest amount of support and comfort for their task. Toward this end the facilitator should suggest several specific Al-Anon or Nar-Anon meetings that the partner could attend, and follow up on these suggestions at the outset of subsequent sessions.

Termination

If TSF has been successful, then termination essentially consists of "turning over" the patient to the care of a 12-step fellowship. The more successfully the patient and the therapist have collaborated toward this end, the more likely it is that the patient will continue his or her progress toward lasting sobriety. This prediction is based in part on AA member surveys, which show that the best predictor of future sobriety is current active participation in AA (Alcoholics Anonymous General Services Office, 1999). In addition, the contribution of AA/NA meeting attendance to maintaining abstinence has received empirical support (Fiorentine, 1999).

Because the overarching goal of TSF is involvement in AA and/or NA, termination should in part consist of an honest appraisal of how much progress has been made toward that end. Questions such as the following are in order:

- "How many meetings per month, on average, do you now attend? What kinds of meetings are they?"
- "Do you have a home group?"
- "On average, how many AA/NA friends do you call by phone each week? How many AA/NA people call you?"
- "Do you have a sponsor?"
- "Have you taken on any responsibility at a meeting—for example, making coffee, setting up, or cleaning up?"

Besides monitoring AA/NA activity, the facilitator should check to see whether the patient has absorbed key 12-step concepts, and whether his or her attitudes about addiction and recovery have changed at all as a result of participation in TSF. Questions such as the following can be useful for this purpose:

- "To what extent do you think that alcohol or drug use made your life unmanageable prior to coming to the program?"
- "Do you believe now that alcoholics and addicts can 'control' their drinking or drug use?"
- "Do you think that willpower is enough to achieve sobriety, or do addicts need to reach out to others?"
- "What do the following concepts mean to you: *denial*, *enabling*, *higher power*?"
- "What role, if any, has AA or NA played so far in your effort to stay clean and sober?"
- "What are your plans relative to AA (or NA) now that this program is coming to an end?"

Finally, the facilitator should take a moment (preferably prior to the actual termination session) to reflect on the issue of the relative responsibilities of patient and therapist in this model. In this regard, the concept of detaching is as relevant to the facilitator as it is to any significant other in the patient's life. Clinical experience suggests that the best the facilitator can hope to do is to introduce key concepts in ways that the patient can understand them, actively encourage the patient to give 12-step fellowship a try, confront the patient constructively with the role that alcohol or some drug has played in making the patient's life unmanageable, and answer questions about AA or NA to the best of his or her ability. How many sober days the patient has had, and how active she or he has become in AA or NA, is not within the control of the facilitator. In the final analysis, the facilitator must be able to "turn over" the patient and his or her future to the care of whatever higher power the facilitator happens to believe in.

Advanced Work

This chapter has focused on a structured, time-limited intervention for what has been called "early" recovery. It is unlikely that any more ground than what has been described here could reasonably be covered in brief therapy. Indeed, the goals of TSF are ambitious. I do not recommend attempting to do more advanced work with patients until they have a minimum of 6 months of uninterrupted sobriety and have satisfied all goals of the core program.

TSF does include an advanced or "elective" program (Nowinski & Baker, 2003, pp. 95–154; Nowinski et al., 1992, pp. 59–96) that provides therapist guidelines for covering the following topics: genograms, enabling, emotions, moral inventories, and relationships. A discussion of this material is beyond the scope of this chapter; however, parts of the elective program may be considered for patients who have consolidated their early recovery and are ready to work, for example, on Steps 4 and 5 (the so-called moral inventory), or who are ready to begin the process of healing wounded relationships.

Case Study

The following is offered as an illustration of how the TSF model of intervention described in this chapter may be applied.

Bob and Kathy, married for 20 years, came to see the author ostensibly for help with long-standing marital difficulties that had reached crisis proportions since their youngest child had left home for college. Though it was initially obscured by discussions and arguments about money and sex, it became apparent after a while that Bob had a drinking problem that needed to be evaluated.

He was asked to come in individually for two sessions to talk about this problem.

The assessment sessions revealed that Bob had several signs of alcohol dependency. He had a powerful tolerance, drank daily, and had experienced a number of drinking-related consequences, not the least of which was a seriously strained marriage. In addition, it was discovered that he was in trouble at work as a consequence of his drinking, a problem he'd kept secret from his wife.

Bob at first was reticent to change the focus of therapy from his troubled marriage to his drinking. He was assured that his concerns about the marriage were legitimate and would be dealt with. But he was told that first he needed to examine his drinking and either take action about it or risk losing his job and/or his marriage.

The story of Bob's private struggle for control over alcohol was a testament to stubborn determination as much as it was a classic story of the power of addiction. Having started out sipping beers stolen from the refrigerator as a youth barely 12 years old, Bob had been drinking for nearly 30 years. Things didn't get "really bad," though, according to him, until after he was married and the kids were born. Two things happened then. First, he felt obligated to stay in a job that paid well but that he had intended to leave. Second, his relationship with Kathy, in his words, became "diluted" as a consequence of the demands of family life—meaning that sex between them became a very occasional thing, and that she paid much less attention to him in general than she did when they were a couple.

It was around this time that Bob developed the habit of having "a cocktail or two" every night after work and before dinner. For a long time Kathy went along with this, though she did notice that "a cocktail or two" eventually became three, four, or more. She didn't much care for alcohol herself, and she had little personal experience with it in her own family. Out of naivete she took Bob's ability to "drink others under the table"—in other words, his tolerance—to be a good thing. Ironically, she believed that this ability to "hold his liquor" was actually a sign that Bob could *not* become addicted.

As time went on, the process of addiction gradually set in. Instead of eating lunch with his colleagues in the company cafeteria, Bob started going out alone for lunch two or three times a week to a local bar where he'd grab a sandwich and a couple of cocktails. By the time he got home he was anxious to "relax"—his euphemism for having more cocktails. Kathy and the kids soon found that anything that stood between Bob and his cocktails made him irritable. He didn't want to be bothered with problems until he was "relaxed." Of course, by that time he was also intoxicated, emotionally unstable, and prone to losing his temper. In time the family learned to avoid him. Kathy took to solving most of the household problems by herself, or else she let them go. The kids, meanwhile, led their own lives and had minimal communication with their father.

Though he was very hesitant to admit it for a long time, privately Bob had struggled long (and ultimately unsuccessfully) to control his drinking. He hadn't wanted to be like his own father: a "quiet drunk" who was less flamboyant than Bob in his drinking, but who had "liked his liquor" no less, and who had also been a social isolate and a "nonfactor" (as Bob described both himself and his father) within the family.

The story of Bob's private efforts to control his drinking sounded like something right out of the AA Big Book: drinking only wine, drinking only beer (no cocktails) at lunch, drinking from a smaller glass, adding more ice cubes to his cocktails, and so on. While he was conscious on some level of gradually losing control, he continued to tell himself that he was really alright. It was not until his boss smelled liquor on his breath that the shell of self-deceit that Bob had built was finally and abruptly shattered. He was called onto the carpet and told that a second such incident would result in disciplinary action. It also affected, he felt sure, his subsequent performance evaluation, which was lukewarm to say the least.

By the time he and Kathy came for "marriage counseling," Bob had managed to fall 2 years behind on his tax returns and owed the government several thousand dollars. According to Kathy, the house they lived in was falling apart faster and faster on account of maintenance projects that Bob refused to hire someone to do but kept putting off doing himself. Their son, who had just turned 18, was failing half of his courses in his freshman year in college; meanwhile their daughter "hated" Bob and alternately fought with and ridiculed him. On top of all this, Kathy had been sexually turned off to Bob for some time, which left him feeling frustrated and filled with self-pity.

The assessment process involved carefully chronicling first the progression of Bob's drinking, from cocktails on weekends to cocktails at lunch, how he had built a tolerance, and how drinking affected him (i.e., making him irritable and withdrawn). We then proceeded to talk at length about the methods that Bob had used to "control" his drinking, followed by discussion of all the ways in which his life had become increasingly unmanageable. At the end of this process Bob was willing to admit that he had a drinking problem and "probably" needed to stop drinking altogether. At that point, however, he was not willing to entertain the idea of using AA as a resource for helping him implement his desire to stop drinking. On the other hand, he was willing to defer marriage counseling while he met with the author to work on his drinking problem.

In subsequent sessions Bob reported that he was drinking less than before, but had not gone more than 1 day without a drink. At that point the author moved ahead to a discussion of Step 1, reading it aloud and then talking with Bob about it at length, making sure he covered the following points:

- "What does this statements mean to you? What is your initial reaction to it . . .
  - *Emotionally*: How does it make you feel?
  - *Intellectually*: What thoughts do you have in response to it?"
- "How do you relate to the concept of *powerlessness*? What kinds of things can people be powerless over in their lives?"
- "Can you see how some people might be 'powerless' over alcohol or drugs?"
- "Have you ever felt powerless over something in your life? What have you felt powerless over?"
- "At this point do you believe that you can still control your use of alcohol? What makes you believe this?"
- "In what ways has your life become more *unmanageable* over the past several years? Where are the areas of conflict? In what ways are things not going well for you?"

The *recovery tasks* discussed at this time focused on getting Bob to begin reading some of the material in the Big Book, especially "Bill's Story" and "We Agnostics." This material was particularly relevant to Bob, who was personally alienated from organized religion and who stereotyped AA as a religion. In addition he was a strong believer in self-determination, to the point where it was all but impossible for him to find the humility necessary to admit that he'd been ultimately unsuccessful, on his own, in controlling his drinking.

Reluctantly, and only after a frank discussion of humility combined with an appeal to be more open-minded, Bob agreed to attend a few different AA meetings as an observer. He agreed to a recovery task that involved going to meetings, listening to the stories being told, and trying to focus on *identifying* as much as possible with the theme of progressive loss of control, acceptance, and surrender. He was not asked to speak or to participate in any other way. On the other hand, he was advised to avoid focusing his attention on how he was different from other people at these meetings–for example, in terms of background, education, or financial circumstances.

One frequent problem of alcoholics who resist giving AA a try is their internalized stigma about alcoholism. Bob was no exception to this. He held very negative stereotypes about alcoholics, and fully expected to discover himself in the company of derelicts and criminals when he went to AA. Of course, he discovered just the opposite, which made it easier to encourage him to continue. In fact, he made a friend at one of the very first meetings he went to, and this person eventually became his first sponsor.

The next focus of treatment was denial. Bob had attempted to avoid coming to terms with his loss of control over drinking as fiercely as any alco-

holic. His first line of defense had always been to get angry whenever the subject was brought up by his wife. After blowing up, he'd usually change the subject, either launching into an attack on Kathy, or else complaining long and loudly about some other problem, like finances, his in-laws, or their sex life. In response to the ever-growing list of household chores that went undone, he pleaded fatigue—after all, he said, he worked hard all week and needed the weekends to "unwind."

Not surprisingly, Bob's denial extended outwardly to his behavior, and even inwardly to his own thought processes. For example, he went out of his way to associate with men who drank as much or even more than he did, and then comforted himself by drawing the comparison between his own use and theirs. Of course, he concluded that he was merely "average" (and therefore "normal") among his peers. At times when he felt guilty pouring that fifth or sixth martini, he'd tell himself that he "deserved" it—for example, because of the stress of having to endure an unsatisfying job. His trouble at work he tried writing off to a combination of bad luck and a vindictive boss; his increasing tendency toward sexual impotence he attributed to his wife's rejection of him and her preoccupation with their children.

As is often the case, once Bob was able to admit to someone else (i.e., to me) the ways in which he'd denied his drinking problem, the more open he became to accepting it. At this point he was even willing to admit it to Kathy and did so in a conjoint session. He continued to express reservations about whether he was a "true alcoholic," as he put it, but he was willing to keep going to AA on the premise that he did have the requisite desire to stop drinking.

As brief as this case example is, I hope it gives the reader a flavor for TSF as a mode of intervention. With respect to process, it incorporates elements of education, confrontation, interpretation, and suggestion. It is based on the 12-step model of addiction and recovery, and it clearly relies upon sophisticated clinical skills for its successful implementation.

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