Helping Substance Abusers Take Responsibility for Their Actions:

Understanding 12-step Programs

By Greg Milbourne

Physicians and therapists are frequently confronted with tremendous difficulty in treating alcoholics and addicts. There is a great deal of debate about whether they suffer from disease, moral weakness, or are products of a dysfunctional environment. As healers, our concern stems from our limited effectiveness in treating such people. Faced with large caseloads, short meeting times, and limited ability to take on long-term treatment with chronic cases, the question becomes: What outside resources can I utilize to help this person? Specifically, how can I help this person understand and take responsibility for his actions?

There are AA programs in over 150 countries and AA literature is printed in many languages, including Russian.

One option available worldwide is one of the many 12-step, self-help groups that enable alcoholics, substance abusers, and those with other addictions—such as gambling, shopping, or sex—to abstain from these destructive activities. This article looks at the history, main tenets, and uses of these programs in an effort to provide healthcare professionals with a greater understanding of their concept. Admittedly, these are not the only successful self-help programs available, but their effectiveness and worldwide scope make them worthy of consideration. Finally, while this article is written from the perspective of a therapist, it is important that primary care providers be aware of this option.

The History of Alcoholics Anonymous and Its Tenets

In the United States, the concept of self-help has a history dating back to the country's earliest immigrants. In the mid-nineteenth century an organization called the Washingtonians advocated for temperance in drink and set about helping desperate alcoholics stop drinking. They flourished and helped thousands until the politics of the national temperance movement caused them to argue among themselves and lose momentum. Then, about 65 years ago, two alcoholics met in the American Midwest and started an organization that continues to play an important role in the lives of many addicts today. Bill Wilson and Dr. Bob Smith found that by first helping one another, and then helping others, they were able to stop drinking. Knowledgeable of the flaws that ruined the Washingtonians, Wilson and Smith advocated for an organization committed exclusively to helping other alcoholics, one that would have absolutely no official stance on any outside cause or political movement. The organization drew its name from the book that it published in 1939, Alcoholics Anonymous, more commonly known as AA. Since then, over two million people in more than 150 countries have stopped drinking, using the steps and traditions that they established.

According to AA's official tenets, "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with one another [so] that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking." The organization requires no membership dues or fees; each group is self-supporting through member contributions. It is not allied with any [religious] denomination, politic[al association], organization, or institution, and its "primary purpose is to [help members] stay sober and help other alcoholics to achieve sobriety."[1]

The 12 steps (see Table 1) set forth by AA are drawn from many sources, but rooted in the Christian tradition. Common to most of the world's religions, these steps have been embraced as a model by many other organizations dealing with addictive behaviors and lifestyles.

Options for Care

Because the 12 steps are designed to help people identify and change problem behaviors, this model of treatment works very well in a variety of settings. In addition to traditional AA meetings, programs based on this model are used in inpatient and outpatient treatment facilities, recovery houses, and group homes. Obviously, such facilities vary dramatically from coun-

try to country. In Kiev, for instance, I visited an outpatient drug and alcohol treatment center that uses a 12-step approach. Within 100 miles of my home near Philadelphia, there are nearly 1,200 drug and alcohol treatment centers, which vary from very structured, inpatient settings to outpatient clinics that have drug and alcohol therapists who offer weekly one-on-one therapy. Types of treatment facilities include:

- freestanding chemical dependency rehabilitation;
- hospitals with chemical dependency units;
- long-term residential programs emphasizing 12-step and structured, professionally-managed programming;
- psychiatric hospitals with separate chemical dependency treatment programs;
- psychiatric hospitals with integrated chemical dependency treatment programs;
- substance abuse detoxification facilities; and
- other supportive living situations, such as group homes.

One successful grouphome organization is the Oxford House program, which is governed by a strict set of rules. According to their literature, to obtain and retain their charter, all Oxford Houses must be democratically self-run and immediately expel any member who uses alcohol or drugs. Furthermore, all residents of a house must assume responsibility for all of the household expenses. The houses range in size from six to 15 residents and are segregated by gender, although there are houses that accept women with children. There are currently 650 Oxford Houses in the United States in places ranging from Seattle to the US Virgin Islands. This system provides an effective and low-cost way of preventing relapse.

Truthfully, in America treatment is largely determined by a client's ability to pay. Government reimbursement policy and private insurance have dramatically changed the types of services offered to people trying to break an addiction. Private insurance may pay for deluxe facilities, such as the renowned Betty Ford Center, where wealthier people can go to "dry out," but less well-insured individuals have their treatment "capitated" and may only be able to go to a center for a shorter period of time. In the 1960s, President Kennedy opened the first community mental health centers, which provide mental health services for those who cannot otherwise afford it. Addicts without insurance may qualify for a short-term stay in a detoxification facility or rehab, but are usually referred to an outpatient clinic as soon as possible.

The great benefit of a 12-step program is that it is free. The only cost is that of the time and energy it takes an individual to get to a meeting, and clients with limited financial resources need not donate any money when attending a meeting.

The 12 Steps

1. We admitted we were powerless over alcohol, that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. 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.

Figure 1. All 12 step-programs use these steps, but substitute their addiction where alcohol is used in Steps 1 and 12. Steps copyright by AA World Services, Inc.

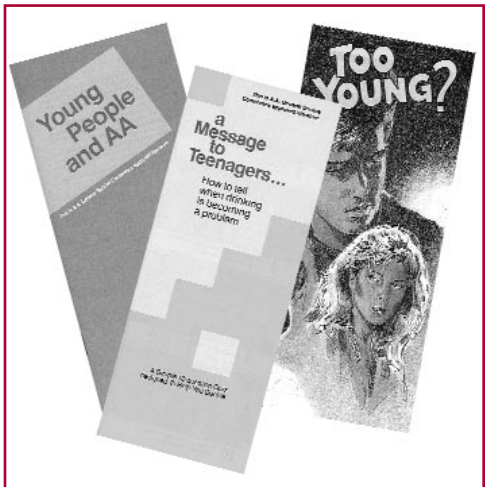
The AA Structure

In terms of structure, there are several types of meetings. Closed meetings are those reserved exclusively for alcoholics, and non-alcoholics are not invited. Open meetings are accessible to all interested individuals, whether they have a problem with their drinking or not. Since it is helpful to learn about programs like this first hand, I encourage healthcare providers to attend a meeting versus relying on articles like this and anecdotes of attendees. If the only meeting you can find is closed, contact the group anyway, explain why you want to attend, and ask if they might let you sit in.

Meetings also vary by content. AA has several main pieces of literature which are frequently read in groups:

- "Alcoholics Anonymous," the main text;
- "Twelve Steps and Twelve Traditions," (see Fig. 2) detailing ways individuals and groups can use the program effectively; and
- "Living Sober," a book of common sense advice for newly sober alcoholics, such as how to spend time that used to be spent drinking, what to eat, and how to deal with the anxiety and stresses that once "sent them to the bottle."

During each meeting, the leader typically reads from a section of one of these texts and then invites discussion. During a "speaker meeting" about half of the meeting time is devoted to listening to the drinking history of one member. At a "topic discussion meeting" the chairperson introduces a topic and all are encouraged to talk about it. Examples of topics are the fear of drinking when going out with friends; how to handle stressful or difficult situations; loneliness; anger; and powerlessness.



AA has created many pieces of literature targeting youth. For example, "Too Young" talks about problems with alcohol and the 12-step approach using a comic book format.

Meetings begin with a brief statement about AA and usually end with a prayer. Most last one to two hours, and are followed by "the meeting after the meeting" at which people break off and talk together over coffee or tea. During the meeting itself, one person speaks at a time, and a chairperson may interject to keep such sharing to a certain length or request that people stick to a particular topic.

Such meetings differ in several ways from professional groups. Most obviously, they lack a professional leader. Because of this, and depending on the individual facilitator—and their length of sobriety—meetings may not create a sufficiently "safe" space for some people suffering from severe mental disorders. Therapeutic help and support is especially necessary when people suffer from dual diagnoses of addiction and mental illness (see "Recognition and Treatment of the Dual Diagnosis Patient," page 18). As would be expected, many people who attended AA also suffered from depression or anxiety problems. If a patient returns with a negative story about a meeting, encourage them to explore other groups, until they find the right fit.

Once clients are at a stage of change where they are ready and willing to completely stop all drug and alcohol use, AA and other 12-step programs are excellent sources of support. In addition to helping individuals "put down" drinking and drugs, AA provides a strong and encouraging social network for the individual. People who have spent much of their lives surrounded by alcohol welcome the new network of friends who actively encourage new patterns of behavior and a sober way of living.

One caveat is that some in AA perceive psychotropic medication as inherently bad. Having long abused drugs and alcohol, many in recovery have difficulty accepting another medication designed to change how they feel or behave. When working with such clients, it is essential to hear their concerns and, if necessary, to remind them that there are several places in AA literature where seeking medical advice is strongly encouraged.

Effectiveness of AA

It is difficult to know empirically whether AA works. While one of AA's greatest strengths is its anonymity—no one may tell another nonmember that they saw someone there—this rule inhibits research on its effectiveness. But, AA's survival and growth both inside the US and internationally attest to its efficacy. So while little empirical research exists on the exact "cure rate" of people introduced to the AA program, much anecdotal evidence can be gathered from AA members and their families and friends about the dramatic and long-lasting effects of the program.

Obstacles to Treatment

The greatest obstacle to getting people into the program, or any program for that matter, is motivation. As therapists, we strive to gain insight into what exactly clients want when they see us. Quite often people do not want to stop drinking, but want to stop feeling so bad. So we work with them to understand their goals from their point of view. Once we know what they want for themselves, we can begin to help them realize that drinking may be standing in the way of achieving some of their goals. Toward that end, we may give advice, remove barriers, provide choice, decrease the desirability of using a drug, practice empathy, provide feedback, clarify goals, and actively help.

Knowing what we can do is useful, but understanding where a client is in the recovery process is more difficult. When they were doing research on smoking cessation, Prochaska and DeClemente came up with a model of change useful in understanding addictive behavior.[2] The six stages they identified are:

- precontemplation, during which the therapist's goal is to raise doubt and increase clients' perception of the risks and problems with their current behavior;
- contemplation, during which the therapist strives to tip the balance and evoke reasons for the client to change, understand the risks of not changing, and strengthen the client's self-efficacy for change of current behavior;
- determination/preparation, when the therapist helps the client determine the best course of action to take in seeking change;
- action, when the therapist helps the client take steps toward change;
- maintenance, during which the therapist works to identify and use strategies with the client to prevent relapse; and
- Relapse, when the therapist helps the client to renew the processes of contemplation, determination/preparation, and action, without becoming stuck or demoralized because of mistakes.

Clients in the early stages of change are not ready for AA. By definition, someone in the precontemplation stage does not recognize that he has a problem and is not willing to look at ways of fixing it. Similarly, in the contemplation stage, clients may begin to consider that there is a problem, but not want to fix it. Once people get to the preparation stage, they are thinking about ways to change their behavior, and may be ready for a referral to AA. The people in the action stage are those in the process of change, often those in AA who have given up drinking and "working the steps" of the program. Therapy with these clients can be fun, because together the client and therapist accept and create new patterns of living.

Motivating a Patient Toward Change

Five general principles of reducing harm and moving the client toward change may be helpful:

- express empathy;
- develop discrepancy;
- avoid argumentation;
- roll with the resistance; and
- support self-efficacy.

The key to this method of work is remembering that each client has his own sense of what works for him. A therapist's goal is to help the client gain new insight and understanding about his own patterns of behavior, without casting judgment on them. We do not say, "Drinking is bad." Instead we look at the behavior and its effects and say, "hmm, when you drink, you seem to lose control, and then you lose your job, and the people in your life don't want to be around you and leave. Maybe there is another way of behaving?"

The 12 Traditions

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority —a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purposer.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

Figure 2. The traditions do for the groups what the steps do for the individual—they protect them from themselves. If alcoholism and addiction are diseases of self-injury, the steps help curb these destructive instincts in the individual, and the traditions do the same for groups.

But why suggest a 12-step versus another program? Basically, because it is easy. First, it takes minimal time and effort from the therapist. Second, it can create dramatic change in difficult clients, not merely with sobriety issues, but in other areas of their life. The therapist can encourage the client to apply the skills learned through the 12-step program to other problems they are facing. And, third, when working individually with someone, giving them the benefit of a group experience can be very powerful. Groups allow peers to confront users on the patterns of their use and denial of its effects in very powerful ways.

There are some downsides to these programs, primarily rigidity. The insistence that sobriety is the starting point for all treatment can pose a major obstacle for many drinkers. While many people may recognize that their lives are a little crazy or that they could benefit from reducing their consumption, giving it up absolutely can be extremely difficult. In September 1997, *U.S. News and World Report* ran an article on "What AA Won't Tell You, " advocating "moderation may be the answer for many." While this is not a new debate, referring clinicians must recognize that clients who are only seeking to curb or lessen their drinking may not be ready for AA's "abstinence only" stance.

Other potential problems include stigmatization and the program's spiritual language. To be fully accepted in AA, you must embrace the label of alcoholic. That can be quite difficult for some. Others balk at the spirituality of the program. Nonbelievers can feel uncomfortable with the insistence upon some sort of "higher power" as a pillar of their recovery. Although there are atheists and agnostics who regularly attend and benefit from the recovery model, there are many in AA who insist upon faith as the foundation of the program.

As stated at the beginning of this article, 12-step programs are only one of the many options available to patients wanting to break an addiction and to the healthcare providers helping them move toward healthier lifestyle choices. Beyond attending an actual meeting or reading articles like this that outline the philosophies, strengths, and weaknesses of the program, healthcare providers can get more information by reading the 12-step literature or going to www.aa.org.

References

1. The AA Preamble, as copyrighted by *The AA Grapevine*.
2. William R. Miller and Stephen Rollnick, *Motivational Interviewing: Preparing People to Change Addictive Behavior* (Guilford Press, December 1992).

Gregory Milbourne is a doctoral candidate in clinical psychology at Widener University in Philadelphia; gregmilbou@aol.com.