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Twelve Step Facilitation Therapy for Drug Abuse and Dependence

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FORWARD

This manual reflects our work at the Yale University Psychotherapy Development Center to understand and improve drug abuse treatment by specifying and evaluating innovative psychotherapies. This Twelve Step Facilitation (TSF) manual for drug dependence reflects the work of numerous individuals who have contributed to the series of clinical trials conducted at the Yale Substance Abuse Treatment Unit that have evaluated TSF in comparison to other treatments. These include, primarily, Stuart Baker, Art Woodard, and Dr. Joseph Nowinski, who, as therapists, supervisors, trainers, and authors, have fostered this exiting and promising treatment approach.

Other investigators contributing to the series of studies in which this approach has been evaluated include: Bruce Rounsaville, M.D., Charla Nich, M.S., Sam Ball, Ph.D., Elinor McCance, M.D., Ph.D., and the Project MATCH Research Group. The project staff and coordinators included Charla Nich, M.S., Tami Frankforter, Joanne Corvino, M.P.H., Monica Canning-Ball, Meghan Brio, Roseanne Bisighini, M.S., Jennifer Owler, Lynn Gordon, R.N., and Kea Cox. We also gratefully acknowledge the critical contributions of Drs. Pat Owen, Dan Anderson, and Fred Holmquist of the Hazelden Foundation in Center City, Minnesota, who consulted in the development of the original Project MATCH TSF manual.

This manual describes an adaptation of Twelve Step Facilitation for use with drug-dependent individuals. Major sources for this version of the manual include:

- Nowinski, J., Baker, S., & Carroll, K.M. (1992). Twelve Step Facilitation Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence. NIAAA Project MATCH Monograph Series Volume 1, DHHS Publication No. (ADM) 92-1893. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Nowinski, J. & Baker, S. (1992). The Twelve Step Facilitation Handbook: A Systematic Approach to Early Eecovery from Alcoholism and Addiction. Lexington Books. An Imprint of Macmillan, Inc. New York.
- Nowinski, J. & Baker, S. (1998). The Twelve Step Facilitation Handbook. San Francisco: Jossey Bass.

RESEARCH SUPPORT

Although approaches similar to the treatment described here are in wide use in the clinical community, there was, until recently, very little empirical evidence supporting their use (Holder et al., 1991; Miller et al., 1995). This occurred, primarily, because this type of approach had not been described in a form (i.e., a detailed treatment manual) necessary for evaluation in controlled clinical trials. This, and our other TSF manuals, are thus an important contribution to both the and research communities. Now that this approach has been manualized and we can train therapists to use it consistently, a number of important studies have recently been completed that suggest this manualized TSF approach is very effective:

First, in NIAAA-supported Project MATCH (Project MATCH Research Group, 1993, 1997), the largest alcohol treatment trial ever done, involving over 1700 alcohol-

dependent individuals in 9 clinical research units across the country, TSF was associated with excellent retention and very good drinking outcomes. Moreover, TSF was found to be comparable in effectiveness to Cognitive-Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET), two forms of treatment with strong records of empirical support (Project MATCH Research Group, 1997). Furthermore, in the few instances where there were differences in outcome on some variables (such as in rates of complete abstinence and negative consequences of drinking), these tended to favor the Twelve Step Facilitation approach over CBT and MET (Project MATCH Research Group, 1997). Although Project MATCH was designed to detect patient-treatment interactions (matching effects), only one significant matching effect was seen, which also favored TSF: In the outpatient arm of the study, clients low in psychiatric severity (as measured by the ASI) had more abstinent days after TSF treatment than CBT; neither treatment was clearly superior for patients higher in psychiatric severity.

Second, we have also used TSF in our recently completed trial of psychotherapy and medication for cocaine-dependent patients who also abuse alcohol (Carroll et al., 1998). This twelve-week randomized clinical trial of disulfiram and three forms of manual-guided psychotherapy (TSF, CBT, and Clinical Management) indicated the following: First, the two active psychotherapies, Cognitive-Behavioral Coping Skills Therapy and Twelve-Step Facilitation, were more effective than Clinical Management, a psychotherapy control condition, in fostering longer periods of consecutive abstinence from cocaine, abstinence from both cocaine and alcohol simultaneously, as well as a higher percentage of cocaine-free urine specimens. Moreover, the benefits of TSF and CBT compared with the minimal treatment were sustained through a one-year follow-up.

The therapeutic approach underlying this manual is grounded in the principles and twelve steps of NA/CA/AA. It is important to note, however, that this manual has no official relationship with, or sanction from, any 12-Step program. The fellowship of NA/CA/AA is described in official 12-Step program literature and is realized through their worldwide meetings. NA/CA/AA do not sponsor or conduct research into drug dependence or its treatment or endorse any treatment program. While intended to be consistent with 12-Step principles, this treatment program is designed for delivery in research protocols and in clinical settings. Its goals are to educate patients regarding the NA/CA/AA view of drug dependence and to facilitate their active participation in NA/CA/AA.

CAUTIONS

This manual, like any other, should not be used without appropriate training and ongoing supervision. It may not be applicable to all patient types, nor compatible with all clinical programs or treatment approaches. This manual may supplement, but does not replace or substitute for the need for adequate assessment of each patient, careful case formulation, ongoing monitoring of patients' clinical status, or clinical judgment.

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1. Description, Goals, and Overview

Description

Background and Rationale

12-Step Facilitation Therapy (TSF) is a manual-guided treatment that was developed for use in psychotherapy research protocols for the treatment of alcohol abuse and dependence. Since its initial development, the TSF manual has been adapted for the treatment of drug abuse and dependence, including patients presenting with cocaine and opiate problems. The facilitation program in this manual is intended for use in brief, individual outpatient treatment for persons who satisfy the DSM IV criteria for drug abuse or dependence. The protocol is designed to be used as primary treatment for patients who may have previously participated in Twelve Step programs, patients who have never been exposed to Twelve Step programs, and/or patients who may or may not have had previous substance abuse treatment.

The program described in this manual is intended to be consistent with active involvement in Twelve Step recovery programs such as Narcotics Anonymous (NA), Cocaine Anonymous (CA), and Alcoholics Anonymous (AA). It assumes that addiction is a progressive disease of mind, body, and spirit, for which the only effective remedy is abstinence from mood-altering substances, *one day at a time*. TSF adheres to the concepts set forth in the Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981) of NA/CA/AA.

The overall goal of this therapy is to promote abstinence by facilitating patients' active involvement and participation in the fellowship of 12-Step recovery programs (NA, CA, AA). Active involvement in 12-Step programs is regarded as the single most important factor responsible in maintaining sustained recovery from drug dependence, and therefore, is the desired outcome of participation in this treatment.

Disease Model

According to NA, addiction is a chronic, progressive illness which if not arrested, may lead to insanity or death. It is characterized by loss of the ability to control (limit) the use of drugs. It is described here in Narcotics Anonymous (Narcotics Anonymous, 1988):

“At first, we were using in a manner that seemed to be social or at least controllable. We had little indication of the disaster that the future held for us. At some point, our using became uncontrollable and anti-social. This began when things were going well, and we were in situations that allowed us to use frequently. This was usually the end of the good times. We may have tried to moderate, substitute or even stop using, but we went from a state of drugged success and well-being to complete spiritual, mental and emotional bankruptcy. This rate of decline varies from addict to addict. Whether it occurs in years or days, it is all downhill. Those of us who don't die from the disease will go to prison,

mental institutions or complete demoralization as the disease progresses.” (Narcotics Anonymous, 1988, pp. 6–7)

Drug addiction, like all chronic illnesses, has predictable effects on an individual (symptoms) and a predictable course. As noted above, in addition to the physical aspects of addiction, the individual suffers psychologically, socially, and spiritually.

Addiction to mood-altering substances is characterized by denial, or resisting to accept the limitations of the addiction.

“Many of us did not think that we had a problem with drugs until the drugs ran out. Even when others told us that we had a problem, we were convinced that we were right and the world was wrong. We used this belief to justify our self destructive behavior.” (Narcotics Anonymous, 1988, p. 5)

Twelve-Step Recovery programs such as NA, CA, and AA are not a treatment method, but a fellowship of peers connected by their common addiction and guided by the Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981). The only requirement to join the fellowship is a desire to stop using mood-altering substances.

12-Step programs make no commitment to a particular causal model of addiction rather they limit the concepts to those of loss of control and denial. From their roots in AA, 12-Step programs emphasize two themes:

- **SPIRITUALITY**
Belief in a “power greater than ourselves”, which is defined individually, by each person, and which represents faith and hope for recovery.
- **PRAGMATISM**
Belief in doing “what works” for the individual, meaning doing what ever it takes in order to avoid taking the first drug.

Treatment Goals and Objectives

Goals

This therapy program has two primary goals (which generally relate to the first three Steps of NA/CA/AA). These two goals are:

Acceptance

The breakdown of the illusion that the individual through willpower alone can effectively and reliably control or limit his/her use of mood-altering substances.

- Acceptance by patients that they suffer from the chronic and progressive illness of drug addiction.
- Acceptance by patients that they have lost the ability to control their use of mood-altering substances.

- Acceptance by patients that since there is no effective “cure” for addiction, the only viable alternative is complete abstinence from all mood-altering substances.

Surrender

- *Surrender* involves a willingness to reach out beyond oneself and to follow the twelve steps presented in 12-Step programs.
- Acknowledgment on the part of the patient that there is HOPE for Recovery, (sustained abstinence), but only through accepting the reality of the loss of control and by having faith that some HIGHER POWER can help the individual whose own willpower has been defeated by addiction to mood-altering substances.
- Acknowledgement by the patient that the fellowship of NA/CA/AA has helped millions of addicts to sustain their recovery, therefore, the patient’s best chance for success is to follow the path of NA/CA/AA.

Objectives

As patients allow themselves to go through this process, they form the basis for early recovery from addiction. The two major program goals are reflected in the following objectives which are congruent with the NA/CA/AA view of alcoholism and addiction:

COGNITIVE

- Patients should understand some of the ways in which their thinking has been affected by drug addiction.
- Patients should understand how their thinking may reflect denial (“stinking thinking”) and thereby contribute to continued drug use and resistance to acceptance (Step 1).
- Patients should see the connection between their drug use and negative consequences that result from it. These consequences may be physical, social, legal, psychological, financial, or spiritual.

EMOTIONAL

- Patients should understand the NA view of emotions and how certain emotional states (anger, loneliness) can lead to drug use.
- Patients should be informed regarding some of the practical ways 12-Step programs suggests for dealing with emotions so as to minimize the risks of using drugs.
- TSF attempts to introduce and guide the individual in the use of 12-Step program tools for dealing with such emotions as anger, loneliness, and grief. These tools include making use of the program slogan “Don’t let yourself get too hungry, angry, lonely, or tired”. (H.A.L.T.)

RELATIONSHIP

- Addiction has been described as a “disease of isolation”.
- TSF provides support for patient to become connected to 12-Step programs by going to meetings, participating in meetings and establishing a relationship with a sponsor.

BEHAVIORAL

- Patients should understand how the powerful and cunning illness of drug addiction has affected their whole lives and how many of their existing or old habits (people, places and things) have supported their continued drug use.
- Patients should replace people, places and things that threaten their abstinence with people, places and things that support their recovery.
- Patients should turn to the fellowship of NA and to make use of its resources and practical wisdom in order to change their addictive behavior.
- Patients should “get active” in NA as a means of sustaining their abstinence.

SOCIAL

- Patients should attend and participate regularly in 12-Step meetings of various kinds, including NA sponsored social activities.
- Patients should access NA whenever they experience the urge to use or when they slip or relapse.
- Patients should re-evaluate their relationships with “enablers” and fellow drug users.

SPIRITUAL

- Patients should experience hope that they can recover from their drug addiction.
- Patients should develop a belief and trust in a power greater than their own willpower.
- Patients should explore and re-evaluate their purpose in life.
- Patients should make a commitment to ethical and moral behavior, and acknowledge specific immoral or unethical acts, and harm done to others as a result of their drug addiction.

TSF Treatment Overview

This treatment consists of 12 session topics which provide a structure and focus for the treatment to be delivered as a time-limited, brief treatment. Typically, the treatment ranges from 12 to 24 weeks. Often a topic may need to be covered over several sessions, depending upon factors that may vary from

patient to patient. In pacing the presentation of material, the therapist may need to assess, for example; (1) as a result of chronic and/or recent substance use, how cognitively available is the patient for treatment, (2) what level of commitment does the patient have to the treatment, (3) can a patient understand and retain a particular concept or idea?

Each session is highly structured and has a specific agenda. Patients are asked to keep a personal journal, and recovery tasks are suggested each week to do between sessions.

Central to this approach is strong encouragement to attend several different kinds of 12-Step meetings per week and to read the 12-Step program literature throughout the course of treatment.

Core Topics

Topics judged to be central to the treatment are presented first in the *Core Program*. These five core topics, discussed later in detail, should be delivered in the following order for most patients:

Topic 1: Introduction to Treatment and Assessment

Topic 2: Acceptance

Topic 3: People, Places, and Things (Habits and Routines)

Topic 4: Surrender

Topic 5: Getting Active in 12-Step Programs

Elective Topics

The *Elective Program* follows the *Core Program*. Depending on the needs of a particular patient, several of these topics may be chosen for use in treatment. The *Elective Program* topics are:

Topic 6: HIV Risk Reduction (recommended for all patients)

Topic 7: The Genogram

Topic 8: Enabling

Topic 9: Emotions (H.A.L.T.)

Topic 10: Moral Inventories

Topic 11: Clean Living

Conjoint Program

The *Conjoint Program* is offered to those patients with a supportive significant other. The program includes two topics designed to involve the significant other in the patient's recovery.

- Enabling
- Detachment

Termination

The final part of the Twelve Step Facilitation Therapy Program is the *Termination* process. This consists of a session(s) which focus on changes and gains made by the patient, as well as, plans for continued growth in recovery.

It is intended that the core topics plus *Termination* be provided to all patients. There is more flexibility in the therapist's use of the elective topics. Any core or elective session may be repeated if necessary to meet the needs of the patient. The use of a combination of core and elective topics allows this program to develop individualized treatment plans within broad parameters. For example, it can be used with patients who have had no prior exposure to 12-Step programs and concepts, patients who have never participated in treatment of any kind for drug addiction, and patients who have had one or more inpatient treatment experiences plus extensive exposure to 12-Step programs.

Journals

Patients are asked to maintain a personal journal, which is reviewed by the therapist at the beginning of each session, and which is used to record the following:

- All NA/CA/AA meetings attended (dates, times, places)
- Personal reactions to and thoughts about meetings
- Reactions to suggested readings
- *Slips* (occasions when the patient has used) and what was done about them
- Reactions to recovery tasks
- Cravings or urges to use and how the patient managed them

Session Format

Topic 1: Introduction and Assessment

In the first session, the therapist introduces TSF and provides an overview of the treatment, including the goal of treatment, which is active involvement in 12-Step programs. The therapist also helps patients evaluate their level of drug involvement, introduces the 12-Step view of drug abuse and dependence, and attempts to motivate patients to stay clean and sober.

Topics 2-11

Beginning with Session 2, the four additional core topics, as well as all elective topics follow a prescribed format and structure known as the 20/20/20 rule (Carroll, K.M., 1998).

20/20/20 RULE

- First Third of Session: Review
Assess substance use, craving and dangerous people, places, and things, since last session.
Listen for/ elicit patient's current concerns.
Review and discuss recovery tasks from previous week.
- Second Third of Session: New Material
Introduce and discuss new material.
Relate session topic to current concerns.
- Final Third of Session: Recovery Tasks and Wrap-up
Suggest recovery tasks for next week.
Explore patient's understanding of and reactions to new material.
Review plans for upcoming recovery week.

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Review

Urges

Slips

12-Step Tools

This includes a review of the patient's attempts at maintaining abstinence and a review of any slips, urges to use or thoughts about using, since the last session. Slips are handled by first examining the antecedents to the drug use, then suggesting appropriate 12-Step tools that might have been employed to avoid the slip (meetings, contacting sponsor/peers, reading of recovery materials). Slips should be treated non-judgementally and interpreted as times when the power of the illness of drug dependence overcomes the patient's willpower.

Meetings

It is essential that the therapist congratulate the patient for each clean and sober day and for their efforts to remain abstinent *one day at a time*. The therapist explores the patient's reactions to any 12-Step meetings attended. If no meetings were attended, or the patient seems reluctant to attend meetings, the therapist explores this with the patient in an attempt to understand his/her resistance.

Readings

Journal

A review of the patient's reaction to assigned readings or audio tapes, etc., and a review of their journal, give the therapist an opening to assist the patient in working through barriers that s/he may be experiencing in becoming actively involved in 12-Step programs.

Recovery Tasks

Finally, the therapist follows up on any other suggested recovery tasks such as contacting a sponsor, taking on service work at a meeting, etc. This review of the week provides the patient a chance to talk about their day to day life and provides the therapist with an opportunity to teach and encourage the use of the tools of 12-Step programs for dealing with life situations. This part of the session takes approximately 20 minutes.

New Material

Following the review, each session should move on to cover a specific topic. Using material presented by the patient during the review of the week, the therapist can connect the patient's personal experience to the new material for the current topic. This tailors the session material specifically to the patient's concerns, making it more relevant for the patient. For example, the patient may have expressed frustration with the behavior of a co-worker or a boss. The therapist may wish to use this material to talk about the concept of "Powerlessness" and the first Step of NA, or about using 12-Step tools to handle emotions, etc. About 20 minutes are devoted to this section.

Recovery Tasks

Preparation for staying clean and sober during the coming week (or period between sessions) comes next. The therapist and patient discuss suggested recovery tasks which may include readings from recovery literature, listening to recovery tapes, or performing recovery related activities such as contacting recovering peers or going to 12-Step related social activities, etc. Specific recovery tasks include:

Meetings Readings

- A mutually agreed upon list of 12-Step meetings to be attended.
- Suggested readings from NA/CA/AA texts:

Alcoholics Anonymous (Alcoholics Anonymous, 1976). "The Big Book".

Twelve Step and Twelve Traditions (Alcoholics Anonymous, 1981). "12x12".

Narcotics Anonymous (Narcotics Anonymous, 1988). "The Big Book".

Living Sober (Alcoholics Anonymous, 1975)

Hope, Faith & Courage (Cocaine Anonymous, 1993)

- Other suggested readings, including pamphlets, and other materials that the therapist is familiar with and would recommend for the patient's recovery.

Wrap-Up

The therapist does a session wrap-up by asking what the patient learned or found valuable in the session, and whether or not they clearly understand their recovery tasks and are willing to commit to doing them. Some therapists may shake hands with their patient or ask their patient to sign an agreement to follow through on their assignments. Recovery tasks and wrap-up should take approximately 20 minutes.

NOTE: When offering patients advice or giving them recovery tasks from the point of view of a 12-Step oriented program like TSF, it is important to remember that 12-Step programs prefer the word *suggestion* to the word *rule*. Specific strategies for staying clean are as varied as the number of people who

are in the 12-Step fellowship. It is important for each individual drug abuser to do what works for them to maintain abstinence.

In keeping with the spirit of 12-Step programs, therapists using this manual are advised to avoid making *assignments*, in the sense of telling patients what they should do. The 12-Step tradition tells us that it is better to share “some things that other addicts have found helpful in your situation” without pressing for the kind of commitment that other therapies might.

Suggestions made by the 12-Step therapist should be consistent with what is found in 12-Step publications. Examples of strategies for dealing with urges and slips that are consistent with 12-Step programs include:

- Calling a friend
- Going to a meeting
- Going to a 12-Step social event
- Calling your sponsor
- Calling the NA/CA/AA Hotline
- Changing a habit pattern
- Distracting yourself

Aside from being consistent with 12-Step traditions, recovery tasks should be specific, and the therapist should make a point of following up on them at the beginning of each session.

Finally, the therapist should be familiar with 12-Step literature, as well as with the locations, times, and types of meetings that may be available in the area.

Technical Problems

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

LATENESS/CANCELLATIONS

Patient is consistently late for appointments/cancels sessions. In general, the therapist should begin by exploring the reason why the patient was late, missed, or rescheduled a therapy session.

Listen for evidence of denial. “I can do this on my own”, “I don’t think my problem is as bad as you seem to think it is”, “I don’t believe I’ve lost control of my drug use”, “I was busy and forgot about our session”, and so on.

When denial seems to be the issue, the therapist should identify and interpret as part of the illness of addiction. Remember that denial is not

necessarily verbalized, but may be *acted out* through behavior or through various excuses for not going to meetings, not doing suggested readings, and so forth. One form that denial often takes is chronic lateness and cancellations. If this pattern emerges, but patients refuse to “own up to it” as resistance, try to engage them in a frank and non-judgemental discussion of their reservations about treatment. If the pattern continues, a more open discussion about motivation for treatment may be helpful.

Keep in mind this form of resistance does not invariably reflect denial of the addiction. In some cases, it may be due to a fear of failure or social shyness. Help resistant patients clarify their reasons for resisting active involvement in 12-Step programs and work from there.

PATIENT COMES TO SESSION HIGH

Do not proceed with a session if a patient shows up under the influence of drugs or alcohol. Ask the patient to call the NA/CA/AA Hotline, a 12-Step program friend, or his/her sponsor. If the person is not willing to do this, have him/her call a significant other to arrange for transportation home.

PATIENT RESISTS GOING TO MEETINGS

This common resistance can take many forms, from making excuses to criticizing the 12-Step meetings and/or their members. Interpret this respectfully as denial, as evidence of the patient’s refusal to accept loss of control and the fact that drugs are making life progressively more unmanageable (Step 1).

It is appropriate to coach patients regarding how to go to a meeting and what to expect. The therapist should *not* offer to take the patient to a meeting but may do anything reasonable short of that, such as role-playing or arranging for an escort through various 12-Step program contacts the therapist has developed.

If a patient continues to resist going to meetings, patiently persist in trying to get the person to make definite commitments to meetings, using the NA/CA/AA meeting schedule to identify specific meetings that would be appropriate for him/her. However, a TSF therapist should never terminate a patient for refusing to go to meetings, as this would be inconsistent with 12-Step programs.

PATIENT USES DIFFERENT SUBSTANCES

Substance substitution is one symptom of addiction and should be interpreted as such if the patient appears to be using a substitute for their primary drug of choice. Addicts cannot be allowed to believe that they can safely use other substances, for two reasons. First, uses of another substance will reduce resistance to use of the patient’s substance of choice. Second, there is a risk of

cross-addiction (multiple addiction) if the patient turns to a substitute mood-altering substance.

EMERGENCIES

When working with patients who may be actively using or whose abstinence is compromised by slips, it is not uncommon for therapists to be confronted by various *emergencies*. Typical examples of such emergencies include:

- Getting arrested for drug related charges
- Having a family dispute as a result of drug use
- Feeling depressed about being dependent on drugs
- Getting into trouble on the job as a consequence of drug use
- Needing medical detoxification as a consequence of a binge
- Re-awakening of intense urges to use drugs and fear of full blown relapse

TSF Response to Emergencies

Usually, in times of crisis, the TSF therapist should consistently encourage patients to turn to the resources of 12-Step programs as the basis for their recovery. The therapist may offer specific advice and help in this regard, such as assisting the patient in contacting the NA Hotline or the patient's sponsor.

Serious emergencies of a psychiatric nature (e.g., suicidal ideation, psychosis, violence, self-injury) or of a medical nature (need for detoxification) require either an emergency session with the therapist, a referral to an emergency mental health service, or to a hospital emergency room for evaluation and possible intervention. In such instances, patients' continued participation in the TSF program may require review.

2. Defining TSF

Active Ingredients in TSF, Therapist Behaviors Prescribed and Proscribed

All behavioral or psychosocial treatments include both common factors as well as unique factors or active ingredients (Strupp & Hadley, 1979). *Common factors* refer to dimensions of treatment that are shared across most psychotherapies. These common factors include the provision of education, a convincing rationale for the treatment, enhancing expectations of improvement, provision of support and encouragement, and in particular, the quality of the therapeutic relationship (Rozenzweig, 1936; Castonquay, 1993). A positive therapeutic relationship, or alliance, has repeatedly been associated with better outcome in a range of psychotherapies (Horvath & Luborsky, 1993), including substance use (Luborsky et al., 1985; Carroll, Nich & Rounsaville, 1997). A positive working relationship is an essential component of virtually all therapies, yet, by itself, is not necessarily sufficient to produce change. *Unique factors* refer to a treatment's *active ingredients*, or those techniques and interventions which distinguish or characterize particular psychotherapies. While common factors are shared, unique factors might include transference interpretations in psychodynamic psychotherapies or invoking the "Twelve Steps", as in TSF.

TSF, like most therapies, consists of a complex combination of common and unique factors. For example, in TSF mere delivery of didactic information about 12-Step program tools without grounding in a positive therapeutic relationship leads to a dry, overly didactic psycho-educational approach that alienates or bores most patients and ultimately has the opposite effect of what was originally intended. It is important to recognize that TSF is thought to exert its effects through this intricate interplay of common and unique factors and a major task of the therapist is to achieve appropriate levels of balance between delivering the information about 12-Step recovery tools and attending to the relationship. For example, without a solid therapeutic alliance, it is unlikely that a patient will either stay in treatment, be sufficiently involved to learn the use of 12-Step recovery tools, or to share successes and failures in trying to apply these tools to living. Conversely, empathic delivery of knowledge about recovery tools to help the patient manage his/her life more effectively, with the therapist giving the message of, "I see you really struggling with craving. These are some suggestions of effective ways that others have used to deal with it", may form the basis of a strong working alliance.

To specify TSF in terms of its active ingredients and to clarify the range of therapist interventions that are consistent and inconsistent with this approach, TSF interventions will be described in terms of the system recommended by Waltz and colleagues, 1993. First, TSF's essential and unique interventions, that is, the active ingredients that are specific and unique to TSF. Second, TSF's recommended interventions, those that are thought to be *active* and important, but which are not necessarily unique to TSF. Third, interventions, behaviors, or processes that are acceptable within the therapy but are not essential or unique. Finally, interventions, behaviors, or processes that are proscribed, or not

consistent with this approach.

Essential and Unique Interventions

In TSF, the active ingredients which distinguish it from other substance abuse treatments and that must be delivered in order to adequately expose the patient to TSF include:

- Taking a drug history, identifying positive and negative consequences of drug use, and giving feedback as ground work to Step 1.
- Providing education about: Steps 1, 2, and 3 of the 12-Step programs; the Process of Denial as it relates to the Grief Process; the 12-Step program view of addiction as a disease; the principles of recovery in 12-Step programs.
- Examination of the patient's "stinking thinking" about substance use and suggesting the use of slogans and the Serenity Prayer as tools to change this.
- Exploring discrepancies between the patient's stated goals and actions in terms of denial.
- Identification of "People, Places, and Things" that could trigger drug use and identification of "People, Places, and Things" that support recovery.
- Encouraging patients to actively work the "Twelve Steps" as the primary goal of treatment.
- Supporting the point of view that the best chance of staying clean over the long run is if you accept the loss of control over drugs, and reach out to fellow recovering drug abusers through the 12-Step programs.

Recommended but Not Unique Interventions

Interventions or strategies which should be delivered, as appropriate, during the course of each patient's treatment, but are not necessarily unique to TSF include:

- Discussing, reviewing, reformulating the patient's goals for treatment
- Monitoring drug use and craving
- Monitoring general functioning
- Exploring positive and negative consequences of drug use
- Exploring the relationship of affect and drug abuse
- Providing feedback on urinalysis results
- Setting agenda for the session
- Identifying alternative activities to replace drug use
- Making process comments as indicated
- Discussing the advantages of abstinence as the goal of treatment

- Exploration of the patient's commitment to abstinence
- Supporting patient efforts
- Explaining the difference between a slip and a relapse
- Including family members or significant others in conjoint sessions

Acceptable Interventions

Interventions which are not required or strongly recommended in the delivery of TSF, but are compatible with this approach include:

- Eliciting concerns about substance use and consequences
- Self-disclosure by the therapist regarding their recovery status

Proscribed Interventions

Interventions which are *not* consistent with TSF:

- Functional analysis of substance use
- Coping skills training
- Practice of skills during sessions
- Exploration of interpersonal aspects of substance use
- Exploration of patient's underlying conflicts or motives
- Provision of reinforcement for abstinence (e.g., vouchers, tokens)

Compatibility with Adjunctive Treatments

This manual describes TSF for drug abuse as a short-term, individual, stand alone treatment. However, TSF is compatible with various other approaches and treatments which address a wide range of comorbid problems and severity of the disorder. These include pharmacotherapy for drug use and/or concurrent psychiatric disorders, family and couple therapy, vocational counseling, parenting skills, and so on. When TSF is provided as part of a larger treatment package, it is essential for the TSF therapist to maintain close and regular contact with other treatment providers.

TSF in Contrast to Other Treatments

It is often easier to understand what a treatment is in terms of what it is not. This section discusses TSF for drug abuse and dependence in terms of its similarities and differences with other psychosocial treatments for substance abuse.

Approaches Most Similar to TSF

TSF for drug abuse and dependence is similar to TSF for Alcohol Abuse and Dependence that was developed for Project MATCH (Nowinski, Baker &

Carroll, 1992). Both treatments share the same goal: The active use of 12-Step programs as a means for the patient to remain clean and sober. While the techniques employed by both approaches are very similar, changes in TSF for Drug Abuse and Dependence reflect differences in the resources that are drawn upon for help.

From experience using the TSF manual for alcohol abuse and dependence with alcohol and cocaine addicted patients, (Carroll et al., 1997) the core topics have been added to and are delivered in a new order. The changes are reflected in the following table.

TSF (ALCOHOL)	TSF (DRUG)
1. Assessment	1. Introduction and Assessment
2. Acceptance	2. Acceptance
3. Surrender	3. People, Places, and Things
4. Getting Active	4. Surrender
	5. Getting Active

These changes were made because some patients appeared to experience difficulty processing the material on Surrender (Steps 2 and 3) so early in their recovery. Other patients needed to restructure their daily activities in order to maintain abstinence. As a result, the topic, "People, Places, and Things" was added to the core topics and the topic of Surrender is delivered later in treatment.

Another difference in the two TSF approaches is related to reference materials recommended to the patients. In TSF for alcohol, materials from Alcoholics Anonymous are recommended. In TSF for drugs, additional references from Narcotics Anonymous and Cocaine Anonymous programs are used.

In addition, this TSF manual for drug abuse and dependence now includes a topic on HIV Risk Reduction. This has been added to provide accurate information about this disease, couched in terms of 12-Step recovery. This module was originally developed for a study of treatment with civilian PTSD substance abusers and has been adapted for use with a general substance abuse population (Triffleman, et al., 1997).

Approaches Most Dissimilar to TSF

While it is important to recognize that all psychosocial treatments for drug abuse share a number of features and may overlap and closely resemble one another in several ways, there are some approaches which are more dissimilar to TSF.

TSF vs CBT

TSF, or disease model approaches, are dissimilar to Cognitive Behavioral Therapy (CBT), or learning model approaches, in a number of ways. TSF is grounded in the concept of drug addiction as a spiritual and medical disease. The content of this treatment is consistent with the Twelve Steps of NA/CA/AA, with the primary emphasis given to Steps 1 through 5. In addition to abstinence from all psychoactive substances patients are actively encouraged to attend self-help meetings and to maintain journals of their 12-Step group attendance and participation. While TSF and CBT share some concepts, for example the similarity between TSF's *people, places, and things*, and CBT's *high risk situations*, there are a number of important differences. While TSF is grounded in a conception of addiction as a disease that can be controlled but never cured, behavioral models see substance abuse as learned behavior that can be modified. While the learning model approaches emphasize self-control strategies, TSF emphasizes the patient's acceptance of loss of control over substance use and other aspects of life due to the disease of addiction and willingness to follow suggestions from 12-Step programs to recover from addiction. With CBT-like models, the focus is on what the patient can do to recognize the processes and habits that underlie and maintain substance use, and what can be done to change them. The major change agent in TSF is involvement in the fellowship of 12-Step programs such as NA/CA/AA and working the 12 Steps. TSF assists the patient in overcoming his/her resistance to accepting help and suggestions. Behavioral learning approaches teach coping skills to replace old, unsuccessful coping strategies the patient may have used in the past (i.e., using drugs to deal with negative affect.) Contrasts between TSF and CBT are also found in Table 2.1.

TSF vs IPT, SE

TSF is also different from interpersonal and short term dynamic approaches such as Interpersonal Psychotherapy (IPT), (Rounsaville & Carroll, 1993), or Supportive-Expressive Therapy (SE), (Luborsky,1984). IPT is based on the concept that many psychiatric disorders, including substance abuse and dependence, are intimately related to disorders in interpersonal functioning which may be associated with the onset or perpetuation of the disorder. IPT for substance dependence has four definitive characteristics: (1) adherence to a medical model of psychiatric disorders, (2) focus on the patient's difficulties in current interpersonal functioning, (3) brevity and consistency of focus, and (4) use of an exploratory stance by the therapist that is similar to that of supportive and expressive therapies. IPT and SE differ from TSF in several ways: TSF is a structured approach, whereas IPT is more exploratory. Extensive efforts are made in TSF to teach and encourage the patient to use the tools of 12-Step programs to address substance use as the primary problem, while the more exploratory approaches view substance use as a symptom of other difficulties

and conflicts. As a result, substance abuse may not receive direct attention. Contrasts between IPT and TSF are also found in Table 2.1.

Table 2.1

Contrasts Between TSF and Other Treatments

Adapted from: Carroll, K.M. (1997). Cognitive-Behavioral Coping Skills Treatment for Cocaine Dependence. Yale University Psychotherapy Development Center, NIDA P50 DA 09241.

	Twelve Step Facilitation (TSF)	Cognitive-Behavioral (CBT)
Goals of Treatment	Encourage patient to accept the diagnosis of addiction and understand addiction as a progressive, fatal disease. Facilitate patient's integration into NA/CA/AA.	Help patient master coping behavior as effective alternative to drug use. Increase patient's self-efficacy.
Approach	Medical/disease oriented	Behavioral
Agent of Change	Treatment Fellowship/Higher Power	Treatment Mastery of skills
Labelling	Labelling patient as <i>addict</i> is encouraged, as this label provides the framework for the treatment. Acceptance of the diagnosis is necessary, it determines a set of symptoms (e.g., loss of control, denial) and the steps required for recovery.	Labelling discouraged; drug abuse/dependence is conceived as overlearned behavior that can be broken down into a finite set of discrete problem situations and behaviors.
Control	Emphasis on loss of control. Patient cannot control drug use; as s/he has the disease, addiction, which s/he is powerless to control. Patient can control whether s/he has the next run, whether or not s/he uses NA/AA, whether or not patient harbors the idea that s/he can control drug use.	Emphasis on self-control. Patient makes decisions regarding drug use over which s/he has control. Patient can learn to understand and better control the decision-making process. Patient can exert self-control by choosing to engage in alternative behaviors.
Responsibility	Patient responsible for own sobriety, by <i>working</i> the 12-Step program.	Patient responsible for own behavior. Emphasis on enhancing self-efficacy through skills training.
Conception of Craving	Because of disease processes, patient's body will crave drugs periodically. First use will trigger craving.	Craving as conditioned response. Craving can be coped with and reduced through stimulus control, urge control, etc.

Motivational Enhancement (MET)**Interpersonal Therapy (IPT)**

Maximize patient's motivation and commitment to change his/her drug use.

Help patient develop more productive strategies for dealing with social and interpersonal problems associated with drug use.

Motivational

Brief dynamic

Patient
Readiness for change

Treatment
Acquisition of alternate strategies for meeting interpersonal needs

Labelling is strongly discouraged; alternative conceptions of drug use are accepted/encouraged.

Labelling strongly discouraged; drug use seen as highly individualized and related to interpersonal context.

Emphasis on choice.
Patient has full control over decision to alter drug use.

Emphasis on self-control and the function that drug use serves for the patient. Symptom of drug use seen as a method of controlling environment and others to get needs met.

Patient responsible for own choices.
Emphasis on autonomy, self-efficacy.

Patient responsible for own behavior.
Exploration of own role in interpersonal relationships.

Patient free to develop and capable of developing strategies for dealing with craving on his/her own.

Signal of unresolved interpersonal problem. Patient should begin to translate what triggered craving into underlying interpersonal problem.

Table 2.1 (cont.) Contrasts Between TSF and Other Treatments

	Twelve Step Facilitation (TSF)	Cognitive-Behavioral (CBT)
Strategies Addressing Ambivalence and Motivation	Remember last run. Addiction is a disease that motivates denial, educate patient re <i>sinister</i> aspects of disease. Current problems attributed to disease.	Positive/negative consequences of decisions to use or stay abstinent. Instill belief that effective coping will provide alternatives to drug use.
Patient's Response to Substance Use	External, uniform approach. Use NA/AA social network (call sponsor, go to a meeting). Remember slogans (eschews alternative strategies, because of denial). "Do not think you can control the consequences of use."	Individualized approach. Develop and use individualized set of coping strategies (challenge cognitions, problem-solve, etc.). Examine antecedents, behaviors, and consequences. "You can learn skills to avoid lapses and prevent lapses from becoming relapse."
Coping Behaviors	NA/AA fellowship/network constitute a ready-made set of strategies and the one preferred solution.	Individualized set of strategies, generalizable problem-solving approach. Specific training in drug refusal skills, urge control, altering cognitions, emergency planning, etc.
Cognitions	Generally interpreted as evidence of denial, e.g., "stinking thinking".	Identified, examined, and challenged; encourage alternative perceptions/cognitions.
Handling Resistance	Confrontation of denial, exhortation of acceptance of addiction.	Application of problem-solving. Reinforcement of even minimal positive steps.
Role of Spouse/S.O. in Treatment	Reduce enabling, facilitate detaching, seek support through Nar-Anon.	Reinforce positive behavior change.
Phone Calls/crises	Refer patient to NA sponsor. "Use the fellowship".	Encourage patient to implement coping and problem-solving strategies.
Level of Structure	Highly directive and structured	Moderately directive and structured

Motivational Enhancement (MET)	Interpersonal Therapy (IPT)
<p>Acknowledge validity of patient feelings, elicit self-motivational statements.</p> <p>Empathic listening, primacy of patient's choice. FRAME.</p>	<p>Challenge positive view of drug effects and emphasize deleterious effects by enumerating cost repeatedly. Emphasize authentic gratification patient will experience from improved interpersonal functioning.</p>
<p>Internal, individualized approach. Reviews progress, reviews/evaluates initial plan, renews motivation and commitment.</p>	<p>Explore interpersonal consequences of drug use and what needs were being met by using. Call attention to discrepancy between patient's goals and drug use.</p>
<p>"It's up to you whether you use or not."</p>	<p>"You feel more sociable when you're high, yet your cocaine use has alienated your family. What about that?"</p>
<p>Patient free to develop own coping strategies. Development of strategies encouraged, but not provided by therapist.</p>	<p>Patient free to develop own coping strategies. Development of strategies is encouraged, but not provided by therapist. Encouragements to use social supports instead of drugs.</p>
<p>Accepted as valid, met with exploration and reflection.</p>	<p>Exploration of effects of distorted thinking on interpersonal relationships is critical.</p>
<p>Reflection, empathy, reframing. Patient actively avoids evoking resistance.</p>	<p>Explored and interpreted in interpersonal context. Limited exploration of transference.</p>
<p>Facilitate patient's motivation to change drug use behavior.</p>	<p>Explore ways of providing support to patient. Exploration of relationship vis-a-vis drug use.</p>
<p>Meets patient's concerns with reflection.</p>	<p>Reinforce use of interpersonal contact instead of drugs in times of crisis. Encourage use of social supports.</p>
<p>Patient structured</p>	<p>Moderately directive and loosely structured</p>

3. Core Topics

In order to expose patients to key 12-Step concepts of drug dependence, therapists need to cover thoroughly all 5 core topics described in this chapter. These topics should be presented in the following order:

Topic 1: Introduction and Assessment

Topic 2: Acceptance

Topic 3: People, Places, and Things (Habits and Routines)

Topic 4: Surrender

Topic 5: Getting Active in 12-Step Programs

It may be necessary to refer back to the core topics from time to time throughout the treatment. Sometimes patients become complacent about their recovery and/or their denial may resurface. At these times the patient may be more vulnerable to relapse and review of core topics is essential in helping the patient maintain their abstinence. In addition, material presented by patients in later sessions may be best addressed by referring to concepts presented in the core topics. Therefore, once topics have been covered, it is important to draw on them, when appropriate, throughout the treatment.

Topic 1: Introduction and Assessment

The objectives of this session are to: (1) establish rapport with the patient; (2) introduce the patient to the NA view of drug abuse and dependence; (3) help the patient assess their level of drug involvement (including symptoms of dependency); (3) assess the patient's motivation for change and commitment to abstinence; (4) explain the 12-Step facilitation program; (5) attempt to engage the patient in active participation in 12-Step programs, (NA/CA/AA). The therapist asks questions, gathers information, builds a case for abstinence, and promotes involvement in 12-Step programs, *one day at a time*.

Establishing Rapport

The first session begins with the therapist establishing rapport with the patient. Why has the patient come at this time for help? Were there any outside pressures from job, family, or the law? How does then patient feel about coming for treatment? If the patient was mandated to come, what possible benefits could the patient derive from treatment? Give the patient an opportunity to tell his/her story.

Previous Treatment

By exploring the patient's past experience with treatment, how they benefited from treatment, and how much clean and sober time they had afterwards, the therapist may learn about possible obstacles in helping the patient, as well as, possible strengths and skills the patient may have to maintain abstinence. In the same way, information about the patient's past experiences with 12-Step recovery groups is also useful. Some patients have had positive experiences with both treatment and 12-Step groups, for others it has been mixed, and for others both treatment and 12-Step groups have been less than satisfying. By understanding the patient's previous experiences with 12-Step programs, the therapist can begin to adjust the treatment plan, tailoring the treatment to the specific needs/issues of the patient.

Let's look at a case example. A woman presents for treatment, having been referred by a hospital social worker. She is four months pregnant and using crack cocaine one to two times per week. During the initial part of the interview she states that she is grateful that the social worker gave her the referral because she felt too ashamed to ask for help. She states that two years ago she successfully completed a local 18 month residential treatment program and that she remained clean for 11 months after that. She has very positive feelings and thoughts about her experience with treatment and with the NA meetings she attended. She attributes her relapse to becoming re-involved romantically with her old boy friend, who was released from prison about a year ago. At first she resisted using cocaine, but gradually began to use. She stopped going to NA group meetings and stopped calling her NA friends. She feels too embarrassed to go back to her meetings. When asked about having a sponsor, she reports that she had good friends at NA, and never saw the need for a sponsor.

This patient presents several clues for the therapist. On the positive side, she has had the opportunity to learn and practice the tools of 12-Step recovery

programs, and that she feels good about her experience there. Potential areas for work would be overcoming her fear of returning to NA meetings, feelings of guilt and shame, embarrassment and looking at the toxic parts of her relationship with her boyfriend.

The therapist may begin by questioning the patient about his/her goals for and expectations of treatment. Some patients make no connection between recovery and accomplishing their goals, while others are very clear from the beginning that their goal is maintaining abstinence. Responses to this question give the therapist an opportunity to assess the patient's motivation for change.

Drug and Alcohol History

The comprehensive drug and alcohol history is taken in a format unique to TSF. Therapists introduce this section by advising the patient that completing this history will help them begin to make sense of what has happened in their life in relation to their use of drugs. It is an opportunity for the patient to tell his/her story. As the patient's story unfolds, look for patterns of increased amounts of drug use and/or an increase in the frequency of use. Pay attention to the losses the patient has experienced in his/her life associated with their use of mood-altering substances. The goal of this exercise is to help the patient connect their drug use with natural negative consequences. This "connecting the dots" helps lay the ground work for Step 1, admitting powerlessness and acknowledging unmanageability over drug use. The goal is to begin the breakdown of the patient's denial system. The therapist creates a table on which the pertinent information is written. The categories covered are: Age; Drug used (amount and frequency); Positive and Negative Consequences of Use; Major Life Events at this age (Figure 3.1).

Substance Use History			
AGE	TYPE OF DRUG AMOUNT USED HOW OFTEN	POSITIVE/NEGATIVE CONSEQUENCES	SIGNIFICANT EVENTS AT THIS TIME OF LIFE

Figure 3.1 (See Appendix 3.1).

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Patterns of Drug Use

The purpose of taking a drug and alcohol history is to take a look at the patient's relationship to mood-altering substances over the course of their lifetime by examining different periods of time. The TSF therapist begins with the age of earliest use, outside the home, and then progress by looking at different time periods. Typically, the TSF therapist would ask about a period of time three years after the initial use, and then ask about subsequent periods of time in five year intervals. For example, a patient entering treatment is 28 years old. She started using marijuana at age 12. The TSF therapist would start here, then go to age 15, then to age 20 (or late teens), then to age 25 (or early 20's). Finally, the TSF therapist would ask about the past year to get a sense of current use patterns and issues. At each age the TSF therapist would work across the table, asking about each of the categories. As this is done, patterns usually emerge.

Assess Use of All Mood-Altering Substances

When asking about drugs used, amount and frequency of use, include all mood-altering substances, including cocaine, alcohol, marijuana, etc. Also, note what substances might be taken in combination, for example: cocaine and alcohol, or cocaine and marijuana, or cocaine and heroin. Pay special attention to any increase in the amount and frequency of use, periods of time that the patient abstained from use or attempted to control their use. This information can illustrate the patient's "Loss of Control" over the use of mood-altering substances, which is one of the symptoms of the disease of addiction.

Positive and Negative Consequences

Use of mood-altering substances has positive and negative consequences. Examine these at each time period. Some patients are surprised that the therapist might ask about positive consequences of use. The reality is people would not start using mood-altering substances if it did not feel good. This section documents the quality of the relationship that the patient has with drugs. Typically, with drug use, the relationship starts out very positively with tremendous enjoyment by the patient. However, as drug use increases in amount and frequency, one often sees an increase in negative consequences (e.g., spend too much money, problems at work, problems at home, legal problems). These negative consequences are evidence of the "unmanageability" referred to in the first Step.

Examining major life events at different ages helps to place the patient's relationship with drugs in perspective. Substance use takes place in a context, it is not an isolated behavior. Major life events include questions like: where was the patient living; with whom; were they working or in school; what kind of worker or student were they; were they in a relationship; dating; what was their relationship with their family like; were there any major crises or events at that time; etc.?

Once the therapist has gathered all of this information, which for some patients may extend over several sessions, it is time to formally *connect the dots*. Looking at the history, ask the patient what sense they make of it. For some, this is the

Negative Consequences

first time they have looked at *the big picture* of how drug use has affected their life, and they may feel somewhat overwhelmed. Some may note that they knew things were not going well, but had not realized how early their use had started. Some will simply note their addiction. The therapist highlights the negative consequences from the use of drugs in the following areas:

PHYSICAL. Health problems, accidents, or injuries the patient may have experienced.

LEGAL. Arrests, with or without convictions, difficulties with child protection agencies, civil problems, law suits, etc.

SOCIAL. Loss of friends, family relationship problems, lack of supportive relationships, lack of social skills.

SEXUAL. Changes in sexual functioning, positive and negative, trading sex for drugs.

PSYCHOLOGICAL. Possible depression after drug use, shame and guilt about using despite the intention to remain abstinent.

FINANCIAL. Entire pay checks or entitlement checks spent on drugs.

Problems in these areas are clear evidence that the patient's life has become unmanageable.

Tolerance

Exploration of the amounts of drug used and the frequency of use yield clues to changes in the patient's tolerance to various drugs. Drug tolerance is the increased amount of a substance required to reach the same effect that was reached before with less of the drug. In other words, as tolerance for a drug increases, it takes more of the drug to reach the same effect that a smaller amount used to create. As you look at the patient's drug history, patterns of drug tolerance may begin to emerge. For example, some patients progress from weekend use to several times a week use, to daily use over a period of time. Others may keep their use to one to two days a week, but may use more of the drug on each occasion over a period of time. What is important to note is that an increase in tolerance is a symptom of the disease of addiction.

Loss of Control

Next, review the history for evidence of loss of control over the use of mood-altering substances. This includes:

- Repeated failed attempts to stop
- Repeated failed attempts to restrict or control use
- Protecting/hiding the drug supply
- Using alone
- Using within an hour or two of waking up
- Using before social occasions to get a *head start*

- Feeling upset or concerned if one's supply of drugs is low
- Using more than intended on a number of occasions
- Preoccupation with using
- Substance substitution

Summary

Using the evidence offered by the patient, usually the only logical conclusion is that the patient is drug dependent. Some patients have known that they had a problem, but lacking knowledge, never thought of themselves as addicts. Explain to the patient that addiction is a disease that is chronic (patient will remain an addict for the remainder of their life), progressive, and if left untreated, can be fatal. Because of the nature of the disease, once a person becomes an addict, they can never return to *safe* use of mood-altering substances. The progressive nature of the disease is noted in the patient's history of increasing losses and problems and increasing amounts and frequency of use over time. The good news is that drug dependence is treatable. The therapist needs to stress that what has worked best for most is to abstain from all mood-altering substances, *one day at a time*. In order to learn how to do this and to gain support to do this task, recommend that the patient make use of 12-Step recovery programs such as NA/CA/AA. This leads naturally and easily into contracting with the patient about participating in TSF therapy.

Overview of Treatment

TSF is a structured treatment program. Explain to the patient how many sessions to expect, over how many weeks. Depending on the needs of the clinic or project, this varies from as short as 12 sessions in 12 weeks, to 24 sessions over 24 weeks.

Objectives

Review with the patient the following objectives of treatment:

- Understanding the 12-Step view of drug abuse and dependence
- Understanding how NA/CA/AA "work"
- Understanding key 12-Step concepts
- Learning to use 12-Step programs as a resource for staying clean and sober, *one day at a time*

Responsibilities of Therapist

The therapist defines his/her role in TSF to the patient as one of both *coach* and *cheerleader*. The job of the TSF therapist is to educate the patient about 12-Step programs, to offer advice, support and encouragement to the patient for remaining clean and sober, *one day at a time*.

Responsibilities of Patient

The patient's responsibility is to attend all sessions, complete agreed upon recovery tasks, maintain a record his/her 12-Step program experience in a journal, honesty, open-mindedness, willingness, and most importantly, to focus staying clean and sober, *one day at a time*.

Recovery Tasks Meetings

In the final third of the session, give the patient a copy of appropriate 12-Step meeting schedules and teach them how to use them. With drug addiction, we have had good success with Alcoholics Anonymous Groups (AA), Cocaine Anonymous Groups (CA), and Narcotics Anonymous Groups (NA). Help the patient find a few meetings to attend. Some patients may be reluctant at first about attending meetings. Encourage these patients to try one meeting. Point out that some meetings are open to the general public. All that is required is that the patient go to the meeting, sit and listen, then report back to the therapist what s/he observed.

Journal

In TSF journal keeping is a highly structured activity. The key areas to cover in the journal are:

- NA/CA/AA meetings attended (dates/times/type of meeting)
- Reactions, thoughts, feelings about the meetings
- Reactions to reading materials
- Clean days
- Urges to use or thoughts about using and how they handled them
- Slips: where, when, with whom

Drug dependent patients come to treatment with varying levels of cognitive ability, depending on the recency or severity of their drug use. Some will write little or nothing in their journals, others will write copiously.

Ask the patient to bring the journal to each session to discuss it with the therapist.

Readings

Provide the patient with a packet of reading materials. With drug dependent patients, Narcotics Anonymous (Narcotics Anonymous, 1988) and Hope, Faith and Courage (Cocaine Anonymous, 1993) have been added to the original recommendations of Alcoholics Anonymous (Alcoholics Anonymous, 1981); Living Sober (Alcoholics Anonymous, 1975), and Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981). Suggest that the patient start reading Living Sober (pp. 1-7), and the first three chapters of Narcotics Anonymous (Narcotics Anonymous, 1988).

Ask the patient to begin reading these books, and make any specific suggestions

you like with respect to them, keeping in mind the patient's reading level and amount of time that can be reasonably devoted to reading.

Wrap-Up

The therapist should end this session by checking the patient's willingness to follow through on recovery tasks. Help patients to articulate any resistance you detect, and encourage them to do as much as they can, with primary emphasis on attending 12-Step meetings. Clinical judgement and therapeutic skill should be utilized to modify recovery tasks if necessary (for example, if written material appears to be above the patient's reading level, or if they have already done extensive reading).

Troubleshooting

The purpose of the first session is to engage the patient's interest in voluntarily committing to this 12-Step facilitation program. Approaches that utilize excessive pressure, threat, or coercion toward this are likely to elicit a false commitment from the patient at best. This false commitment is called "compliance". The compliant patient is "talking the talk" of recovery, but is not "walking the walk" of recovery, in the sense of being truly motivated to give the fellowship of 12-Step programs an honest try. In this treatment, the therapist is advised to take a direct, non-judgemental, and educative approach to confrontation. Stick to the facts as you see them, and do not allow yourself to be talked out of your interpretation of those facts. At the same time, respect the patient's resistance to the idea of being powerless over mood-altering substances.

The history of drug use, along with symptomatology (tolerance, etc.) and an understanding of the process of addiction should be relied on consistently as the basis for directly confronting patients with their current situation. The therapist who is convinced that addiction is a disease process should have confidence that drug dependent patients have struggled to control their use and should attempt to elicit evidence of this in a direct yet supportive and empathetic way. Similarly, slips can be discussed frankly and sympathetically as the result of a disease that is more powerful than individual willpower.

Faced with resistant patients, the therapist should attempt to provide feedback to them regarding:

- How their life is becoming increasingly unmanageable due to drug abuse.
- How individual efforts have not proven effective in stopping or controlling drug use over the long run.

Resist temptations to be distracted from the main subject of this treatment, which is the patient's drug use and NA/CA/AA. Remember that the goal here is facilitation of the patient into 12-Step recovery programs. Concurrent problems (e.g., marital, job, depression, posttraumatic stress) can be handled initially by encouraging the patient to make use of 12-Step program resources such as meetings, recovering peers, sponsors, and social events.

For patients who have a difficult time understanding the concept of *powerlessness* as it applies to drug use, reading the story excerpted from the “Big Book” might be helpful:

“Our behavior is as absurd and incomprehensible with respect to the first drink (first use) as that of an individual with a passion, say for jay-walking. He gets a thrill out of skipping in front of fast-moving vehicles. He enjoys himself for a few years in spite of friendly warnings. Up to this point, you would label him as a foolish chap having queer ideas of fun. Luck then deserts him and he is slightly injured several times in succession. You would expect to see him, if he were normal, to cut it out. Presently he is hit again and this time has a fractured skull. Within a week after leaving the hospital a passing car breaks his arm. He tells you he has decided to stop jay-walking for good; but within a few weeks he breaks both legs.

“On through the years his conduct continues, accompanied by his continual promises to be careful or to keep off the streets altogether. Finally, he can no longer work, his wife gets a divorce, and his friends laugh at him. He tries his best to get the jay-walking idea out of his head. But the day comes when he races in front of a fire engine, which breaks his back.

“The fact is that alcoholics (drug dependent persons), for unknown reasons, have lost the power of choice in drinking (drug use). Their so-called willpower becomes practically non-existent. They are without defense against taking the first drink (use).” (p. 37)

Follow this up by engaging the patient in a discussion of this story, asking questions like:

“Can you relate to the idea of ‘compulsion’ that is presented in this story?”

“Would you say that jay-walking was ‘out of control’ in this case?”

“Have you known anyone who had a compulsion or an obsession that they couldn’t control?”

“Can you see how some people are as out of control of their drug use as this man was out of control of his jay-walking?”

NOTE: In approaching drug dependent patients using this treatment, it is important that the therapist accept addiction as a no-fault illness. In other words, consider addiction to be a disease to which individuals are genetically predisposed. It is not their fault that they have either the predisposition or the illness itself; therefore, guilt over being drug dependent is as inappropriate as guilt over having heart disease or diabetes. There is also no cure for drug addiction; rather, there is only a method for arresting the process, which is active participation in 12-Step programs.

While drug dependent patients are not responsible for their illness, they are

responsible for their recovery. Addicts cannot blame anyone else for their illness or assign responsibility to anyone else for their recovery.

Topic 2: Acceptance (Step 1)

Following Topic 1, all core topics and elective topics will follow the format reviewed in Chapter 1: one-third of the session for a review of the previous week and of previously assigned recovery tasks; one-third of the session for presenting and discussing new material; and one-third of the session devoted to preparing for the coming week and suggesting recovery tasks.

Review

Journal Meetings

The review at the beginning of each session becomes part of the reinforcement to the patient about the importance of involvement in 12-Step programs. Begin by asking the patient if s/he kept a journal. If so, what parts would they be willing to share with the therapist? If they did not keep a journal, what made it difficult to do so? Did the patient attend any 12-Step meetings? At this early point in treatment, simply praise any efforts that patients make in meeting attendance or respectfully ask what barriers kept them from attending.

Urges Slips 12-Step Tools

Did the patient experience any urges or thoughts about using? If so, what did they do about them? Praise any efforts on the patient's part to stay clean and sober. This may provide an opportunity to talk about making use of 12-Step tools (e.g., phone calls, going to meetings). Did the patient use any drugs? If so, explore with the patient the antecedents to use and what the patient did to stop using. Praise the patient for their honesty and willingness to continue treatment.

The review at the beginning of each session becomes a part of the structure expected by patients. Some patients have made sure that they attended a meeting during the week because they didn't want to "disappoint" the therapist. Others will come in and automatically begin reporting on their *recovery week*, meaning what their efforts have been towards staying clean and sober since the last session. By beginning the session this way TSF maintains a clear focus on therapy being the business of working a recovery program.

New Material

This topic introduces the first Step of 12-Step programs and the key concepts of Powerlessness (and limitation), Unmanageability, and Denial (versus acceptance).

Step 1

Write the first Step on a board or flip chart and read it aloud. The first Step of NA, for example, is:

*"We admitted that we were **powerless** over our addiction and that our lives had become **unmanageable**."*

we

Ask the patient what this means to them. Listen carefully. Some patients may respond that they think it means that they are *helpless* over their addiction and insist that they are still in control, or that they cannot change. Others may not see any connection between their use and the unmanageability in their lives. Begin by breaking the Step down into **key words**. The first word of the first Step is “we”. 12-Step programs work on inter-dependence among members. People get better by helping each other. One slogan from 12-Step programs that reflects this nicely is that “You alone can do it, but you can’t do it alone”. Each recovering person is responsible to make the needed efforts to stay clean and sober, but they have the support of every other recovering person.

powerless

The next key word in the first Step is “powerless”. Rephrase this concept to accepting a “limitation”. Everyone is faced with accepting limitations of one kind or another on a daily basis. Ask the patient what kind of limitations they have had to face in their life. Most will come up with several examples. In this case, the limitation is that the patient can no longer use drugs *safely*. Most patients are experts on how to use drugs, however, they can no longer use safely. Does the patient believe that s/he can still control his/her use? This concept seems easily grasped by most patients. While they are powerless over the fact that they can no longer use safely, they have the power to do something about it. This is the paradox of accepting “powerlessness”. How does it feel to be powerless? Anger and sadness are common responses. Ask the patient if they have ever accepted a limitation in another part of their life. What was that like? What were their thoughts and feelings about that experience?

unmanageability

Move next to talking about the “unmanageability” in the patient’s life. For those patients who resist the idea of their lives becoming unmanageable, review the history of their drug use from Topic 1. Unmanageability is all of the negative consequences that have occurred throughout the patient’s career of substance use.

Grief Process

Explain to the patient that the natural human response to facing *powerlessness* and *unmanageability* is grief. The first stage of the grief process is denial. As one moves through the process of acceptance of being “powerless” the stages that one experiences are similar to those of accepting loss. This explanation helps to humanize the experience of denial with the patient. Outline the stages of grieving and assure the patient that this is a process with movement back and forth among the stages, and that 12-Step programs help with this.

STAGES OF GRIEF

Denial

Anger

Sadness/sorrow/depression

Bargaining

Acceptance

Denial

Explore with the patient how they have used denial in relation to their disease by reviewing the following examples of denial:

- Simple Denial
 - Refusing to discuss drug use
 - Resisting doing a serious drug use history
 - Refusing to acknowledge the real consequences of using
 - Rejecting clear evidence of tolerance
 - Refusing to go to 12-Step meetings
- Minimizing one's own use and maximizing others' use
- Avoidance through sleep, isolation, other compulsive behavior, work
- Rationalizing or finding excuses to use
- Distracting or changing the topic away from one's drug use
- Contrasting self with others, believing, "I'm different"
- Pseudo choice or "I really wanted to experience those negative consequences!"
- Bargaining to placate self or others

Next ask the patient how s/he has used denial and make a list on a flip chart or board. This is a good point to talk about the dual nature of addiction. Drawing a rough outline of a person, indicate one part, a small part, that wants recovery today, then indicate another part, much larger, that pulls the person to want to use drugs. This much larger part is composed of many *voices* that talk to the patient or the *Anti-recovery Committee*. Ask the patient what messages that s/he gives him/herself about using. Note these next to the figure on the using side. This is a catalog of the patient's denial. The *Anti-recovery Committee* never completely goes away. An NA slogan is that "While I am in the rooms getting recovery, my disease is in the parking lot doing push-ups!" The job of recovery is to strengthen the recovering part, the human part. Ask the patient how s/he can do this. Suggest that 12-Step programs offer support and positive messages about recovery and living.

At this point, review the stages of acceptance and ask the patient to pick where they fit relative to these stages and to identify where they are in the process of denial versus acceptance.

STAGES OF ACCEPTANCE

Stage One: I have a problem with drugs.

Stage Two: Using is gradually making my life more difficult and is causing problems for me.

Stage Three: Since I have lost my ability to effectively limit my use of drugs, the only alternative that makes sense is to give them up.

Summarize this portion of the session with a brief recap of how 12-Step programs view the disease of addiction:

There is no cure, only recovery.

Abstinence — *one day at a time* — is the only option that works.

Self-reliance and willpower are not enough. The support of peers is vital.

Remind the patient that the goal of 12-Step programs is to maintain abstinence by avoiding the first use, *one day at a time*.

Recovery Tasks

Meetings Journal Readings

The last third of the session focuses on what recovery tasks the patient will do during the week. Contract with the patient about which specific 12-Step meetings they will attend during the week. Remind them to keep their journal and ask them to answer the questions on the “First Step Worksheet” handout (see Figure 3.2).

Suggested readings include:

The Narcotics Anonymous Recovery Text (Narcotics Anonymous, 1988, pp. 17–22)

Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981, pp. 21–24)

Living Sober (Alcoholics Anonymous, 1975, pp. 7–10)

Alcoholics Anonymous (Alcoholics Anonymous, 1976), “The Doctor’s Opinion” (p. xxiii), “Bill’s Story” (p. 1), and “More About Alcoholism” (p. 30)

First Step Worksheet

First Step Worksheet

The first step of NA/CA/AA suggests that:

“We admitted we were powerless over our addiction, that our lives had become unmanageable.”

Experience has shown that people who have been able to remain clean and sober have come to terms with this statement as it applies to their lives. In order to assist you in taking this step, try *honestly* answering the following questions in your journal. After that, discuss these with your sponsor (if you have one) or your Twelve Step Therapist.

The first thing is to admit *powerlessness*, or, in other words, to say “I can’t control my use of drugs, or the consequences of my use of drugs.”

- How have drugs placed your life, or the lives of others, in jeopardy?
- How have you lost self-respect due to your drug use?
- How have you tried to control your use of drugs?
- What types of physical abuse have happened to you, or others, as a result of your drug use?
- Are you happy with yourself about your alcohol/drug use?

Next, it is important to honestly look at how the consequences of our drug use have affected us. This is “connecting the dots”. When I use, this is what happens. Looking back over your drug use career:

- What health problems have you had?
- What family/personal problems have you had?
- What sexual problems have you had?
- What legal problems have you had?
- What financial problems have you had?
- What work problems have you had?

Remember that “loss of control” (powerlessness) and problems (unmanageability) are symptoms of the disease of drug dependence. In order to recover, people have admitted their limitations and accepted that the solution is to be open to support from others (NA/CA/AA) and to stay away from the first use, *one day at a time!*

Figure 3.2 (See Appendix 3.2).

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Wrap-Up

Before ending the session, ask the patient what they understood to be the gist of the session. Then ask them if they understand the recovery task assignments and ask for their commitment to follow through on them.

Troubleshooting

Once the concept of denial is presented, slips and resistance to getting involved in 12-Step programs can be interpreted in this light. These interpretations should be made frankly and repeatedly, though non-judgementally. One approach to denial regards it as a normal part of the grief process. People seem to be naturally predisposed to deny losses and limitations, and drug dependence represents both. Here are some examples of interpretations that reflect this point of view:

“I think that part of your unwillingness to go to meetings is denial. I think there’s a part of you that does not want to accept this limitation —

that you are drug dependent and you have to give up using drugs. That part of you wants you to avoid going to an NA/CA/AA meeting.”

“You slipped because you fooled yourself into thinking you were safe. So you met with your old friends, thinking you could do that and not use.”

“The part of you that wants to deny your addiction tells you that you can control your use, that it was okay for you to use at XX’s party. You fooled yourself into believing that you could limit your use, because you wanted to believe that.”

“I know you don’t like to hear this, but I see your denial at work again. The part of you that still wants to use — that doesn’t want to let go of drugs was telling you that you could use just a little, and that you would be able to stop there, even though experience proves you can’t.”

A second way of conceptualizing denial is to think of it as “insanity” as that word is used in 12-Step programs. Addiction as a form of insanity is implied in Step 2 (“Came to believe that a Power greater than ourselves could restore us to sanity”). The form of insanity involved in addiction is the addict’s belief (delusional because it flies in the face of experience) that they can use safely.

Addiction has been described as an illness of the mind as much as an illness of the body. The addict rationalizes using and creates an illusion of choice when, in fact, using is an obsession that leaves no room for free will or conscious (rational) choice. From this perspective, resistance to accepting a diagnosis of addiction or of continuing to think and act in ways that promote using are aspects of addiction itself, just as much as physical tolerance is. The therapist can interpret resistance in these terms as follows:

“Addiction is in fact an illness — an illness of the mind and of the body. It affects you physically — for example, you’ve had heart palpitations from cocaine. It also affects you mentally — in the way you think, even when you’re clean. When you went to that party last weekend, you convinced yourself that it would be okay to use as long as you used only at the party. Then you went home and continued using until you passed out. That’s the illness at work. It’s called ‘stinking thinking’ in 12-Step programs.”

“From the 12-Step point of view, that fact that you don’t want to go to meetings is just another symptom of the illness. You know from experience that once you start using you can’t stop until you run out of money or pass out, but you continue to convince yourself that you really don’t have this obsession or that you can control it in some way when the facts speak to the contrary.”

Finally, some therapists may find it helpful to approach denial by viewing it as an internal conflict. The addict can be thought of as someone who has a “dual personality”: the part of the self that wants to stay clean and enjoys clean and sober consciousness and clean and sober living (the recovering personality) versus the part that resists the idea of limitation, craves drugs, and will do anything to get them (the addict personality). Recovery represents an ongoing

struggle between these two forces within the drug dependent patient. The therapist needs to ally with the recovering personality and assist the patient in strengthening it, while confronting the addict personality consistently but with respect and compassion. Keep this phrase in mind throughout treatment: *Denial never sleeps*. Recovery demands eternal vigilance, which is what active involvement in a 12-Step recovery program can provide.

In order to align effectively with the recovering personality within the patient, the therapist must recognize the following facts:

- Addiction is more powerful than the patient's individual willpower alone, so the addictive personality and denial will inevitably win out if the patient chooses to fight them without help in the form of a 12-Step program.
- It is normal human tendency to resist accepting limitation and to test limitation. This is deadly to the addict in the long run.

The addict personality is cunning and clever and will make every effort to lower the defenses of the recovering personality by trying to convince the addict that s/he is safe (no longer needs NA/CA/AA or can use safely). Some have compared being in recovery to walking up a down escalator: As soon as addicts stop working a recovery program, the illness will begin bringing them down. Alternatively, it could be said that recovery requires eternal vigilance.

Topic 3: People, Places, and Things (Habits and Routines)

Review

Journal Meetings

As in previous sessions, ask if the patient has kept a journal. If so, ask if they are willing to share parts of it. Did the patient attend any 12-Step meetings? If they did attend, discuss their reactions. This therapy is based on the belief that the best way for the patient to remain clean and sober is through active involvement in 12-Step recovery programs. Take time to help the patient make sense of their experience at 12-Step group meetings. If the patient failed to attend 12-Step meetings, explore their resistance. What interfered with their ability to access this resource for recovery? Some patients may act out their denial by failing to attend agreed upon meetings. When confronting denial remember to separate the person from their disease. Constructively point out how their failure to follow through with commitments is symptomatic of the disease of addiction.

Readings

Next, review the patient's reactions or thoughts about any assigned readings or recovery activities. Could the patient relate to any of the material? Some patients see themselves as different from others in 12-Step programs because they have not experienced the losses they hear or read about. The slogan "Y.E.T." is fitting in this instance. This stands for "You're Eligible Too!", meaning that anyone with this disease, who continues to use drugs, will continue to experience progressively more severe symptoms/problems. Encourage patients to keep an open mind about what they hear or read.

Urges

Ask the patient if they experienced any thoughts about using or cravings to use. In early recovery from drug addiction strong cravings are common. How does the patient experience cravings (e.g., physical signs, thoughts, feelings)? How did the patient manage their cravings? Did they use any 12-Step tools? Offer support for all positive efforts made to avoid that first use of drugs. If needed, suggest other 12-Step tools such as calling other recovering peers, keeping to a routine schedule of meetings, putting off using and getting busy with safe activities, etc.

Slips

If the patient relapsed, or continued active use, review the events that occurred prior to use. What set off this behavior? Be sure to congratulate the patient for stopping, returning to treatment and being honest with the therapist. Review what role the patient's denial may have played in relapse or continued use. If

necessary, return to review Step 1 and acceptance. At any time in the treatment process, it is reasonable to review the first Step with the patient.

Getting Active

Ask about what efforts the patient has made in becoming actively involved with 12-Step programs. What efforts have they made at obtaining a sponsor? Have they committed to any service work, participated in any social activities, obtained any new phone numbers or called any recovering peers? Be sure to congratulate the patient for each clean day since the last session.

New Material

The new material for this session deals with the pragmatic details of changing one's lifestyle. Adages in 12-Step programs are that "if nothing changes, nothing changes" and "avoid slippery people, slippery places, and slippery things, unless you want to slip". There are often powerful people, places, and things (habits and routines) connected with drug use. By identifying those people, places and things (habits or routines) that are dangerous to recovery and exploring new people, places and things that can be put in place that support recovery, the patient can begin to develop a plan for making concrete behavioral changes.

Lifestyle Contract

The heart of this session is the "Lifestyle Contract" (see Figure 3.3), a table with four columns and three rows. In the left two columns are those things which are dangerous to recovery or do not support recovery. In the right two columns are those things which support recovery and are healthy for recovery. The rows are people, places, and things (routines, habits). If the patient is currently abstinent, ask about those people, places and things that used to be dangerous. For those who are currently struggling with being clean and sober, ask who, where, and what the current dangers are to recovery. Be specific. For example, list people by first name. Name as many as necessary, prompting the patient to think of any one else. Be specific about places and habits, routines and rituals. Once the patient has exhausted all possibilities on the dangerous side, list those people, places, and things (habits, routines, and rituals) that are supportive of recovery. In early recovery from drug abuse or dependence, this list is typically short. By posting these on a board or flip chart the weight of the negative lifestyle can be dramatically seen by the patient. What then can the patient do to shift this balance and fill the void left by abandoning dangerous people, places, and things? As part of this topic's recovery tasks, contract with the patient to identify one new positive person, place and activity to shift the balance away from danger.

Lifestyle Contract			
DANGEROUS TO RECOVERY (What needs to be given up)	PATIENT'S FEELINGS ABOUT DANGERS	SUPPORTS RECOVERY (What needs to be substituted)	PATIENT'S FEELINGS ABOUT SUPPORTS
People			
Places			
Things (Rituals/routines)			

Figure 3.3 (See Appendix 3.3).

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Recovery Tasks

Lifestyle Contract

Meetings

Journal

Readings

The last part of the session focuses on the recovery tasks the patient will do during the upcoming week. Remind the patient of the three things they agreed to do to actively change their lifestyle during the exercise and get a commitment from them about specific 12-Step meetings they will attend during the week. Remind them to keep their journal. Suggested readings include:

Narcotics Anonymous (Narcotics Anonymous, 1998, pp. 84–96)

Living Sober (Alcoholics Anonymous, 1975; chapters “Changing Old Routines”, “Being Wary of Drinking Occasions”, and “Is it Necessary to Give Up Old Companions and Habits?”)

Wrap-Up

Wrap up the session by asking the patient what they understood to be the gist of the session. Then ask them if they understood the recovery task assignments and get their commitment to following through with them.

Troubleshooting

An issue that may arise doing this exercise is the patient’s resistance to letting go of some of those things listed on the dangerous side of the chart. Be sensitive to the process of letting go and grieving the past. Even though, for example, some people may be dangerous to a person’s recovery, they have also been a source of companionship. Some individuals, like spouses and lovers, may straddle the chart. Take time to explore what about the patient’s

relationship with these people makes recovery difficult or what about it supports recovery? If the patient's own home is dangerous to recovery, what can the patient do to change this? Does the patient need to leave this situation? Often, drug dependent patients live in toxic situations with cohorts who are also addicted or abusive. This exercise heightens the awareness of this conflict for some patients. What achievable goal can the patient work on to shift the balance towards recovery?

Topic 4: Surrender (Steps 2 and 3)

Review

Journal Meetings

Begin the session with a review of the patient's recovery week. Ask the patient if there is any part of their journal that they wish to share. If they have not kept a journal, explore what obstacles prevent them from doing so. Did the patient experience any urges to use, and/or follow through on keeping their commitments to attend 12-Step meetings? Explore any resistance to or avoidance of meetings. How might this be a reflection of denial? Some patients present the situation of putting others' needs and wants ahead of their own needs and wants. In this situation, the therapist may want to remind the patient that recovery must come first. If the patient returns to use, then any plans or hopes for the future are for naught. The 12-Step adage to put "first things first" is appropriate here. Another slogan from 12-Step programs is "whatever you put in front of your recovery is the first thing you lose".

Recovery Tasks

Urges

Slips

12-Step Tools

Review any reactions that the patient has from the previous session recovery task assignments. Did the patient follow through? What got in their way of trying to add new people, places and things for recovery? Did the patient "slip"? If so, explore the antecedents in terms of "stinking thinking", denial, and dangerous people, places, and things. What 12-Step tools might have helped the patient? Has the patient made efforts to collect and use phone numbers of recovering peers? Have they established a routine for attending 12-Step meetings on a regular basis? What strategies to delay the first use of drugs did they apply? What have they learned from this? How many clean and sober days did the patient accomplish? Congratulate all efforts made by the patient towards recovery.

New Material

The new material is about the process of surrender, Steps 2 and 3 of the 12 Steps. Step 1, which deals with "powerlessness" and "unmanageability" can be phrased as "I can't handle it". Step 2 deals with belief that someone or something more powerful than the individual can help. Step 3 states that one is going to allow an outside force to help.

Some patients are very wary of the spiritual part of 12-Step programs. By this point in treatment, they may have already mentioned some of their concerns. This topic allows a structure for discussion of these concerns. Begin with Step 2:

"Came to believe that a power greater than ourselves could restore us to sanity."

Ask the patient what the words mean to them. Reassure the patient that 12-Step fellowships are open to people of all beliefs and backgrounds, including atheists and agnostics.

Step 2

came to believe

spirituality

As with the first Step, break Step 2 down into its **key concepts**. The action of the Step is “Came to believe”. Explore with the patient their beliefs. What are the nature and qualities of their “higher power”? How did they come to this belief? In what religious background was the patient raised? Has this been a positive or negative experience in their life? If they don’t have a belief, what would they be open to exploring or trying? What is the patient’s definition of spirituality? At this point the therapist may want to differentiate between *spirituality* and religious belief. One possible definition of *spirituality* is: What gives a person a sense of purpose in their life. The process of becoming more spiritual is discussed in Alcoholics Anonymous (Alcoholics Anonymous, 1976, pp. 569–570). Some patients may feel ashamed and guilty about past behaviors that they do not believe that anyone or anything would care about their welfare. Others may be angry because of the traumatic events in their life. The therapist needs to be prepared and open to whatever issues patients present. Remind the patient that recovery is a process that takes place over time. They may not believe today, but remain open to the possibility that they may come to believe in the future.

power greater than ourselves

Next explore ideas about what a “power greater than ourselves” means to the patient. What forces outside of themselves have been more powerful than they? Did they ever have people that they looked up to or admired? What did they admire or respect about those people? What “higher powers” have been benign and loving? Share with the patient that recovery from addictions works best when it is *with* and *through* other people. The appropriate slogan is, “We alone can do it, but we can’t do it alone”. Explore with the patient what their relationship with their “higher power” is like? When was the last time the patient used prayer or meditation to help themselves? Does the patient want help? Does the patient believe s/he can be helped? Does the patient believe that he is worth helping? What is the patient’s experience with asking for help?

restore us to sanity

The last key phrase of this Step is to “restore us to sanity”. Does this mean that addicts are insane? What were some of the “insane” behaviors that the patient engaged in while actively using drugs. These are all examples of “unmanageability” from Step 1. Some examples of the insanity of drug addiction are the poor decisions people make regarding managing their lives, the stubborn belief that they can stay in recovery without help (arrogance), and the sense of false pride that they don’t need others advice or help (defiance). One definition for “insanity” that comes from 12-Step programs is “continuing old behaviors and expecting new results”.

Tying this all together, who then is responsible for restoring the addict to sanity? Clearly, the Step states that it is the job of one’s *higher power*. What is required in Step 2 is the *belief* that this can happen.

Step 3

As mentioned above, Step 3 has to do with allowing someone or something to help:

“Made a decision to turn our will and our lives over to the care of God,
— as we understood him.”

Write Step 3 on a board or flip-chart and read it aloud. What reactions or thoughts does the patient have to this Step? The third Step is an action step. Like a key opening a locked door, moving away from the destruction, hopelessness and despair of addiction towards the hope and opportunity of recovery. The patient’s willingness to work this Step is demonstrated by their ability to accept and follow the suggestions of others about recovery. This may mean going to meetings and changing old habits and routines. Turning one’s will over to the care of a *higher power* does not mean that God will take care of everything in one’s life. It does mean that one will be presented with opportunities to take care of oneself. The individual is responsible for taking advantage of those opportunities to help him/herself.

made a decision

Discuss the **key phrases** in the Step and discuss the meaning of each. The action of the Step is that we “Made a decision”. While in Step 2 it was a process of coming to believe, here it is an action of decision. The decision is to trust one’s life to someone or something outside themselves. This decision is made repeatedly throughout recovery. This is a conscious and deliberate decision on the part of the patient.

turn our will and our lives over

The next key phrase is to “turn our will and our lives over”. This is what is meant in 12-Step programs by “turning it over”. What has the patient’s experience been with trusting others? Have they ever followed another’s advice? How did that turn out? How does the patient decide who is trustworthy and who is not? What does the idea of “turning over” your will mean to the patient? Ask the patient if they believe that the experience of other addicts and alcoholics can have any relevance for them. Part of recovery may involve following a “common wisdom” such as that found in the 12 Steps. Working this Step means setting aside one’s will as it applies to using, and being open to following the suggestions of others about staying clean and sober. Some patients have major therapeutic issues around trust due to past traumas and may require more time and care with this Step (Baker and Triffleman, 1998).

care of God, as we understood Him

The final key phrase is that one’s will is turned over to the, “care of God, as we understood Him”. Depending on personal experience, some people have a more caring concept of God than others. One suggestion for newcomers is to consider the possibility that the 12-Step recovery groups act as their “higher power” at first.

Recovery Tasks

Meetings Journal Readings

Recovery tasks for this topic include readings from Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981, pp. 25–33, 34–41), Alcoholics Anonymous (Alcoholics Anonymous, 1976), “There is a Solution” (p. 17), “We Agnostics” (p. 44), “Spiritual Awakening” (p. 569), Narcotics Anonymous (Narcotics Anonymous, 1988, pp. 22–26), and Living Sober (Alcoholics Anonymous, 1975, pp. 77–87). Contract with the patient about what 12-Step group meetings they will attend between sessions, remind them to keep their journal and assign appropriate readings. The hand out on “Thinking about a Spiritual *vs* a Non-spiritual Way of Living” (Figure 3.4) also makes a good reading assignment for recovery tasks, or may be covered in a session as part of the new material for that week.

Spirituality Worksheet

Thinking about a Spiritual *vs* a Non-spiritual Way of Living

Spirituality has to do with meaning and purpose in life; what it means to be human, who we are, why we are here.

Spirituality does NOT mean mysticism or spiritualism, or an Eastern religious practice.

It is NOT a set fo rules about what is good and bad, right and wrong.

It is NOT church doctrine or religious belief.

Spirituality is a way of life, a way of thinking, that helps sobriety.

The following is a comparison of non-spiritual *vs* a spiritual way of living and thinking:

	NON-SPIRITUAL	SPIRITUAL
VALUE	Things	People
THE GOAL IS	Acquire Things	Good Relationships
THE GOOD LIFE IS	Money	Friends
GET THE GOOD LIFE BY	Competing and Getting	Caring and Giving
GET SELF-WORTH THROUGH	Doing Being Perfect Success	Being (Who I am as a person) Being Human (Accepting my limits and dependence) Faithfulness

Figure 3.4 (See Appendix 3.4).

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Wrap-Up

Ask the patient to summarize the session and contract to follow through on their commitment to complete the agreed upon recovery tasks.

Troubleshooting

Again, when presenting material in Steps 1, 2 and 3, the best therapeutic stance is frank but non-judgemental. The therapist must believe in the illness model of addiction: that drug addiction is an illness affecting the body, mind, and spirit. The therapist must be prepared, however, for the patient to resist these ideas. Patients may criticize or demean NA/CA/AA and the 12 Steps or may attempt to draw the therapist into a discussion (or argument or debate) about whether addiction is really an illness or whether or not controlled use is possible. They may attempt to change the agenda of this program, for example, to make it into marital therapy or psychodynamic psychotherapy. The therapist is advised not to enter into such debates, not to react defensively to criticism, and not to get off the track of the program. Keep the following in mind:

- The objective of this treatment is facilitation of the patient's active involvement with 12-Step programs.
- The therapist does not need to defend NA/CA/AA — it does very well on its own and will continue to whether or not this particular patient believes in it.
- Believing that the 12 Steps can help, or in a Higher Power may be less important than simply going to meetings, which should be the first goal.
- Addiction is a powerful and cunning illness, and patients may just insist on doing it their way for now.
- Every clean and sober day (and sometimes every clean and sober hour) is important and should be recognized. Whenever you are confronted with a slip, think about how many clean and sober days (hours) the patient has had since seeing you last.
- Addiction is an illness that defeats the will and causes addicts to regress, becoming more and more infantile (impulsive, self-centered) and difficult to deal with over time. It is important to separate the illness from the person it affects.

Topic 5: Getting Active in 12-Step Programs

Review

Journal Meetings Slips Urges 12-Step Tools

Begin the session with a review of the patient's *recovery week*. Be sure to cover keeping a journal, attending agreed upon meetings, following through with readings and other activities. Does the patient have any thoughts about the material on spirituality or Steps 2 and 3 covered over the past sessions? Did the patient slip? If so, process this as in past sessions. How is the patient's slip connected to their unwillingness to follow suggestions from 12-Step programs? What can they learn from their experience. What 12-Step tools are available? Has the patient experienced any urges or thoughts about using? What were the antecedents to the thoughts or urges? How have they handled these? What 12-Step tools may help (e.g., phone calls, meetings, delaying the first drug use)? How many clean and sober days have they had? How many consecutive days? Congratulate the patient for each clean and sober day. By this point in treatment patients tend to be very well versed in the flow of the session.

New Material

The point of this session is that just stopping drug use is not enough. This leaves a void in a person's life that needs to be filled.

"Just stopping drinking (using) 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 our drinking (using) a positive program of action." (*Living Sober*, Alcoholics Anonymous, 1975, p. 13)

Getting Involved

Addiction to drugs is a disease that erodes all parts of a person's life: mental abilities, emotional well being, physical well-being, social relationships, spiritual well-being, and willpower. Recovery, then, needs to address each of these parts. Getting involved in 12-Step programs and following the suggestions of what has been helpful to other addicts seems to be what has worked the best for most.

Simply stopping use with out changing one's lifestyle, beliefs or attitudes leaves an addict vulnerable to relapse. Explain the difference between "white knuckle" abstinence and sobriety with a recovery program. White knuckle abstinence refers to someone who has stopped use, but is still unhappy because they are carrying around resentments and self-pity from the past. Often addicts can go for long stretches without using, but because they do not have the tools of 12-Step recovery, are more vulnerable to relapse when life presents a stressful situation. Sobriety with a program of recovery offers an opportunity to learn

about living life on life's terms with out unnecessary feelings of resentment and self-pity. Ask the patient if they have noticed people in different stages of recovery at 12-Step meetings. What is the difference between those who have surrendered and are willing to follow suggestions and those who are still struggling with acceptance? Encourage the patient to *stick with the winners* in 12-Step programs. The patient's job is to learn from those who have recovered.

Another danger is growing complacent about recovery. This phenomenon is common in early recovery. Some 12-Steppers refer to it as being on a "pink cloud". The danger is that after a period of abstinence the person relaxes their participation in 12-Step recovery efforts (i.e., cutting back on the number of meetings they attend or allowing other activities, like work, to take precedence over recovery). This leaves a person vulnerable to relapse.

As mentioned in the material on Step 3, simply believing that a "higher power" can help is not enough. Each person is responsible for their own recovery. Put another way, "faith without works is dead". Explain to the patient that getting active in 12-Step programs, in part, involves going to meetings, making use of telephone therapy, and making use of a sponsor.

Participation

When discussing going to meetings, ask what kind of meetings the patient is currently attending. Review with them the different kinds of meetings available. Some meetings are "open" to the general public and anyone can attend, while some are designated as "closed" or reserved for those people who have decided that they are addicted to drugs. Certain group meetings are designed to discuss different parts of 12-Step recovery programs. For example, some meetings discuss Narcotics Anonymous (Narcotics Anonymous, 1988) or the 12-Steps, while others are a topic discussion meeting. Still others are speaker meetings where people share their story of addiction and recovery. Ask the patient what their experience has been. If they are attending only open speaker meetings, suggest that they try some different groups. If they are already attending some varied groups, what would they like to add the mix? As the patient gains experience with attending 12-Step group meetings, has s/he found one for a "home group"? A "home group" is one that a person decides to join and attend regularly. The patient may decide to take on responsibilities or "service work" at one of the meetings they attend. This may include helping to set up or clean up the meeting, make coffee, set out literature, etc. These jobs are usually assigned during the business meeting held monthly following the regular group meeting. When the patient attends meetings, where does s/he sit? If they sit at the back alone, encourage them to move up to the front. Some successful recovering addicts report that they choose to sit as close to the dais as possible so they won't be distracted during the meeting. What is the patient's experience with speaking at meetings? If the patient appears shy or fearful, role play with them in session about what they might say. Lastly, the 12-Step fellowship offers opportunities to meet other recovering addicts at various group sponsored social activities. These range from dances and sports teams to conventions and "24 hour meetings" and covered dish dinners on major holidays.

The experience has been that those addicts who actively participate in 12-Step group activities were those who have the best chance at remaining abstinent. The guideline has been to attend a meeting a day for 90 days. How many meetings will the patient commit to attend? Note that “getting active” is a relative term. For some patients increasing their attendance from one to three meetings per week is a major accomplishment. The therapist should judge accordingly.

Telephone Therapy

Telephone therapy has a long tradition in 12-Step programs. Since the day when Bill Wilson, one of the co-founders of AA, used the telephone to contact another alcoholic for help, 12-Step group members have made use of the phone to gain support from recovering peers. Explain the tradition of using the telephone as a recovery tool. Ask the patient if they have observed other group members exchanging phone numbers. Advise them that someone may ask for their number. Explore what the patient’s experience has been with this and any resistance there may be to using the phone. Does the patient have a phone? Examples of when to use the phone to reach out to recovering peers are:

Daily, to stay in touch and keep reaching out

Whenever there is an urge to use

As soon as possible after a slip

Whenever they feel hungry, angry, lonely, or tired

Whenever they feel overwhelmed

Whenever they feel good

Ask the patient if they would be willing to commit to obtaining phone numbers from at least three 12-Step program members during the coming week. Be sure to advise them to get at least 2 numbers from same sex friends. Then, commit to calling at least one of these people and having a 5 minute conversation with them. If necessary, role play with the patient around, (1) asking for a phone number and, (2) talking to a recovering peer on the phone. For some patients, using the telephone has been a turning point in their recovery.

Sponsor

The last part of “getting active” involves finding a 12-Step sponsor. The tradition of sponsorship started in the early days of AA. Originally sponsors were people who were willing to take responsibility for visiting alcoholics in the hospital and for taking them to an AA meeting when they were discharged. Also, sponsors were used as resources for questions about material in the Alcoholics Anonymous literature.

Today, in 12-Step programs, sponsorship has evolved into a way for newcomers to get practical advice and support from more experienced peers.

Explain to the patient that being a sponsor is both a privilege and a

responsibility. The job of a sponsor is to provide basic information about 12-Step programs and their traditions, to answer questions about working the Steps, to suggest 12-Step meetings that may be helpful, to introduce the newcomer to other recovering addicts. In short, the sponsor facilitates the newcomer's participation in 12-Step recovery. A sponsor is not a therapist, a judge, or a parent. A good sponsor can only share by example and make suggestions to the newcomer.

Likewise, a therapist is not a sponsor. Both the therapist and sponsor offer support and advice, however, there are important differences. A therapist knows the patient for a prescribed period of time, with specific appointment times. Once treatment is over, the therapist is no longer part of the patient's life. A sponsor however, is available throughout the patient's life, for as long as that relationship exists. A sponsor does not use therapeutic techniques to treat the patient, rather s/he shares experience through self-disclosure and offers support. Whereas the roles of the therapist and the sponsor differ, it is not uncommon for each to give the patient similar advice.

12-Step programs have published brochures on sponsorship. Some common guidelines for choosing a sponsor are:

Sponsors should be of the same sex as the patient. (With Gay or Lesbian patients, care should be taken to avoid situations with the potential for sexual attraction, as involvement in an intimate relationship too early in recovery may trigger a relapse.)

Sponsors should be of the same age or a little older than the patient. Having shared experiences makes it easier to bond.

Sponsors should have at least one full year of recovery from drugs and be actively working a 12-Step program, including going to meetings, using the telephone, and having their own sponsor.

Explain to the patient that the simplest way to find a sponsor is to ask for a "temporary sponsor" at a meeting. As most patients are just getting involved in 12-Step recovery, they do not know many people well. A "temporary sponsor" can be available to a patient until they find someone else who can be their regular sponsor. Let the patient know that there is nothing binding about sponsorship. If the relationship is not working out, it can be ended.

Another way to find a sponsor is to observe and listen at meetings and look for someone they can relate to and who they respect. Advise them to seek out someone who is happy in recovery and working a solid 12-Step program. Encourage the patient to then seek this person out, before and after meetings. Some patients are more shy than others. It may be necessary to role play asking someone to be a sponsor. Ask the patient to commit to looking for a sponsor over the next week, before the next session.

Recovery Tasks

Recovery tasks for this topic include the following readings:

Living Sober (Alcoholics Anonymous, 1975, pp. 13–18, 24–30)

Narcotics Anonymous (Narcotics Anonymous, 1988; chapters 5, 8, 9; and “I Kept Coming Back”, pp. 238–242)

Contract with the patient about which 12-Step meetings they will attend during the upcoming week. Ask the patient to continue to work towards the goal of “90 meetings in 90 days”. Ask what specific commitments they are willing to make to becoming more active in their recovery program (e.g., obtaining three phone numbers, calling at least one recovering peer, finding a sponsor).

Wrap-Up

In closing, ask the patient the gist of today’s session. Do they understand the recovery tasks and are they willing to follow through with them?

Troubleshooting

The therapist should be thoroughly familiar with the material in all readings: Narcotics Anonymous (Narcotics Anonymous, 1988), Hope, Faith and Courage (Cocaine Anonymous, 1993), Alcoholics Anonymous (Alcoholics Anonymous, 1976), Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981), and Living Sober (Alcoholics Anonymous, 1975), and should make efforts to integrate readings from all into each session. These books are filled with practical advice and wisdom and should be resources to therapist and patient alike. Do not hesitate to read a relevant passage together and discuss its relevance to any issue at hand.

A guide for the therapist with “Getting Active” is to meet the patient where they are in regards to accepting the need for involvement with 12-Step programs in an aware and sensitive manner. *Getting Active* is a process that takes place on a continuum of activity level. At one end of the continuum is the patient who flatly refuses to go to meetings, yet who appears for scheduled therapy sessions. With this situation the therapist may want to suggest that the patient give 12-Step programs a *fair chance*. We are not asking that people join NA/CA/AA, but that they go to meetings, sit, listen, and process their experience with us. Some dually diagnosed patients with fears about group meetings may need encouragement to gradually approach and experience meetings. For example, a patient was encouraged to first drive by the meeting site, then enter the parking lot, peek in the window of the meeting room, and finally enter the meeting. This process took several weeks. Other patients may have fears of disclosing too much about themselves to *strangers*. In these cases encourage the patient to not share at first, but to sit and listen at meetings. If possible, encourage them to return to the same 12-Step group meetings on a regular basis. What the patient will discover is that what was once a room full of strangers has become a room full of friends. As you process their experience at meetings, explore in depth their feelings and thoughts about what was said and if any of the people in the meeting room seemed trustworthy. How might they begin to relate to these people? What might they have in common with

some others in the meeting, etc? More typically, patients may attend one to two meetings per week at first. With the “Getting Active” topic, the goal is to increase the patient’s level of participation. This may include increasing the number of meetings attended during the week. The target goal is to attend daily 12-Step meetings for ninety days (90 in 90). If a person is attending only one meeting per week, a reasonable goal might be to push for three meetings per week.

Looking for a sponsor can be a daunting task for some patients. Some of our patients have been hurt by past personal relationships and are very slow to trust others. One helpful strategy is to ask the patient what qualifications s/he would look for or want in a sponsor. The purpose of this topic is to introduce the concept of sponsorship and encourage the patient to begin looking for a temporary sponsor. Temporary sponsors may or may not turn into permanent sponsors. The idea is that the relationship is on a *trial basis* for both parties. This may help alleviate some fears for patients.

4. Elective Topics

Topics in this chapter should be incorporated into the individual patient's treatment as appropriate and as time permits. The therapist needs to select topics that would be most beneficial, depending on the issues that are relevant for the patient. The primary factor that influences the choice of elective topics is the patient's overall progress in getting active. For many patients, the main work of this treatment is focused on the five core topics. However, as progress permits, one or more of the elective topics may be covered:

Topic 6: HIV Risk Reduction

Topic 7: The Genogram

Topic 8: Enabling

Topic 9: Emotions

Topic 10: Moral Inventories

Topic 11: Clean Living

NOTE: This treatment focuses primarily on three objectives:

Going to 12-Step meetings

Getting active in 12-Step programs

Getting and using a sponsor

Even when the agenda for a session involves an elective topic, do not lose sight of the importance of these objectives. Take whatever time is necessary to explore resistances, to make suggestions, and to elicit a commitment to any reasonable progress in these areas.

Topic 6: HIV Risk Reduction

Many drug dependent patients, especially those who have used, or are using, drugs intravenously (IV), are at risk for HIV and other infectious diseases. Therefore, it is strongly recommended that all patients be given this elective topic. Within research protocols, all patients complete the Risk Assessment Battery (Metzger et al., 1992) before and after treatment to assess their level of risk and change in risk behaviors across time (Appendix 4.1). The intent of this topic is to assist the therapist in engaging the patient in a discussion of their concerns about AIDS and motivating them to change to safer behaviors. The therapist will assist the patient in identifying a need for further education, testing, and in identifying those behaviors which have put him/her at risk of contracting AIDS or other sexually transmitted diseases (STD's) in the past. By using tools from 12-Step programs, the therapist engenders a sense of hope in the patient and supports his/her accepting responsibility for changing risky behaviors.

Review

Journal

Meetings attended.

Reactions to meetings.

Discussion of why meetings were not attended, if appropriate. Link to denial, as appropriate.

Slips

Where, when, and with whom?

What did the patient do about them?

What could the patient do about them in the future that would be consistent with NA/CA/AA?

Urges to Use

When and where?

How did the patient handle it?

What could the patient do in the future that would be consistent with NA/CA/AA?

Clean Days

How many?

How many successive?

Congratulate with recognition of a significant accomplishment.

Does the patient have any questions or concerns about last session's topic?

New Material

Review the first step of NA/CA/AA and examine the unmanageability that

results from the disease of addiction. Emphasize that an important part of recovery is repairing the wreckage of one's past. Point out that while one is "powerless" over being addicted to various substances, one has the power to choose what to do about it. The unmanageability of addiction causes many problems, particularly in the areas of health and relationships. The issue of sexually transmitted diseases (STD), especially AIDS, dramatically illustrates this point.

To begin, explore what fears or concerns the patient may have about damage to their health caused by drugs and alcohol. Ask what fears or concerns they may have about HIV/AIDS in general, then more specifically about themselves.

Ask the patient if he/she has had any education or training about HIV/AIDS in the past. Where was this and from whom? What did the patient learn?

If the patient has had education about HIV, how has he/she altered their behavior as a result of this training?

Based on what knowledge the patient has now, is he/she aware of any behaviors that they have engaged in that put them at risk in the past or that currently put them at risk?

Risky Behaviors

The therapist and patient review the patient's composite/summary scores from the Risk Assessment Battery (Metzger et al., 1992), noting the level of risk from unsafe needle practices, unsafe sexual practices, and history of HIV testing. Composite/summary scores are presented on a written form, with a copy for the patient to keep. Some examples of behaviors that put people at risk include:

- Having unprotected sex (anal, vaginal, or oral) with someone who has the virus.
- Having unprotected sex with partners who may have engaged in high risk behaviors, had sex with several partners, and/or who inject drugs.
- Sharing injection drug equipment (needles, syringes, cookers, cotton, and rinse water).
- Reusing needles.

The therapist asks for the patient's reactions to his/her level of risk, reflecting and elaborating on the patient's reactions (P: "I guess I didn't realize how many people I have slept with since I've been on this run." T: "What do you make of this?") as a strategy to bolster awareness of risk and motivation for change.

The Serenity Prayer and Unmanageability

The Serenity Prayer (Niebuhr, R., 1950) can be applied when dealing with the unmanageability associated with addiction. The risky behaviors reviewed above are examples of unmanageability. Begin this section by writing the Serenity Prayer on a flip-chart and asking the patient to read it aloud:

**GOD GRANT ME THE SERENITY
TO ACCEPT THE THINGS I CANNOT CHANGE,
COURAGE TO CHANGE THE THINGS I CAN,
AND THE WISDOM TO KNOW THE DIFFERENCE.**

Ask what thoughts and/or feelings that the patient has in response to this prayer and their status regarding HIV/AIDS or other sexually transmitted diseases (STD's).

As a suggested exercise, review with the patient those events or things about the past that can not be changed and contrast them with those behaviors or things about the present that can be changed.

Examples of what can be changed include:

- Staying abstinent from all mood-altering substances. Use of some drugs, alcohol in particular, weakens the immune system. People who are HIV positive and who are abstinent have a higher survival rate.
- Avoiding emotional entanglements for the first year of recovery
- Working a spiritual program
- Letting go of old, drug-using friends and making new, clean and sober friends
- Changing attitudes about relationships and sex, becoming more mature
- Obtaining HIV/STD education
- Obtaining HIV testing and counseling
- Practicing safe sex
- Attending an HIV 12-Step meeting learning and using safe needle practices in case of relapse

The following worksheet can be used to record the patient's responses to this exercise. (Figure 4.2 follows)

Alcoholics Anonymous (Alcoholics Anonymous, 1976, pp. 83–84), “The Promises”

Wrap-Up

What did the patient learn today?

Does the patient understand what behavior put him at risk for HIV/STD's?

Does the patient understand and will he/she follow through with the Recovery Tasks?

Troubleshooting

Many patients will appreciate this frank education and awareness raising exercise. Prior to doing this with your patient it is extremely important to have prior arrangements with a referral source in your community for further medical evaluation and counseling. As with other recovery tasks, follow up with the patient at the beginning of the following session as to their progress on connecting with the referral. The passage from the Alcoholics Anonymous (Alcoholics Anonymous, 1976), “The Promises,” offers hope for change. For many patients following up on this referral becomes one more very important way of dealing with the consequences of their addiction and making amends to themselves.

Topic 7: The Genogram

This topic makes use of the patient's family tree. It is a powerful tool for examining the impact of addiction on a patient's family and serves as a means of motivating the patient to "break the chain" of addiction. The patient can use this material to understand that addiction is a disease that leads "good" people to act in self-destructive ways and in ways that are hurtful to loved ones. Doing the genogram exercise with the patient has the potential for unearthing old traumas for the patient and should be done with care. This is one of the few times that the therapist may direct the patient to call him/her following the session if they experience emotional distress after completing the genogram. The primary messages of this material are that the patient is powerless over the presence of the disease of addiction in his/her family, that the disease of addiction leads "good" people to act in ways that are harmful to themselves and others, and that the patient can break the chain of addiction by actively working a 12-Step recovery program.

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient's level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day.

How is the patient doing with living *one day at a time*?

Urges to Use

When and where?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient's reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material

The Genogram or “Family Tree”

Genograms have the potential to evoke intense emotional reactions from patients. Sometimes these reactions are immediate and powerful; but it is not uncommon for genograms to have their greatest impact after a session is over. Preparation is important! Refer to the “Troubleshooting” section for this session before going ahead.

The goals of this topic are to present the patient with the ideas that:

- Drug addiction is a disease that can usually be traced across generations, in other words it is a “family illness”.
- The patient can break the cycle of addiction by working a 12-Step Program.
- Whether or not an individual in the family drank or used mood-altering substances, they were influenced by this disease.
- The disease of addiction has harmed not only the patient, but also it has harmed others in the family and in previous generations.

Using a blackboard, flip chart or large piece of paper begin construction of the patient’s genogram (see Figure 4.3). Begin with:

- His/her generation — the patient and his/her siblings
- His/her parental generation — the patient’s parent, aunts, and uncles
- His/her grandparents — maternal and paternal
- His/her children — whether they live with the patient or not

After gathering this information, review the diagram and find out:

- Who has or had problems with alcohol or other drugs?
- Who has or had problems with mental illness? physical illness?
- If an individual is deceased, how did s/he die?
- Have any individuals married people or been in relationships with people

who have had problems with alcohol or other drugs?

- For those individuals who have had problems with alcohol or drugs, what consequences did they endure?
 - Legal (DWI, fights, public intoxication, etc.)
 - Social (divorce, abusive relationships, etc.)
 - Occupational (lost jobs, poor reviews, etc.)
 - Physical (health problems)
 - Emotional/psychological (depression, suicide, etc.)
 - Financial (chronic money problems or bankruptcy)

With the information above added to the genogram, review with the patient:

- How many individuals in the family were affected by the disease?
- Is there a pattern e.g., males, females, maternal side, paternal side, etc.?
- What consequences have people in the family suffered as a result of this disease?

What does the patient conclude from reviewing the genogram?

*****The patient is *powerless* over the presence of the disease in his or her family. The patient is *empowered* to break the chain of addiction in his/her family by choosing to actively work a 12-Step recovery program.**

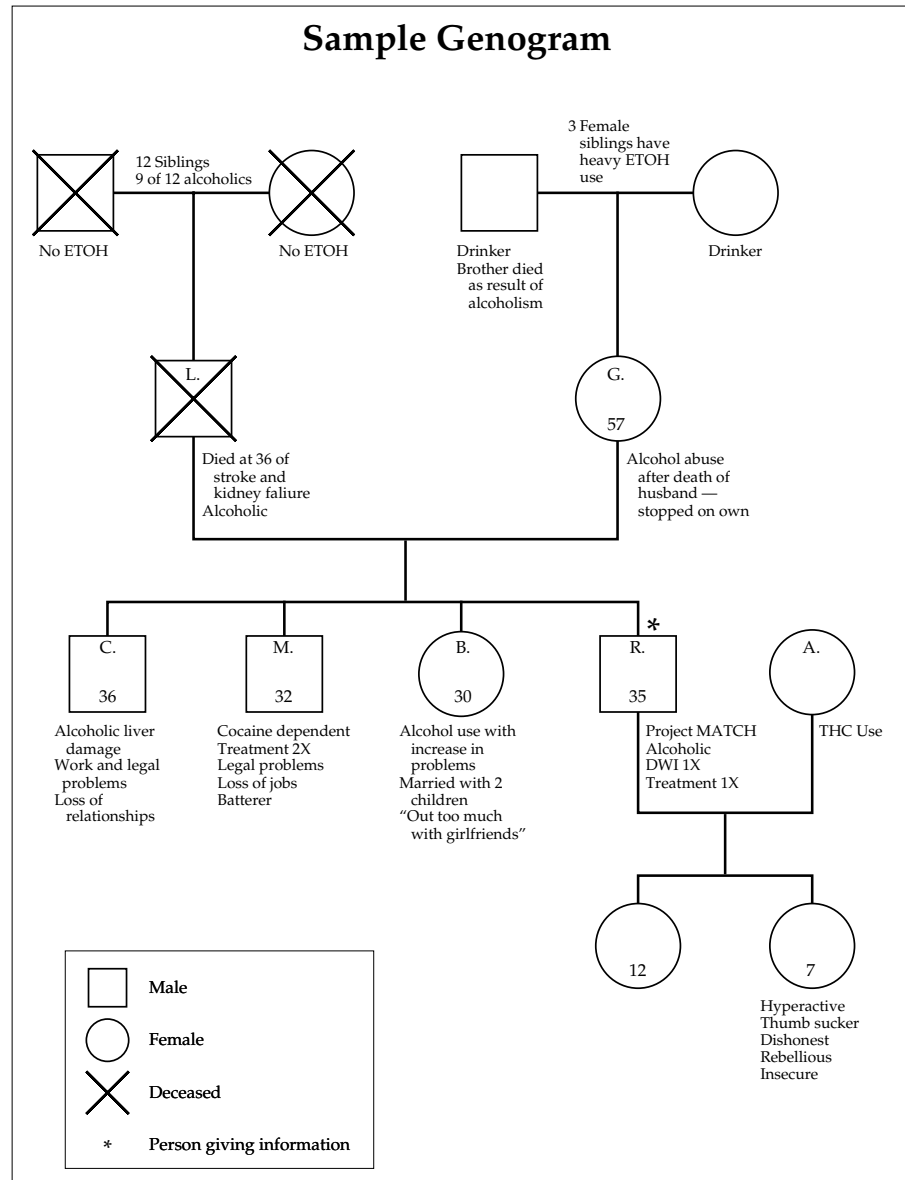


Figure 4.3 (See Appendix 4.3).

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Recovery Tasks

Meetings

Make a list of meetings to attend.

What kind of meetings are being attended?

What is the patient doing to get active?

Telephone Therapy

Collect new numbers

Commit to call program friends

Sponsor

If the patient has a sponsor, how often will they contact that individual?

If the patient does not have a sponsor, what steps will s/he take to find one during the coming week?

Reading

Continue reading Alcoholics Anonymous (Alcoholics Anonymous, 1976) or Narcotics Anonymous (Narcotics Anonymous, 1988), Living Sober (Alcoholics Anonymous, 1975), and Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981).

Other program literature (e.g., meditation books, pamphlets, etc.)

Journal

In addition to routine writing in their journal, encourage the patient to write down any reactions they might experience from today's session. Additionally, encourage the patient to share any feelings s/he might have about the genogram with his/her sponsor, family member, or program friend.

Make a point of asking the patient to call (which is not normally encouraged in this program) in the event that s/he is experiencing distress as a result of the genogram exercise.

Wrap-Up

What was the gist of today's session?

How do you feel about making a commitment to sharing your feelings about your genogram?

Troubleshooting

Any genogram exercise has the potential to stir up many emotions that may have been dormant, sometimes for years. Painful recollections of growing up in a home where there was drug dependence, possible abuse, abandonment, or neglect, can evoke intense anger, anxiety, and shame. The therapist may not be in a position to adequately work through such emotions but should be sensitive to them and prepared to offer helpful guidance:

- Validate emotional reactions as appropriate for their context ("I can understand that it must have been frightening not knowing when your father might get high and become violent.").
- Direct the patient to 12-Step programs as a source of comfort from people who have had similar experiences. For example, you could suggest that the patient speak to an NA peer or sponsor about this genogram and reactions to it.
- Encourage the patient to write down feelings and thoughts about the genogram and the issues it raised.
- Suggest that the patient might experience an urge to use as a result of this exercise and what should be done about it (for example, going to a meeting or calling an NA peer).

If a patient shows signs of extreme distress or discomfort during the genogram, it may be necessary to stop, to focus on those feelings evoked and comfort the patient, and then to discontinue the exercise. It is also advisable to create some balance in the genogram by asking patients to give themselves or others credit for accomplishments and successes; in other words, to honor one's self and others, as well as to acknowledge harm done through drug use. The point is that the people in the patient's family are good people who had an illness that led them to behave in ways that were hurtful to themselves and others. This simple act of providing some brightness now and then in an otherwise grim picture can help to offset a patient's tendency to fly into a rage or to sink into shame and despair.

Topic 8: Enabling

* For patients who are in a relationship with a partner who is willing to participate in treatment, Conjoint Topic 1 may be substituted for this elective topic.

This topic addresses the definition and dynamics of the enabling process. At the heart of this topic is the “Enabling Inventory”. This exercise is designed to help the patient to identify the people who enable him/her, understand their motives, and to assess their own role in encouraging others to be enablers. Lastly, this session focuses on strategies to help the patient resist being enabled by others. The “Enabling Inventory” is the same exercise that is done in the first conjoint session. If the therapist plans on having conjoint sessions with the patient and a significant other, this topic is done in one of those sessions.

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient’s level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day.

How is the patient doing with living *one day at a time*?

Urges to Use

Where and when?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient’s reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material

Enabling

Enabling is any and all behaviors by others that have facilitated the patient's continued drinking or using, or that have helped the patient to avoid or minimize the negative consequences related to drinking or using. Use the Enabling Inventory (Figure 4.4) to address this issue with the patient.

Enabling Inventory			
<i>ENABLERS</i> SIGNIFICANT OTHERS: SPOUSE/GIRLFRIEND/BOYFRIEND, FRIEND EMPLOYER, ETC.	HOW THEY ENABLED (Be specific)	ENABLER'S MOTIVES AND FEELINGS	HOW DID YOU ENCOURAGE THIS ENABLING?

Figure 4.4 (See Appendix 4.4).

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Examples of enabling include:

- Friends who give you drugs
- Friends who make sure they have enough drugs around for you when you visit
- Friends who joke or make light of the fact that you get high as often as you do
- Partners or friends who make drug runs for you
- Partners or friends who "lend" you money for drugs
- Partners or friends who make excuses for you when you're recovering from using (i.e., calling in sick for you)
- Partners or friends who nurse you when you're hung over

Motivation of Enablers

The Dynamics of Enabling

- Why do people enable?

Usually benign and loving, but end up being mutually destructive

Concern for addict, trying to protect the addict and themselves

Guilt about “causing” the addict to use

Confusion about doing the “right” thing and lack of accurate information about drug dependence

- How do “Enablers” feel?

Guilty

Frustrated

Angry

Hopeless

Depressed

Lonely, alienated, isolated

Many of these feelings closely match the feelings that the addict experiences

For the “enabler”, life seems unmanageable due to the chaos of the addict’s behavior

How did the patient *encourage* enabling behavior by others?

Every addict needs to own up to his/her methods of encouraging enabling in others. Getting honest in this area will help you to sustain recovery. Typically, addicts learn to use the emotional vulnerabilities of others, such as their guilt or fear, to promote enabling. A drug addict, for example, may attempt to blame a binge on an argument with his partner (“You made me do it!”); another may attempt to arouse anxiety through some form of threat (“If you don’t cover up for me, I’ll lose my job!”).

You might benefit from doing a personal inventory of who your enablers are and how you yourself encourage them to keep on enabling you.

Resisting Enabling

Explain to the patient that a vital part of recovery involves acknowledging enabling and actively resisting it *one day at a time*.

Be honest with his/her enablers about his/her addiction.

Be honest with self about his/her addiction. Suggest the following affirmation: *I am responsible for my own recovery, which will come through active involvement in the NA/CA/AA fellowship.*

Be honest about his/her behaviors that encouraged enabling.

Recovery Tasks

Meetings

Make a list of meetings the patient will attend before next session.

Suggest other kinds of meetings the patient might attend.

How could the patient become more active in NA/CA/AA?

Telephone Therapy

Collect new numbers

Commit to call program friends

Sponsor

If the patient has a sponsor, how often will they contact that individual?

If the patient does not have a sponsor, what steps will s/he take to find one during the coming week?

Reading

Continue reading Alcoholics Anonymous (Alcoholics Anonymous, 1976) or Narcotics Anonymous (Narcotics Anonymous, 1988), Living Sober (Alcoholics Anonymous, 1975), and Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981).

Other program literature (e.g., meditation books, pamphlets, etc.)

Journal

Is the patient willing to commit to keeping a journal?

Enabling

Is the patient willing to make a firm commitment to do *three* things to actively resist enabling? What would they be?

Wrap-Up

What was the gist of today's session?

How do you feel about making a commitment to actively resist enabling?

Troubleshooting

It is very important when discussing the concept of enabling to not encourage patients to blame others in any way for their drug use. Enablers are typically motivated out of concern, anxiety, or confusion about what to do. Wives of drug addicts, for example, may fear the loss of income or even spouse abuse if they do not somehow help their husbands. Husbands may fear humiliation if they do not cover up for their wives.

Drug dependent persons need to understand how enabling contributes to their drug use and also the role they play in encouraging that enabling. The key insight for addicts here is how they helped to create the enabling system that supports them. The first way to break out of this is to embrace Step 1 and

openly acknowledge unmanageability and loss of control, not just once but on a daily basis. Second, enablers can get support for themselves through Nar-Anon. Drug dependence as a family illness leads to life becoming unmanageable not only for drug addicts, but also for those who are closest to them.

The goal in discussing enabling is to help patients make specific commitments to dismantling their enabling system by either avoiding enablers or by being honest with them about being drug dependent.

Topic 9: Emotions

The purpose of this Topic is to help the patient identify emotions which are most often associated with slips. These are the emotions that most often lead to the first drug use; which in turn sets off the addict's craving and leads to compulsive drug use.

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient's level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day.

How is the patient doing with living *one day at a time*?

Urges to Use

Where and when?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient's reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material

“Don’t let yourself get too tired, too hungry, or too lonely.” (Living Sober, Alcoholics Anonymous, 1975)

H.A.L.T.

The purpose of this Topic is to help the recovering addict make use of 12-Step based tools for dealing with the stresses of everyday life. The advice given in 12-Step programs is don’t let yourself get too *hungry*, too *angry*, too *lonely*, or too *tired* or you may have a slip. This is the acronym H.A.L.T.

Present the idea to patients that they need to be able to identify the following feeling states and do something about them before they use drugs in an attempt to escape them:

Loneliness

Anger

Grief

Anxiety

Resentment

Self-pity

The belief in 12-Step programs is that drug dependent persons are most vulnerable to the above emotions and most likely to use when they are either hungry or tired. Therefore, the program puts a strong emphasis on getting rest and eating well.

Many 12-Step slogans and sayings — *Easy Does It*, *Let Go and Let God*, *One Day at a Time*, *First Things First*, *Turn it Over* — relate to one or more of the above feelings. They reflect common wisdom for handling difficult emotions. Their value lies in their simplicity. Through these sayings and slogans, the fellowship teaches drug dependent persons how they can live without drugs. The therapist should therefore be familiar with these slogans and use them in treatment. In addition, teaching patients to connect particular slogans to situations in their lives that trigger risky emotions can be extremely helpful.

Fatigue

The recovering person needs to develop a lifestyle that allows him/her to get adequate rest and nutrition. A state of exhaustion is an invitation to use.

Related to this Topic is physical conditioning — a body in poor physical condition will get tired more quickly than one that is being taken care of.

- How much sleep does the patient get on average? Is this adequate? What changes, if any, could be made so the person could get more rest?
- Have you experienced using, or had a strong desire to use when you were especially tired?
- What is the overall state of the person's health? Are they capable of doing some routine exercise to gain stamina?

Hunger

Along with the need to avoid exhaustion, NA/CA/AA emphasizes the need for the recovering person to avoid excessive hunger. Regular meals are encouraged and, beyond that, the addict is encouraged to snack so as to avoid getting too hungry.

- What is your diet like now? What did it used to be like?
- Do you sometimes experience cravings for sweets?
- How can you satisfy this need? (For recovering people fresh fruit can be helpful)

Emotions

anxiety

Sometimes a source of anxiety can be from a sense of isolation, not having any one to trust or rely on when faced with a difficult life decision.

- What makes you feel anxious or uneasy?
- How can you make use of the Serenity Prayer (Niebuhr, R., 1950)?

GOD GRANT ME THE SERENITY
TO ACCEPT THE THINGS I CANNOT CHANGE,
COURAGE TO CHANGE THE THINGS I CAN,
AND THE WISDOM TO KNOW THE DIFFERENCE.

Review the Serenity Prayer line by line and see how it can apply to the person's situation.

- Do patients relate to experiencing "existential anxiety": the feeling of being isolated, of facing difficult decisions and choices but feeling totally alone in making them?
- Have they (do they) ever pray, or meditate, or otherwise turn to a Higher Power in times of stress, despair, confusion, or anxiety?
- Do patients relate to having difficulty deciding at times what they cannot change versus what they can (and should) change?
- How would patients feel about saying the serenity prayer at these times, or about talking to other 12-Step friends about the dilemmas they face?

Other methods of dealing with anxiety are found in the following 12-Step slogans:

FIRST THINGS FIRST. The first priority for drug dependent persons is to not take that first hit. At times, addicts, like anyone else, will be in conflict — will have to choose taking care of themselves versus taking care of someone else. At times, the choice may be please yourself or please someone else; make yourself happy or make someone else happy. Patients need to be encouraged to make their ongoing abstinence their first priority, even if that means frustrating or disappointing someone else.

The therapist might elicit examples from patients of situations in which they felt conflicted about taking care of themselves versus taking care of others:

- What could be the price of pleasing or satisfying others at your own expense?
- What did you do in that situation? Was it consistent with putting your abstinence first?

EASY DOES IT. The pressures of deadlines and overcommitment create stresses that invite using as a means of coping. The 12-Step slogan, “Easy does it”, speaks to this particular issue.

- Does the patient identify with the stresses created by having to meet deadlines or competing commitments?
- What in the patient’s life contributes to stress, to time pressure, or to overcommitment?

Strategies for dealing with this form of stress are built around developing a system of realistic priorities.

- Make a list of things to do today, then discard half of it.
- Schedule things twice as far in advance as you usually would.
- Sit quietly for 15 minutes a day.
- Talk to someone else (preferably a recovering person) about your feelings or being overextended.

anger/resentment

Anger and resentment are pivotal emotions for most recovering addicts. Anger that evokes anxiety drives the addict to use in order to anesthetize it. Resentment, which comes from unexpressed (denied) anger, represents a constant threat to abstinence for the same reason.

The therapist should talk to the patient about anger and resentment:

“Resentments, reflecting as they do unexpressed anger, represent past issues. The recovering addict cannot afford to live in the past but must

live in the present (*one day at a time*). Therefore, resentments must be confronted and let go in favor of more effective ways of dealing with anger in the present.”

Use the following guidelines and the Resentment Worksheet (Figure 4.5) when working on these issues:

- What situations are patients resentful over?
How did they handle these at the time they happened?
Can they see how these issues cannot be resolved now but that, on the other hand, they can learn how to express anger better, so as to avoid building up stores of resentments in the future?
- Can the patient make the connection between unexpressed anger (at the moment) and resentment (holding on to the anger)?
- What can the patient learn from those experiences so as to not avoid being honestly angry in the future?
- What would stop the patient from experiencing anger in the future?
- What makes patients angry in the here and now? Are they willing to make a commitment to expressing their anger honestly and to having faith that it will be better if they do that?

Resentment Worksheet			
WHAT HAPPENED	HOW I FELT	WHAT I DID	WHAT I SHOULD DO DIFFERENTLY USING PROGRAM TOOLS

Figure 4.5 (See Appendix 4.5).

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In the course of addiction (and often before drug abuse begins), the addict typically experiences many losses that have gone ungrieved. The therapist should be familiar with the stages of grief:

DENIAL. Minimizing the importance of what was lost, including denying its importance.

BARGAINING. Attempting to replace the lost thing with something else without acknowledging its loss.

ANGER. The breakdown of denial and the natural reaction to loss.

SADNESS. The true expression of undenied loss.

ACCEPTANCE. This comes slowly, only as denial breaks down and the individual feels able to come to terms with the reality of loss (or limitation) and is ready to move on.

Ask patients to go through the above process, identifying one loss in their lives that they have worked through in this way. Then ask them to identify one loss that they have not worked through, about which they may be in denial. Drug addicts need to come to terms with the *loss* of drugs as a means of coping. Another way to look at it is that they need to accept their limitation, which is that they cannot control their use of drugs and have to give them up.

Ask the patient if s/he is willing to write a *good-bye letter* to drugs in their journal. Dependency on drugs needs to be conceptualized as a relationship that must be broken and grieved in the interest of recovery. This requires sensitivity and respect on the part of the therapist, along with an appreciation for the grief process and an ability to work with patients in a sympathetic manner through their grief over the loss of drugs.

Recovery Tasks

Meetings

Make a list of meetings the patient will attend before next session.

Suggest other kinds of meetings the patient might attend.

How could the patient become more active in NA/CA/AA?

Telephone Therapy

Collect new numbers

Commit to call program friends

Sponsor

If the patient has a sponsor, how often will they contact that individual?

If the patient does not have a sponsor, what steps will s/he take to find one during the coming week?

Readings

Continue reading Alcoholics Anonymous (Alcoholics Anonymous, 1976) or

Narcotics Anonymous (Narcotics Anonymous, 1988), and Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981). In Living Sober (Alcoholics Anonymous, 1975) suggest:

“Fending Off Loneliness”

“Watching Out for Anger and Resentments”

“Looking Out for Over-relation”

“Being Grateful”

“Eliminating Self-pity”

“What Can I Do When I Get Lonely?”

“As Long As I Am Happy, Am I Safe?”

Other program literature (e.g., meditation books, pamphlets, etc.)

Grieving

Write a *good-bye letter* to drugs as if it were a relationship that you have decided to end.

Write in your journal about losses that you have not adequately acknowledged and grieved, including losses in each of these areas:

Relationships

Self-esteem

People, pets, or things

Goals

H.A.L.T.

What lifestyle changes is the patient willing to make to address fatigue and nutrition?

Wrap-Up

What was the gist of today’s session?

Do you understand and are you willing to follow through with the Recovery Tasks?

Troubleshooting

The importance of going to meetings, getting involved in them, and developing relationships with other recovering addicts cannot be overstated. The patient can use the fellowship of recovering addicts as a source of support, advice, and comfort. By now, going to meetings should be a part of the patient’s lifestyle; if it is not, the therapist should spend more time uncovering and working through the patient’s resistance to this. A contracting approach can be a useful technique

wherein the therapist and patient agree that the patient will try out a certain number of 12-Step meetings or experiment with some form of participation. Patients' experiences at meetings, like their reactions to Alcoholics Anonymous (Alcoholics Anonymous, 1976), need to be processed at each session.

Role-playing can be another effective technique to help the shy or shameful patient overcome internal barriers to going to meetings or participating in them. Have patients practice, for example, saying their names out loud, as if they were doing so at a meeting. Assure the patients that they will not be pressured at meetings to say more than they feel comfortable with.

Once patients have become regular in their attendance, the next step is to encourage them to talk. Meetings and subsequent contacts with fellow 12-Step program members can be used as opportunities to talk about ongoing sources of resentment and grief. Patients who merely attend 12-Step meetings and do not participate or develop communicative relationships with other recovering people are handicapped in their ability to resist denial and are apt to slip into drug use as a means of drowning those emotions.

Topic 10: Moral Inventories (Steps 4 and 5)

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient's level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day

How is the patient doing with living *one day at a time*?

Urges to Use

Where and when?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient's reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Using the Telephone

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material (Steps 4 and 5): The Moral Inventory

Drug dependence is described in NA literature as a physical and a spiritual illness. It is an illness of the spirit in the sense that drug addicts are driven by their disease to behave in ways that compromise their personal ethics and values. Addicts commit crimes and misdeeds in the process of satisfying their obsession with drugs or as a result of impaired judgement while under the influence of drugs. This undermines their self-esteem, promotes alienation, and makes finding faith and reaching out to others more difficult. Steps 4 and 5 implicitly recognize the fact that drug addicts suffer feelings of guilt and shame related to their behavior and also that acknowledging and sharing these feelings has value.

Many addicts in early recovery are fearful of the pain connected with accepting responsibility for past behaviors. A description of this process from the NA rooms is that in order to get better today, one must begin to deal with the “wreckage” of the past. Acceptance of the past is an essential, though, at times, painful part of the healing process. Step 4, taking a moral inventory, and Step 5, sharing this with God and another human being, suggest a way to confront and accept the past and to begin the process for self-forgiveness, which is necessary for continued recovery.

TSF Therapist Sets the Tone

Because drug dependent patients often suffer feelings of self-loathing, guilt, and shame related to their past behavior, it is essential that the TSF therapist approach the taking of a patient’s moral inventory with sensitivity and in a non-judgemental way. Creating a safe, accepting, and supportive environment facilitates the patient’s ability to accept him/herself as a human being with limitations and allows the patient to honestly acknowledge previous negative behaviors in the context of the unmanageability of their addiction.

Goals

This session has four goals:

- To further work through resistance to Step 1 by asking patients to think and talk about some of the *wrongs* and *errors* they have committed as a result of drug abuse.
- To explore the extent to which patients experience guilt that has not been shared and as a result can threaten their recovery.
- To balance recognition of wrongs done with equal recognition of positives.
- To lessen fear about doing Step 4 and Step 5 in more depth with a sponsor

or member of the clergy later in their recovery.

NOTE: The goal of this session is not to conduct a complete — searching or fearless — moral inventory, in the truest sense of Steps 4 and 5. In general, such a moral inventory is best attempted by an addict who has been actively working a 12-Step program for at least 6 months. It needs to be shared with a trusted person such as a sponsor. It is more often a process than an event. The goals of Steps 4 and 5 in the context of this treatment are more limited: to accept some degree of responsibility for consequences of drinking and to release some guilt. The therapist needs to keep these limited goals in mind while at the same time acknowledging to the patients that they will need to do more work on the Steps.

Facilitating a Moral Inventory

There are two key issues to keep in mind when talking with patients about their moral (ethical) history, honesty, and balance. These need to be communicated to patients in a way that is understandable to them.

Honesty

To be of real value, a moral inventory must be honest. Patients must be carefully guided — without being judged or censured — to own up to ways in which they have hurt others, either willfully or accidentally, or have compromised their ethics as a result of drug use. In this regard, patients need to be encouraged to admit their contributions to strained marriages or friendships, problems with children, and so on. Obviously, this is sensitive therapeutic work. The experienced therapist who is secure in the belief that drug dependence is an illness that is ultimately stronger than individual willpower will be most effective in guiding the patient through this inventory, encouraging frankness without promoting needless guilt. The goal of a successful moral inventory is not guilt but commitment to recovery.

Balance

A moral inventory should also be balanced, meaning that it should not lose sight of the patient's positive qualities, right choices, and heroic efforts. It will not jeopardize the goals of this work if the therapist encourages patients to think about and share positive things about their character and actions; on the contrary, discussing the positives can help minimize excessive guilt and form the basis for renewed self-esteem in recovery.

Begin the moral inventory by reading aloud Steps 4 and 5 from the Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981):

STEP 4: MADE A SEARCHING AND FEARLESS MORAL INVENTORY OF OURSELVES

STEP 5: ADMITTED TO GOD, TO OURSELVES, AND TO ANOTHER HUMAN BEING THE EXACT NATURE OF OUR WRONGS

Negative Qualities

Explore the meaning of these Steps with the patient. Explain that they are concerned with character defects: those negative qualities and tendencies that each and every person (not just drug addicts) possesses. In the case of drug addicts, character defects tend to be exacerbated due to their illness, which takes over the will and leads them to make ethical and moral compromises.

Character defects include qualities such as:

Jealousy
Greed
Selfishness
Impulsiveness
Grandiosity
Arrogance
Self-pity
Meanness
Resentment

Drug abuse has predictable effects on personality, one of which is that character defects that were evident before the illness will get worse. Still others may emerge as a consequence of becoming obsessed with drugs.

- Which character defects have emerged in this patient as a result of drug abuse?
- Elicit specific examples of these character defects and how others have been hurt by them. Take time to explore one or two key incidents in which the patient, under the influence of drugs, has done something that hurt someone else and which s/he now regrets.

Assets

After exploring the negative, finish this part of the session by taking some time to explore some of the patient's better qualities, supported by specific examples of behavior that reflect them. Look for specific examples of qualities such as the following:

Generosity
Heroism
Charity
Altruism
Kindness
Humility
Love

Sharing

Compassion

Document examples of these qualities.

Recovery Tasks

Meetings

Make a list of meeting the patient will attend before next session.

Suggest other kinds of meetings the patient might attend.

How could the patient become more active in NA/CA/AA?

Telephone Therapy

Collect new numbers

Commit to call program friends

Sponsor

If the patient has a sponsor, how often will they contact that individual?

If the patient does not have a sponsor, what steps will s/he take to find one during the coming week?

Readings

Continue reading Alcoholics Anonymous (Alcoholics Anonymous, 1976) or Narcotics Anonymous (Narcotics Anonymous, 1988, pp. 26–32), Living Sober (Alcoholics Anonymous, 1975), and Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981, pp. 42–62).

Journal

Is the patient willing to commit to keeping a journal?

Wrap-Up

What was the gist of today's session?

Do you understand and are you willing to follow through with the Recovery Tasks?

Troubleshooting

Patients may occasionally experience periods of intense guilt or shame associated with Step 4. This may occur during the course of the session, but it is even more likely to occur after the session, when the patient has time to reflect on this material. It can be helpful to prepare patients for this eventuality as well as giving them specific suggestions for what to do in that event. Some key points to keep in mind include the following:

- The concept of amends: The idea that addicts who have the courage to

face their moral mistakes may be able to at least acknowledge them and, in some cases, to do something to make up for them. This gives them an advantage over those who refuse to even acknowledge their defects. The question then becomes: When are amends appropriate, and what constitutes appropriate amends?

- The addict should not be allowed to assume that non-addicts do not make moral mistakes. In fact, addicts who keep an ongoing moral inventory may very well lead more spiritual lives than many non-addicts.
- Patients should be encouraged to keep their positive qualities in mind, without avoiding or minimizing character defects. Helping patients to design one or more personal affirmations — statements that assert positive qualities and which the patient can be encouraged to repeat several times a day — can help counter unreasonable guilt and depression. Many affirmation books are available.
- Sponsors and 12-Step friends, as well as clergy, can be key sources of support during a time of guilt and shame. Patients should be encouraged to identify specific sources of support: people they could talk to who they think could understand their feelings.
- The therapist should not minimize, rationalize, or avoid patients' feelings of guilt and shame. Experiencing these feelings can help undermine resistance to acceptance. It can also have the effect of making patients feel all the more isolated with their feelings. It can help to remind patients that they are not responsible for their illness, though they are responsible for their recovery. Reinforcing this idea can be especially helpful at this time, since it offers hope at the same time that it acknowledges responsibility for harm done.
- Be prepared to talk about the patient's need to grieve the loss of self-esteem associated with the mistakes made under the influence of drugs.
- Advise patients that it would be appropriate in this case to contact you between sessions if they are experiencing an intense emotional reaction to the moral inventory work. An emergency session can be appropriate here, much as is the case when doing a genogram (Topic 6).

Topic 11: Clean Living

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient's level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day.

How is the patient doing with living *one day at a time*?

Urges to Use

Where and when?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient's reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Telephone Therapy

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Living Recovery

In this session, the therapist explores different aspects of the patient's lifestyle, with the expectation that drug dependence narrows the lifestyle. Over the course of the illness, the patient loses or abandons old friends, old hobbies and interests, activities, and so on. Life becomes progressively more centered around drugs — obtaining them, hiding them, using them. In early recovery, the relative emptiness of addicts' lives drives them back toward using out of sheer boredom.

A good way to approach the issue of clean living is to help the patient explore what life was like before drug dependence and from that discussion to set some specific, realistic short-term goals.

Nutrition

How was the patient's diet affected by drug use?

What did s/he typically eat in the course of a day?

What does the patient need to change to create a more balanced diet?

NOTE: Depending on the patient's physical condition, it may be appropriate to suggest a consultation with a nutritionist.

Has the patient gained or lost more than 15 pounds in the past year? Does s/he need to gain/lose weight to be more healthy?

Establish several nutritional goals with the patient.

Exercise

Does the patient have any physical illnesses currently under the care of a physician?

Does the patient have any medical problems that would restrict their ability to exercise regularly?

What kind of exercise can the patient commit to doing on a regular basis (3 times/week)?

Set several specific and *realistic* exercise goals with the patient.

Hobbies and Leisure Time

What did the patient do for fun and relaxation prior to using drugs?

What activities interest the patient?

What hobbies or leisure time activities will the patient commit to doing this week?

Recovery Tasks

Meetings

Make a list of meetings to attend.

What other kinds of meetings might the patient attend?

How can the patient become more active in 12-Step meetings?

Telephone Therapy

Collect new phone numbers
Commit to call program friends

Sponsor

If the patient has a sponsor, how often will they contact that individual during the week?
If the patient does not have a sponsor, what steps will be taken to find one during the upcoming week?

Readings

Continue reading Narcotics Anonymous (Narcotics Anonymous, 1988), Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981), and Living Sober (Alcoholics Anonymous, 1975).

Living Recovery

Ask patients to make one specific commitment to improve their lifestyle in each of these areas: nutrition, exercise, and hobbies.
Suggest that the patient discuss lifestyle commitments with their sponsor and significant others.

Wrap-Up

What is the gist of today's session?
Does the patient understand and is s/he willing to follow through with the recovery tasks?

Troubleshooting

It is advisable to touch on each of the above areas, although you are not limited to these areas in your discussion. Keep in mind that, when making commitments to change, *less is often more*. Resist any attempts by the patient to make commitments that are clearly too ambitious. Setting goals too high, like trying to make too many changes at once, will likely lead to failure, disappointment or to avoidance of getting started.

5. Termination Process

As formal treatment comes to a close, the last session and/or last few sessions focus on the ending of treatment. Use clinical judgement to determine the number of sessions needed for each individual patient.

The final session(s) focus on the patient evaluating his/her treatment experience and setting recovery goals for the future.

Topic 12: Termination

Follow the regular format for the Review portion of the termination session(s), but make it brief, allowing more time to be spent on the *Termination* process.

Review

Meetings

Meetings attended and reactions.

What is the plan for future meetings?

What resistance is there at this point to going to meetings?

What is the patient's level of participation at meetings?

Clean Days

How many?

Reinforce each drug-free day.

How is the patient doing with living *one day at a time*?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, places, and Things to change?

Urges to Use

Where and when?

What did the patient do?

How could the patient use NA/CA/AA to help with urges in the future?

Slips

Where, when and with whom?

How is the patient doing at coming to terms with Step 1?

What can the patient do differently next time: People, Places, and Things to change?

Readings

What is being read?

What are the patient's reactions?

What questions does the patient have?

Getting a Sponsor

What progress is being made?

What is the basis of any resistance?

What suggestions can the therapist make, and what commitments will the patient make?

Telephone Therapy

How is the patient doing at telephone therapy?

What suggestions can the therapist make, and what commitments will the patient make in this area?

New Material: Termination

The final session(s) should focus on helping the patient honestly evaluate the treatment experience and establish goals for the future. The following questions can be used as a guideline in this process.

- What were the patient's views of addiction prior to treatment and what are they now?
 - Do they view drug dependence as a character defect or as an illness?
 - Can addicts control their drug use?
 - How would the addict describe the *addict* part of their personality?
 - How does it work to defeat the recovering part of their personality?
 - Does the patient understand that denial is a natural human tendency to resist accepting personal limitations?
 - Does the patient understand that drug dependency is an illness of the mind characterized by being obsessed with drugs?
- What was the patient's understanding of NA/CA/AA prior to treatment and what is it now?
 - What has been their experience with:
 - Going to meetings?
 - Getting a sponsor?
 - Getting active in 12-Step programs?
 - Calling 12-Step friends?
- Does the patient believe that s/he is drug dependent?
- What negative consequences of continued drug use does the patient fear most?
- What were the most helpful parts of the treatment program?
- What were the least helpful parts of the treatment program?
- What information in the treatment program was most useful and why?
- Would the patient recommend this treatment program to someone else with a drug problem? Why or why not?
- What are the patient's plans regarding 12-Step meeting attendance for the next 90 days?
- Is the patient willing to continue keeping his/her journal?

Troubleshooting

In helping patients evaluate their experience with this treatment program, the therapist needs to encourage honesty. Most likely, different patients will have found different parts of the program more or less helpful. Encouraging honesty in terms of feedback will help to facilitate honesty in making meaningful commitments for how many meetings the patient will attend afterward.

Regardless of the patient's view of success in the treatment (drug free days versus slips), treatment should end on a respectful note. Even patients with many slips and those who are in denial may come around someday. The information offered to them in treatment could be what they need at some point down the road, when they are ready to make use of it.

The therapist may end the final session with a handshake and a reminder that the 12-Step program Hotlines are listed in every phone book under Narcotics Anonymous, Cocaine Anonymous, and Alcoholics Anonymous, and that NA/CA/AA is available 24 hours a day, 365 days a year.

6. Conjoint Program

Conjoint Sessions

The two Conjoint Sessions are offered to patients and their significant other. The significant other may be a spouse, fiancé, sexual partner, sibling, or even an adult child or a close friend. The guideline is to do these sessions with someone who can support the patient's recovery efforts. The Conjoint Session should be scheduled only after the 5 Core Topics have been covered. The format of these sessions is unique, in that there is no real check-in portion of the session and the focus of the recovery tasks are really for the significant other.

Objectives of the two conjoint sessions:

- To estimate the level of significant other involvement in substance use.

- To describe 12-Step Facilitation Therapy

- To encourage the significant other to attend 12-Step Family groups, Nar-Anon or NA/CA/AA, as appropriate.

Significant others who appear to have no harmful involvement with drugs will be educated regarding the following:

- Twelve Step Facilitation Therapy

- The concept of enabling

- The concept of detaching

- Nar-Anon

Significant others who are suspected of being harmfully involved with mood-altering substances will be informed about TSF and the concept of enabling and will also be encouraged to seek an independent assessment of their own drug use and possible need for treatment.

Conjoint Session 1: Enabling

Program Outline (10 minutes)

Before fielding questions from the significant other, try to cover the following essential points about TSF:

12-Step Program Principles

This treatment is grounded in the principles of 12-Step programs (NA/CA/AA)

- Drug addiction is an illness of the body, mind, and spirit that is characterized by the loss of control and obsession with mood-altering substances. Drug dependence has predictable symptoms and a predictable course which, if left untreated, may lead to premature death or insanity.
- There is no cure. The disease can only be arrested. The best method for maintaining abstinence from all drugs is active involvement in 12-Step programs.
- The addict often resists the idea that s/he is drug dependent and will continually try to fool themselves that it is safe to use. This is called *denial*.
- 12-Step programs are based on the idea that the addict needs to resist taking the first drug that will trigger the compulsion to keep using, and needs to do this *one day at a time*.
- Having a “slip” means using after a period of abstinence. Slips are unfortunate, but what is most important is how the addict responds to a slip. It should not be an excuse to use more; rather, the best ways to deal with the slip are going to meetings, calling one’s sponsor, the NA Hotline, and most of all to stop using.
- This program is based on the idea that addicts are responsible for their own recovery. While many factors may lead a person to use mood-altering substances as a way of coping, addiction is ultimately a personal challenge. Drug dependence cannot be blamed on anyone else, nor can anyone else take responsibility for the addict’s slips or for the clean days.
- The significant other did not cause the illness, can not control it, and can not cure it.

Following this introduction, invite questions, answering them frankly, but limit the time to 10 minutes, explaining that there is still important to be covered. If the significant other has many questions and strong reactions, this would be a good time to refer them to Nar-Anon as a resource for additional information, advice, and support.

Significant Other Substance Use (15 minutes)

It is important to ask significant others about their use of alcohol and other mood-altering substances, with the patient present. General questions such as the following may be helpful:

- “How often do you drink alcohol or use any other mood-altering substances?”
- “Have you or your significant other ever felt that you had a problem related to alcohol or other substances?”
- “Do you know where you could go if you ever wanted to get an evaluation of your own substance use?”

Enabling

Explain to the patient and the significant other that enabling is a *dysfunctional* response to drug abuse and dependence. Enabling refers to any behaviors that mitigate or support the natural consequences of drug abuse. Enabling has the often unintended effect of allowing drug abuse to continue and get worse, by cushioning the addict, rather than allowing the addict to take responsibility for his/her behavior. Examples of enabling include:

- Making excuses for individuals when they are high and would otherwise get into trouble.
- Calling in sick for the person who is hung over.
- Excusing or justifying hostility or abuse that results from drug use.
- Accepting apologies after the fact for harm done while using.
- Lending the addict money for drugs, or forgiving a bad debt.
- Making drug runs in order to keep the addict out of trouble.
- Defending the addict’s inappropriate behavior to others.

Essentially, enabling is any behavior or attitude that avoids the real issue, which is drug abuse or dependence.

If there is any doubt that the patient’s significant other understands the concept of enabling, review it briefly and ask the patient to give some personal examples, using the Enabling Inventory. (Figure 6.1 follows).

Enabling Inventory			
<i>ENABLERS SIGNIFICANT OTHERS: SPOUSE/GIRLFRIEND/BOYFRIEND, FRIEND EMPLOYER, ETC.</i>	<i>HOW THEY ENABLED (Be specific)</i>	<i>ENABLER'S MOTIVES AND FEELINGS</i>	<i>HOW DID YOU ENCOURAGE THIS ENABLING?</i>

Figure 6.1 (See Appendix 4.4).

© Baker, S. & Nowinski, J. (1991)

Motives for Enabling

If enabling worsens the problem, why do people enable? Do they, either consciously or unconsciously want the addict to keep using? Some argue that enablers get some form of secondary gain from enabling — usually some control over the relationship. However, when you talk to enablers, the common impression is that they experience great frustration and a sense of impotence, combined with anger and resentment — the exact opposite of feeling powerful and in control.

Ask the significant other what motivated the enabling. Typical responses will be something like the following:

“I did it because I didn’t want him to get into trouble.”

“I was afraid that I’d lose the relationship.”

“I was scared and didn’t know what else to do,”

“Not helping seemed like a cruel thing to do.”

Acknowledge any or all of the above motives for enabling and the fundamental intent behind them. Doing that will help to reduce any stigma associated with enabling, which in turn will enhance motivation for detaching. If the significant other has trouble attributing any motivation at all to enabling, invite the patient to offer some feedback to reinforce these possible motivations.

Make the point to the patient and the significant other that enabling is usually encouraged by addicts, since it promotes their need to continue using and avoid facing their limitation (inability to control their drug use).

Engage both of them in a discussion of how the patient has either encouraged or coerced enabling in the past. The most common methods for this are to appeal to anxiety or guilt:

ANXIETY: “If you don’t help out, something terrible will happen that will

affect us both (loss of job, etc.)”.

GUILT: “Either it’s your fault that I have this problem or else you should cover up for me out of loyalty”.

Ask the patient how s/he encouraged enabling behaviors in the past and make a list for them to use as a reference.

Reactions to Enabling

Not unlike addiction, enabling typically follows a predictable course. In most cases, enablers initially react with concern and a desire to help. As time goes on, however, and the problem worsens, concern and anxiety usually give way to anger, resentment, and ultimately, alienation.

Do *not* attempt to dissuade significant others who imply that they may end the relationship with a patient who fails to stay clean. This may be another natural consequence of drug dependence. Do *not* attempt to resolve conflicts or to explore sources of resentment in any detail in this session. Instead, if any of these issues arise, suggest that they may wish to seek conjoint therapy but that they should wait until the patient has completed this treatment program and attended at least six 12-Step meetings.

Wrap-Up

Thank the significant other for coming, indicating your understanding that they may have felt resentful about it.

Introduce the idea of 12-Step recovery for family members. Contract with the significant other to attend weekly Nar-Anon, CA-Anon, or Al-Anon family group meetings and provide a schedule.

Troubleshooting

The most likely problems to arise as a result of the two conjoint sessions are:

- Significant other resistance (anger, resentment).
- Significant other substance abuse.
- Emergency calls from significant others.

Resistance

In this treatment, significant others are invited and encouraged to participate in the conjoint sessions, but cannot be required to do so as they are not themselves in treatment. The sessions are psychoeducational in structure and purpose and are not intended to be psychotherapeutic. The significant other who initially refuses to attend, or who fails to show up, should be contacted by phone at least once. The therapist should make a reasonable effort to get significant others to commit to coming for the first session. Be sure to reassure the significant other that the conjoint sessions are not therapy nor are they intended to diagnose the

significant other.

Significant Other Substance Abuse

Significant other substance abuse is at the same time a delicate issue and one that needs to be addressed. If the therapist has reason to believe that the significant other is abusing mood-altering substances, the agenda for the second conjoint session can be dropped in favor of pursuing an assessment of the significant other's substance abuse and referring them to an appropriate treatment program.

Emergency Calls

Significant others are most likely to call the therapist if the patient has a slip or if a conjoint session evokes strong reactions. What is consistent with this treatment program is to encourage the significant other to contact Nar-Anon or to seek individual counseling independent of this treatment program. If an emergency session seems important, it should be held as a conjoint session, with both the patient and the significant other present. The therapeutic goal when responding to any emergency is to give advice that is consistent with 12-Step programs.

Conjoint Session 2: Detaching

Goals

Define and illustrate *detaching* using examples drawn from the patient's and significant other's experience together.

To define *detaching with love* and help the significant other discriminate detachment from enabling.

To describe 12-Step groups for family members and encourage significant others to attend six meetings.

Review

Invite questions from the significant other about any material covered in the first conjoint session, trying to limit this discussion to approximately 15 minutes. Indicate that material presented in this session may help to answer questions related to what can be done, and provide the significant other with some direction.

Nar-Anon

Introduce Nar-Anon and other 12-Step family member groups as a fellowship of men and women who are in relationships with addicts and who gather in order to take care of themselves and seek support for their own growth process. Going to a 12-Step meeting does not imply any blame for the addict's problem drug use. 12-Step family groups were originally formed by spouses of addicts in order to help them learn to detach from any feelings of guilt or shame associated with their significant other's illness. Meetings are anonymous, there are no fees, and the only condition for membership is being in a relationship with an addict.

If the significant other has reservations about going to meetings, explore these by asking what questions or concerns they have that would stop them from going to meetings. Some common concerns are:

- "What kinds of people will I find there?"

Response: All kinds of people, some like you and some not like you. The common bond is being in a relationship with an addict.

- "What will I be expected to do?"

Response: Nothing is required of you. You can just go and listen and see if it is helpful to listen to others who share some of your experiences. If you would like to speak, that is also appropriate, either during or after the meeting.

- "What is the benefit of 12-Step family groups?"

Response: Living with an addict is like living with anyone who has a chronic illness. It affects not only the person with the illness, but everyone around them. Over time, their lives get out of control too, and they often experience depression, stress, and frustration. Often they are not sure what to do. The best source of help for these people is others who have had to deal with similar situations. 12-Step family groups offer a program for starting to take care of yourself instead of taking care of everyone else.

Detaching

Detachment is the opposite of enabling. Detaching is allowing the addict to deal with the natural consequences of his/her drug use.

Detaching makes sense to most people, yet on a practical level, many find it hard to adopt a detached attitude and to allow the addict to experience and deal with whatever consequences come their way. Ask the significant other why is this so?

Guilt

The most common barrier to detaching is guilt, which usually has two potential sources:

- Guilt over allowing the addict to deal with the natural consequences of his/her drug use, believing it is disloyal or unloving.
- Guilt over anger and resentment that leads to a vindictive attitude that the significant other is ashamed of.

Guilt that arises from feeling disloyal can be worked through by acknowledging the positive motives for enabling while also pointing out how enabling is self-defeating in the long run and how it unwittingly allows a drug problem to get worse.

Guilt over feeling angry and resentful can be uncovered and worked through by acknowledging such feelings as normal and consequences of enabling and then by clarifying detachment as not being vindictive but benign. Detachment comes from letting go of as opposed to holding on to resentment and anger, whereas enabling builds both. Reinforce this idea of detaching as being the more functional and loving response to problem drug use.

Ask the patient and significant other to think of two specific situations that might arise, and to identify enabling responses versus detached responses.

Example: The addict wakes up hung over and leaves for work more than an hour late.

- Enabling response: The significant other calls in with an excuse.
- Detached response: The significant other lets the addict deal with the employer and refuses to act as a middle man.

Wrap-Up

Wrap up this second conjoint session by encouraging the significant other to make use of any or all of the following resources:

- Nar-Anon, including Nar-Anon sponsors and friends.
- Individual therapy, preferably with a professional trained in treatment of addictions.
- Conjoint therapy after the patient completes this treatment program.

Troubleshooting

Probably the most common therapeutic complication of this session will be the addict's reactions to their significant other's becoming involved in 12-Step programs. This is where detaching needs to be conceptualized as a reciprocal process. Not only must significant others detach from addicts and allow them to be responsible for their own recovery, but also addicts must allow their significant others to take care of their needs and issues, including how addiction has affected them and how they should act in the future. The therapist should try to be an advocate of both the significant other's right to take responsibility for their own issues and to seek the support and guidance of peers.

The second possible complication is that strong emotions will be aroused, especially anger and resentment on the part of the significant other. With only two conjoint sessions, there is little chance of healing longstanding resentments. Rather, the patient and significant other can be encouraged to look into conjoint therapy after the patient has completed this treatment program and after the significant other has attended at least six Nar-Anon meetings. Recognize that problems exist and that the future of the relationship may be in doubt. On the other hand, they may stand to gain by putting off any decisions until both have had a chance to work a recovery program.

7. Therapist Selection, Training, and Supervision

Adapted from: Carroll, K.M. (1998). *A Cognitive-Behavioral Approach: Treating Cocaine Addiction*. NIH Publication 98-4308. Rockville, MD: National Institute on Drug Abuse.

Therapist Characteristics and Training Requirements

In the research studies which have evaluated this approach, TSF has been implemented by mostly masters level therapists with substantial experience in and commitment to 12-Step programs as a therapeutic intervention, who also had extensive experience treating a broad range of substance abusers. These therapists were selected to reduce the likelihood of therapist effects on treatment outcomes by utilizing a comparatively homogeneous group of highly skilled therapists. Furthermore, because therapist training/piloting period for these clinical trials is comparatively brief, it was important to select therapists who already had a high level of expertise and experience in this approach, and thus could achieve optimal levels of adherence and competence rapidly.

However, a much broader range of therapists can, with appropriate training and supervision, implement this treatment effectively. However, because this manual, like most others, focuses on specific TSF techniques and does not cover basic clinical skills, we would recommend certain minimal requirements for clinicians:

- A master's degree or equivalent in psychology, counseling, social work or a related field or certification as a substance abuse counselor, e.g., C.A.D.C. or its equivalent.
- At least 3 years experience working with a substance abuse population.
- Some familiarity with and commitment to a 12-Step approach.

Personal characteristics of therapists that are associated with improved outcome have not been an explicit focus of our research to date. However, we assume the attributes identified by Luborsky and colleagues (1985) as associated with better patient outcome would apply to this treatment as well, including personal adjustment, interest in helping the patient, ability to foster a positive working alliance, and high empathy and warmth.

Role of TSF Therapist

The therapist uses his/her therapeutic skills to help the patient overcome barriers to becoming actively involved in 12-Step recovery programs such as NA/CA/AA. Skills such as active listening, accurate empathy, problem solving, feedback, and confrontation all have a place in this therapy. One role is to act as an educator about 12-Step programs. This psycho-education must be tailored to the specific needs of the patient. Recovery tasks and Topic material are presented in such a way that the patient can incorporate the new information. The therapist, as a believer in the efficacy of 12-Step programs, acts as an advocate. Beyond this, the therapist supports the patient in his/her

ability to successfully work this program of recovery. In layman's terms, the therapist is both "coach" and "cheering squad" for the patient. The therapist provides guidance and advice about how best to access the resources of 12-Step programs. This may be based on the wisdom found in recovering literature, or slogans, or the stories of other recovering addicts. Lastly, the therapist provides empathy and a sense of hope for the patient. The therapist communicates clearly an understanding of the struggles of early recovery. In doing so, the process of acceptance and surrender are "humanized" so that the patient is given support that s/he is not alone. By encouraging the patient to reach out to other recovering addicts, the therapist helps the patient learn that it is possible to go through this process and to recover successfully from addiction.

Familiarity with 12-Step Programs

To be able to deliver this treatment well the therapist needs to do certain things. First, therapists must be familiar with 12-Step programs. This means feeling comfortable with the language of NA/CA/AA, understanding the how group meetings are run, where various 12-Step groups meet, being familiar with 12-Step recovery literature. In order to become familiar with 12-Step programs, the therapist may attend several "open" meetings of 12-Step groups in their area and read through recovery literature.

Active and Facilitative

TSF requires an active, supportive and involved presence by the therapist in sessions. Good TSF appears almost conversational in tone. A good session involves give and take between the therapist and the patient. The session, however, is quite focused. The therapist takes an active part in keeping the focus of the session on recovery. Some therapists begin their sessions by asking the patient, "How has your recovery week been?".

When faced with the day to day struggles of the patient, the therapist refers the patient back to the use of 12-Step program tools. So, for example, after listening with empathy to a patient, a therapist may suggest that s/he talk this problem over with a sponsor or peer as well as talk about the issue at a meeting.

Confrontation

Lastly, the therapist doing TSF uses confrontation constructively. A term for the style of confrontation used by therapists is "care-frontation". This means that the therapist is careful to confront the patient's behavior as it relates to his/her addiction i.e., denial, avoidance, etc. rather than their person. This means separating the person from their disease and communicating that the patient is a *good* person who has a disease (addiction) that leads him/her to act in ways that are hurtful towards him/herself and others, By doing so, the therapist can endorse what ever efforts the patient makes on behalf of recovery.

Therapist Training

Just as reading a textbook on surgery could not be expected to produce a

qualified surgeon, mere review of this manual would be inadequate for a therapist to apply this manual in clinical practice or research. Appropriate therapist training for TSF for Drug Dependence requires completion of a didactic seminar and at least two closely supervised training cases.

Didactic Seminar

The didactic seminar usually lasts from 2 days to one week, depending on the experience level of the therapists. The seminar includes a review of basic 12-Step principles, topic-by-topic review of the manual, watching videotaped examples of therapists implementing the treatment, several role play and practice exercises, discussion of case examples, and rehearsing strategies for difficult or challenging cases.

Supervised Training Cases

The supervised training cases provide an opportunity for the therapist to try on this approach and to learn to adapt their usual approach to conform more closely to manual guidelines. The number of training cases varies, of course, according to the experience and skill level of the therapist. Generally, we find that more experienced therapists require only one or two training cases to achieve high levels of competence, which is consistent with experience from the NIMH Treatment of Depression Collaborative Research Program (Rounsaville et al., 1986; Weissman et al., 1982). Less experienced therapists generally require two to four supervised cases.

For supervision of training cases, each session is videotaped and forwarded to the supervisor. The supervisor reviews each session, completes a rating form (described below) evaluating the therapist's adherence and competence in implementing the treatment session, and provides one hour of individual supervision to the therapist. Supervision sessions are structured around the supervisor's ratings of adherence and competence, with the supervisor noting areas in which the therapist delivered the treatment effectively, as well as areas in need of improvement.

Rating and Assessment of Therapist Adherence and Competence

To have a concrete basis on which to evaluate therapist implementation of TSF, both therapists and supervisors complete parallel adherence rating forms after each session conducted or viewed. The rating forms are provided in the appendix. They consist of Likert-type items covering a range of key TSF interventions (review of recovery tasks, exploration of the patient's use of denial, encouragement to make use of 12-Step programs, etc.).

The therapist version of the form (Appendix 7.1), called the TSF Therapist Checklist (Carroll et al., 1998), asks the therapist to rate what TSF strategies and interventions were implemented in a given session, and how much the intervention was used. The TSF Checklist has a variety of purposes. First, it is intended to remind the therapist, at each session, of the key ingredients of TSF. Second, the TSF Checklist is intended to foster a greater adherence to the

manual through self monitoring of adherence. Third, it can organize and provide the basis for supervision, as the therapist can more readily note and explore with the supervisor the strategies and interventions s/he has trouble implementing with a given patient. Fourth, in our research studies, completion of the TSF Checklist fosters process research by generating a useful record of which interventions were or were not delivered to each patient in a given session. Thus, for example we can construct a session-by-session *map* of the order and intensity of TSF interventions introduced to a range of patients (Carroll, K.M., Nich, C., & Rounsaville, B.J., 1998).

The supervisor version of the form (Appendix 7.2), called the TSF Rating Scale (Carroll et al., 1998) differs from the therapist version by adding a skillfulness for each item. Thus for each intervention, both *quantity* and *quality* are rated. The TSF Rating Scale is an essential part of training, as it provides structured feedback to the therapist and forms the basis of supervision. It also provides a method of determining whether a therapist in training is ready to be certified to deliver the treatment. When used with ongoing supervision, it enables the supervisor to monitor and correct therapist *drift* in implementation of the treatment. Finally, for therapists who have difficulty adhering to manual guidelines but who maintain that they are, pointing out discrepancies between the supervisor-generated TSF Rating Form and the therapist-generated Therapist Checklist is often a useful strategy for enhancing adherence.

For both versions of the scale, it is important to note that not all items on the rating forms are expected to be covered, or covered at a high level, during all sessions. However, items 7–16 do reflect the essential TSF items that should be present at least at a moderate level in the majority of sessions. A copy of the rating manual and rater’s guidelines that accompanies this form is available from Dr. Carroll.

Certification of Therapists

Therapists are *certified*, or approved to implement the treatment at lower levels of supervision, when the supervisor determines that the therapist has completed an adequate number of training cases successfully. We also use more objective criteria, that is, for the most recent case, an adherence score of a 3 or more on any *key* TSF items (items 7–16), and no skill rating below a 3 (adequate) on any item delivered.

After certification, levels of therapist adherence are monitored closely using the TSF Rating Form. When therapist *drift* occurs, and the therapist strays from adequate adherence to the manual, supervisors increase the frequency of supervision until the therapist’s performance returns to acceptable levels.

Ongoing Supervision

We require ongoing supervision for all therapists delivering TSF. However, the level and intensity of ongoing supervision reflects the experience and skill of the therapists, as well as the time available for supervision. The minimum acceptable level of ongoing supervision for an experienced therapist is monthly;

weekly supervision is recommended for less experienced therapists. In addition, supervisors should review and evaluate using the TSF Tape Rating Scale, 1–2 randomly selected sessions per patient. Supervision sessions themselves should include a general review of the therapists current cases, discussion of any problems in implementing TSF, review of recent ratings from the supervisor, and *at least one of every two supervision sessions should include review of a session video tape, with the therapist and supervisor both present.*

Guidelines for Ongoing Supervision

In general, supervision is most effective when conducted at a consistent place, date, and time; the goals of supervision are clear and both participant's roles are defined; the procedures that will be used for evaluation of the therapists are clarified; and feedback to the therapist is based on session tapes and is focused and concrete ("When you explored X's last slip, I thought you could have gotten more information about the events that led up to X's use and connected those to the 12-Step program idea of avoiding slippery people places and things. I think that you need to be more explicit about how X can make use of specific 12-Step program tools.") (Witte & Wilber, 1997).

Common Problems Encountered in Supervision

FAILURE TO BALANCE MANUAL-SPECIFIED INTERVENTIONS AND PATIENT NEEDS AND CONCERNS. As noted earlier, the structure of TSF sessions (20/20/20 rule) is intended to integrate 12-Step program tools with effective supportive therapy that meets the needs of each patient as an individual. Novice therapists, particularly those with less experience in treating substance abusers and the need to maintain a higher level of structure than that to which they may be accustomed, often tend to let sessions become unfocused, without clear goals, and do not make the transitions needed to deliver 12-Step program tools effectively. Such therapists often do not begin to introduce 12-Step recovery material until the last few minutes of the session, which results in rushing through important points, failing to use patient examples or get patient feedback, and neglecting review of the recovery tasks, all of which gives the impression that 12-Step program tools are not very important. Similarly, other therapists allow themselves to become overwhelmed by the constant substance-use related crises presented by a patient and fail to focus on 12-Step recovery tools, or encouraging their use as an effective way to help the patient avoid or manage crises. Falling into a crisis driven approach tends to increase, rather than decrease, patient anxiety and undermine self-efficacy. On the other hand, maintaining a relatively consistent session *routine* and balancing the patient driven discussion of current concerns with focus on 12-Step recovery tools is also a means by which the therapist can model the 12-Step principle of putting "first things first", i.e., putting the focus on recovery, without which nothing else is possible.

Conversely, some therapists become overly fixed and inflexible in their application of teaching 12-Step tools and adherence to the manual. Some

therapists, anxious to *get it right*, present the material in the manual more or less verbatim to patients. This overly wooden approach necessarily fails to adapt the teaching of 12-Step program tools to the particular needs, coping style, and readiness of particular patients. For example, some therapists launch into teaching about 12-Step program tools, which requires considerable activity and commitment from the patient, with patients who are still highly ambivalent or even resistant to treatment. It is important to remind such therapists that the manual is a blueprint, or a set of guidelines for treatment, to be used to provide a clear set of goals and overall structure to the treatment, but manuals are by no means *scripts* for treatment. This often entails considerable sufficient familiarity by the therapist with the didactic material, so the therapist can alter the material to adapt to each individual patient, and the material can be presented in a way that sounds fresh and dynamic, not manual generated. Patients should never be aware that the therapist is following a manual.

A NOTE ON BALANCING ADHERENCE AND COMPETENCE.

There is an important distinction between adherence and competence, that is, the degree to which the therapist follows the guidelines laid out in the therapy manual, and therapist competence, which refers to the therapist's level of skill in delivering that treatment (Carroll & Nuro, 1997). Several investigators have noted that a therapist's adherence and competence are not necessarily closely related (Shaw & Dobson, 1988; Waltz, Addis, Koerner, & Jacobson, 1993). That is, a therapist can follow a treatment manual virtually word-for-word and not deliver that treatment competently or skillfully (i.e., with an appropriate level of flexibility and understanding of a particular patient, using appropriate timing and language). In some cases extremely high adherence (e.g., a wooden, mechanistic, rote repetition of material in the manual) indicates very low competence in a therapist. High adherence and low skillfulness may also occur in cases where a therapist delivers a technique competently, but at an inappropriate level during a session that is insensitive to the needs of a particular patient. Conversely, there are cases of high skillfulness and low competence, for example, where a therapist empathetically responds to the patient and provides incisive interpretations at the precise moment they are most likely to be helpful, but rarely touches on material described in the manual (Carroll & Nuro, 1997). Achieving a high level of adherence to the TSF manual and fostering a positive therapeutic alliance should be seen as complementary, not contradictory, processes.

SPEEDING THROUGH MATERIAL. Many of the 12-Step recovery concepts, while seemingly simple and based on common sense, are in fact quite complex, particularly for patients with cognitive impairment, those with dual diagnoses, and those who have a low baseline of coping skills. Thus, a common error made by many therapists is to fail to check back with the patient to make sure s/he understands the material and thinks

through how it might be applied to his/her current concerns. When this occurs, it often takes the form of presentation of 12-Step recovery material as a lecture, rather than a dialogue between the patient and the therapist. Ideally, for each idea or concept presented by the therapist, the therapist should stop and ask the patient to provide an example or to describe the idea in his/her own words before presenting the next idea.

OVERWHELMING THE PATIENT. For each session topic, a range of ideas and 12-Step recovery tools are presented. Another problem that arises is that some therapists try to present all of the material, in the order presented in the manual, to each patient. For many patients, it is overwhelming. Learning and feeling comfortable with one or two recovery tools is far preferable to having only a surface understanding of several. Similarly, if too much material is presented, the time that can be devoted to practicing particular recovery tools is limited. Introduction of new material can be spread out over several sessions. The topic of "Hungry, Angry, Lonely, Tired", which contains several 12-Step techniques for managing stressful situations, for example, can be spread out over several sessions.

LETTING RECOVERY TASKS SLIDE. Although process data from our clinical trials suggests that the majority of patients carry out recovery tasks and those who follow through with recovery tasks have better substance use outcomes, a number of therapists do not sufficiently attend to recovery tasks. This takes the form of cursory review of completion of recovery tasks in the beginning of sessions (T: "Did you speak at the NA meeting like we talked about?". P: "Yes". T: "Good".), rather than letting review of the assignment provide some structure to the first part of the session. This gives the patient the message that recovery tasks are not important. It also takes the form of rushing through recovery task assignment at the end of sessions, and not being creative in recovery tasks assignments. Often, this reflects a therapist's low expectations that the therapist will carry out the exercise (and often reflects low expectations about the patient's prognosis). Generally, therapists who expect their patients will practice outside of sessions have patients who do so.

ABANDONING THE MANUAL WITH DIFFICULT PATIENTS. Many patients present with a range of complex and severe comorbid problems. Again, some therapists become overwhelmed by concurrent problems and drift from use of the manual in an attempt to address all the patient's problems. In such cases, the therapist often takes a less, rather than the more structured approach needed by the patient. Generally, if the patient is sufficiently stable for outpatient therapy, we have found that the manual, which provides guidelines for a highly structured approach to treatment, prioritizing of concurrent problems, offering limited case management, and focussing primarily on achieving initial abstinence through participation in 12-Step programs, is adequate to contain even fairly disturbed patients.

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Appendix

Substance Use History

AGE	TYPE OF DRUG AMOUNT USED HOW OFTEN	POSITIVE/NEGATIVE CONSEQUENCES	SIGNIFICANT EVENTS AT THIS TIME OF LIFE

First Step Worksheet

The first step of NA/CA/AA suggests that:

“We admitted we were powerless over our addiction, that our lives had become unmanageable.”

Experience has shown that people who have been able to remain clean and sober have come to terms with this statement as it applies to their lives. In order to assist you in taking this step, try *honestly* answering the following questions in your journal. After that, discuss these with your sponsor (if you have one) or your Twelve Step Therapist.

The first thing is to admit *powerlessness*, or, in other words, to say “I can't control my use of drugs, or the consequences of my use of drugs.”

- How have drugs placed your life, or the lives of others, in jeopardy?
- How have you lost self-respect due to your drug use?
- How have you tried to control your use of drugs?
- What types of physical abuse have happened to you, or others, as a result of your drug use?
- Are you happy with yourself about your alcohol/drug use?

Next, it is important to honestly look at how the consequences of our drug use have affected us. This is “connecting the dots”. When I use, this is what happens. Looking back over your drug use career:

- What health problems have you had?
- What family/personal problems have you had?
- What sexual problems have you had?
- What legal problems have you had?
- What financial problems have you had?
- What work problems have you had?

Remember that “loss of control” (powerlessness) and problems (unmanageability) are symptoms of the disease of drug dependence. In order to recover, people have admitted their limitations and accepted that the solution is to be open to support from others (NA/CA/AA) and to stay away from the first use, *one day at a time!*

Lifestyle Contract

DANGEROUS TO RECOVERY (What needs to be given up)	PATIENT'S FEELINGS ABOUT DANGERS	SUPPORTS RECOVERY (What needs to be substituted)	PATIENT'S FEELINGS ABOUT SUPPORTS
People			
Places			
Things (Rituals/routines)			

Thinking about a Spiritual *vs* a Non-spiritual Way of Living

Spirituality has to do with meaning and purpose in life; what it means to be human, who we are, why we are here.

Spirituality does NOT mean mysticism or spiritualism, or an Eastern religious practice.

It is NOT a set fo rules about what is good and bad, right and wrong.

It is NOT church doctrine or religious belief.

Spirituality is a way of life, a way of thinking, that helps sobriety.

The following is a comparison of non-spiritual *vs* a spiritual way of living and thinking:

	NON-SPIRITUAL	SPIRITUAL
VALUE	Things	People
THE GOAL IS	Acquire Things	Good Relationships
THE GOOD LIFE IS	Money	Friends
GET THE GOOD LIFE BY	Competing and Getting	Caring and Giving
GET SELF-WORTH THROUGH	Doing Being Perfect Success	Being (Who I am as a person) Being Human (Accepting my limits and dependence) Faithfulness

We all live and think in both non-spiritual and spiritual ways. One is not good and the other bad; one way is not right and the other wrong.

However, when the non-spiritual way of thinking and living so dominates my life that I don't allow for people and spiritual values. I get into trouble.

If I am chemically dependent (addicted to alcohol or other mood-altering drugs) and my thinking and living is primarily non-spiritual, I will have great difficulty in staying drug free because of the following reasons:

1. This way of thinking is ADDICTIVE.
2. This way of thinking tends to produce feelings of FEAR, ANXIETY, ANGER, and DEPRESSION.

The only way of escape from the non-spiritual way of life without getting into a more spiritual way of life is through drugs; finding "God in a bottle".

All of us need to be LOVED, ACCEPTED, and FORGIVEN. The non-spiritual way of life (things) does not meet these needs.

There are only two sources of LOVE, ACCEPTANCE, and FORGIVENESS: people and God or a Higher Power . We need both sources to have our needs fully met.

ID #: _____

Check if Asked by Interviewer

DATE: ____/____/____

Administered by: _____

Checked by: _____

R A B

Please read each of the following questions very carefully. As you will see, many of these questions are very personal. We understand this and have taken great care to protect the privacy of your answers.

It is important that you answer every question honestly. In fact, it's better not to answer a question at all than to tell us something that is not accurate or true. Some questions may not seem to have an answer that is true for you. When this happens, you should simply choose the answer that is most right. Don't spend too much time on any one question. Remember, always ask for help if you're unsure about what to do.

Thank you for your time and cooperation.

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The Risk Assessment Battery (RAB) Scoring System, v.7;6/92:

Currently the RAB is scored simply by adding the values that correspond to the responses selected by the subject for the items listed below. This total score is then divided by 64, the highest possible score. While this total scale score has been correlated with serostatus and seroconversion, we are currently exploring the psychometric properties of the scale with a new and larger sample. Thus, caution should be used in relying too heavily upon the scores produced by this procedure. It is important that each item be reviewed for its clinical significance and potential to indicate a need for intervention. We anticipate developing sub-scale scores for both drug-related risk and sex-related risk. These tentative sub-scales are also identified in the following listing.

<u>Drug Risk Items</u>	<u>Range</u>	<u>Highest Value</u>	
#13. Injected	0-1	1	_____
#14. Shared	0-1	1	_____
#14.a. # Shared With	0-5	5	_____
#19. Frequency of visit to shooting gallery	0-7	7	_____
#23. Frequency of sharing rinse water	0-7	7	_____
#24. Frequency of sharing cooker	0-7	7	_____
#25. Frequency of sharing cotton	0-7	7	_____
DRUG RISK TOTAL:		35	= _____ DRUGRISK

<u>Sex Risk Items</u>	<u>Highest Range</u>	<u>Value</u>	
#20. Frequency of visits to crack house	0-7	7	_____
#26. Sexual orientation (gay or bisexual=1)	0-1	1	_____
#27. Number of male partners	0-5	5	_____
#28. Number of female partners	0-5	5	_____
Highest value of #29-#32		7	
#29. Frequency of sex for drugs	0-7 (_____)		
#30. Frequency of drugs for sex	0-7 (_____)		
#31. Frequency of sex for money	0-7 (_____)		
#32. Frequency of money for sex	0-7 (_____)		_____
#34. Freq. of condom use	0-4	4	_____
SEX RISK TOTAL:		35	= _____ SEXRISK

TOTAL SCORE = DRUG RISK TOTAL + SEX RISK TOTAL 64 _____ RABSCORE

RAB SCALE SCORE = TOTAL SCORE ÷ 64 1 _____ RABSCALE

DRUG AND ALCOHOL USE

1. In the past **month**, how often have you injected **cocaine and heroin** together (**Speedball**)?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

2. In the past **month**, how often have you injected **heroin** (not mixed)?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

3. In the past **month**, how often have you snorted **heroin** (not mixed)?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

4. In the past **month**, how often have you snorted **cocaine** (not mixed)?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

5. In the past **month**, how often have you injected **cocaine** (not mixed)?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

6. In the past **month**, how often have you smoked **freebase, rock, or crack cocaine**?
 0. Not at all
 1. Few times
 2. A few times each week
 3. Everyday

7. In the past **month**, how often have you used **speed/amphetamine**?

- 0. Not at all
- 1. Few times
- 2. A few times each week
- 3. Everyday

8. In the past **month**, how often have you used **ice**?

- 0. Not at all
- 1. Once to a few times
- 2. A few times each week
- 3. Everyday

9. In the past **month**, how often have you used **Xanax**?

- 0. Not at all
- 1. Once to a few times
- 2. A few times each week
- 3. Everyday

9a. If you have used Xanax, is this **prescribed** by a doctor?

- 0. No
- 1. Yes

9b. If it is prescribed by a doctor, do you use it more than it is prescribed?

- 0. No
- 1. Yes

10. In the past **month**, how often have you used **Valium**?

- 0. Not at all
- 1. Once to a few times
- 2. A few times each week
- 3. Everyday

10a. If you have used Valium, is this **prescribed** by a doctor?

- 0. No
- 1. Yes

10b. If it is prescribed by a doctor, do you use it more than it is prescribed?

- 0. No
- 1. Yes

11. In the past **month**, how often have you used **marijuana**?
0. Not at all
 1. Once to a few times
 2. A few times each week
 3. Everyday
12. In the past **month**, how often have you used **beer, wine or liquor**?
0. Not at all
 1. Once to a few times
 2. A few times each week
 3. Everyday

NEEDLE USE

13. In the **past six months**, have you **injected** drugs?
0. No
 1. Yes
14. In the **past six months**, have you **shared needles or works**?
0. No
 1. Yes
- 14a. With how many **different people** did you share needles/works in the **past six months**?
0. 0 or I have not shot up in the past six months
 1. 1
 2. 2 or 3 different people
 3. 4 to 6 different people
 4. 7 to 10 different people
 5. 11 or more different people
15. In the **past six months**, how many times have you used after someone without cleaning?
0. Never or I have not shot up or shared in the past 6 months
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day

16. In the **past six months**, how many times have others used after you without cleaning?
0. Never or I have not shot up or shared in the past 6 months
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
17. In the **past six months**, how often have you **shared needles** with someone you knew (or later found out) had AIDS or was positive for the AIDS virus?
0. Never or I have not shot up or shared in the past 6 months
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
18. Where did you get your **needles** during the **past six months**?
0. I have not shot up in the past six months
 1. From a diabetic
 2. On the street
 3. Drugstore
 4. Shooting gallery
 5. Other: _____
19. How often have you been to a **Shooting Gallery** in the **past six months**?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day

20. How often have you been to a **Crack House** in the **past six months**?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
21. For the **past six months**, which statement best describes your way of **cleaning your needle**?
0. I have not shot up in the past six months
 1. I always use new needles
 2. I always clean my needle just before I shoot up
 3. After I shoot up, I always clean my needle
 4. Sometimes I clean my needle, sometimes I don't
 5. I never clean my needle
22. If you have cleaned your needles and works in the **past six months**, **how** did you clean them?
0. I have not shot up in the past six months
 1. Soap and water or water only
 2. Alcohol
 3. Bleach
 4. Boiling water
 5. Other: _____
 6. I did not clean my needles in the past six months
 7. I ALWAYS used new needles in the past six months
23. In the **past six months**, how many times have you shared **rinse water**?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day

24. In the **past six months**, how many times have you shared a **cooker**?

- 0. Never
- 1. A Few Times
- 2. About Once a Month
- 3. A Few Times Each Month
- 4. About Once Each Week
- 5. A Few Times Each Week
- 6. Every Day
- 7. More Than Once a Day

25. In the **past six months**, how many times have you shared **cotton**?

- 0. Never
- 1. A Few Times
- 2. About Once a Month
- 3. A Few Times Each Month
- 4. About Once Each Week
- 5. A Few Times Each Week
- 6. Every Day
- 7. More Than Once a Day

Sexual Practices

26. How would you describe yourself?

- 1. Straight/Heterosexual
- 2. Gay/Homosexual
- 3. Bisexual

27. With how many **men** have you had sex in the **past six months**?

- 0. 0 men
- 1. 1 man
- 2. 2 or 3 men
- 3. 4 to 6 men
- 4. 7 to 10 men
- 5. 11 or more men

28. With how many **women** have you had sex in the **past six months**?
0. 0 women
 1. 1 woman
 2. 2 or 3 women
 3. 4 to 6 women
 4. 7 to 10 women
 5. 11 or more women
29. In the **past six months**, how often have you had sex so you could **get drugs**?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
30. In the **past six months**, how often have you **given drugs** to someone so you could have sex with them?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
31. In the **past six months**, how often were you **paid money** to have sex with someone?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day

32. In the **past six months**, how often did you **pay money** to have sex with someone?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
33. In the **past six months**, how many times have you had sex with someone you knew (or later found out) had AIDS or was positive for the AIDS virus?
0. Never
 1. A Few Times
 2. About Once a Month
 3. A Few Times Each Month
 4. About Once Each Week
 5. A Few Times Each Week
 6. Every Day
 7. More Than Once a Day
34. In the **past six months**, how much of the time did you use **condoms** when you has sex?
0. I have not had sex in the past 6 Months
 0. All the time, Every time
 1. Most of the time
 2. About half the time
 3. Less than half the time
 4. None of the time

If you know that you are HIV positive, skip to question 38.

35. How worried are you about getting HIV or AIDS?
0. Not at all
 1. Slightly
 2. Moderately
 3. Considerably
 4. Extremely

ID #: _____

36. How worried are you that you may have already been exposed to the HIV or AIDS virus?

- 0. Not at all
- 1. Slightly
- 2. Moderately
- 3. Considerably
- 4. Extremely

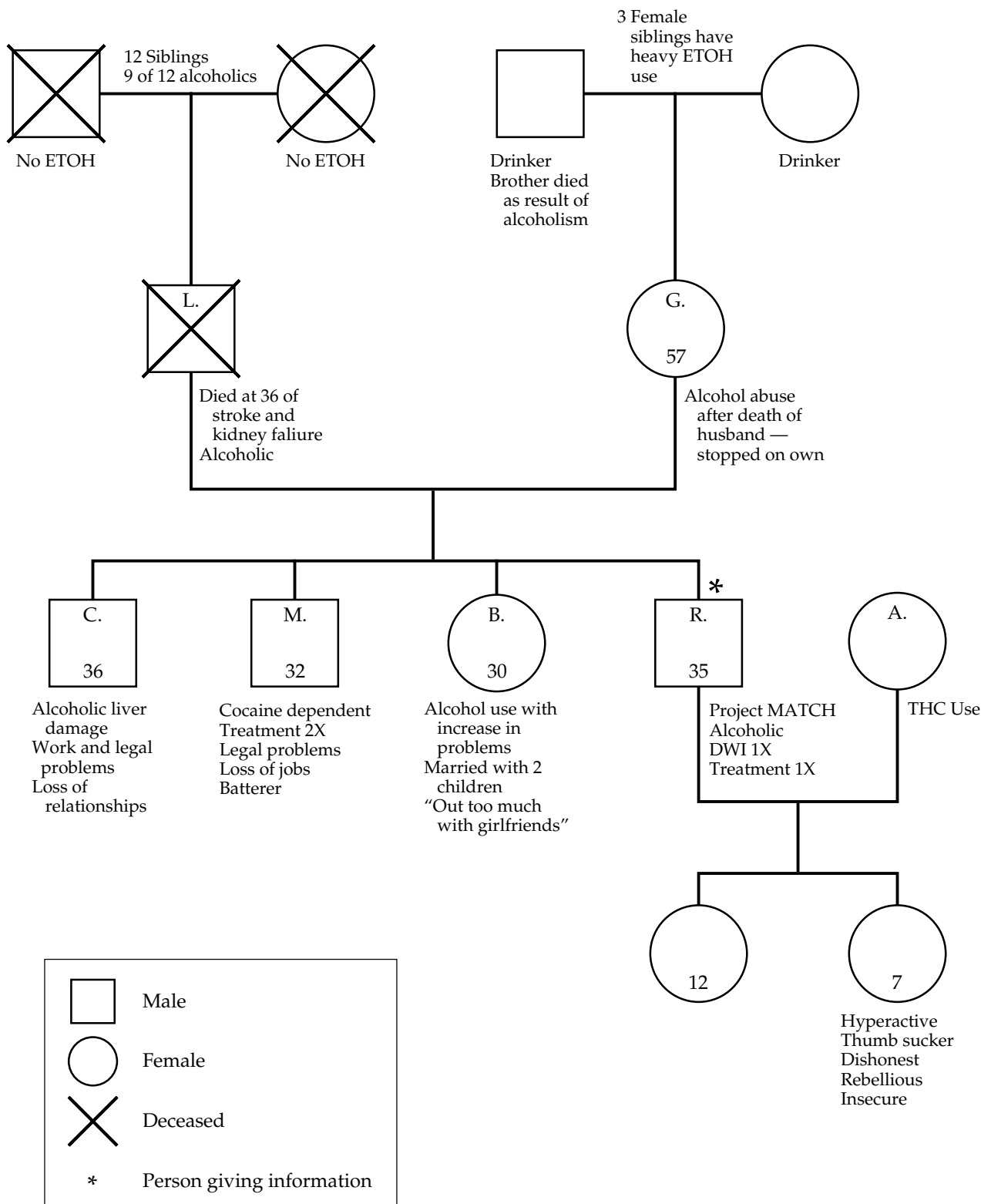
37. How many times have you had a blood test for the AIDS virus (HIV)?
(circle response):

0 1 2 3 4 5 6 7 8 9 10+

38. Were you ever told that you had the AIDS (HIV) virus?

- 1. Yes
- 0. No
- 2. Never got the results

Sample Genogram



Enabling Inventory

ENABLERS SIGNIFICANT OTHERS: SPOUSE/GIRLFRIEND/BOYFRIEND, FRIEND EMPLOYER, ETC.	HOW THEY ENABLED (Be specific)	ENABLER'S MOTIVES AND FEELINGS	HOW DID YOU ENCOURAGE THIS ENABLING?

Resentment Worksheet

WHAT HAPPENED	HOW I FELT	WHAT I DID	WHAT I SHOULD DO DIFFERENTLY USING PROGRAM TOOLS

12-Step Facilitation Therapist Checklist:

STUDY: ___ PATIENT ID: ___ ___ ___ ___ DATE: ___ ___ / ___ ___ / ___ ___

SITE: ___ ___ ___ THERAPIST ID: ___ ___ WEEK: ___ ___ SESSION: ___ ___

**PLEASE COMPLETE THE FOLLOWING BASED ON THIS SESSION WITH THE PATIENT.
DO NOT COMPLETE IF THIS WAS AN EMERGENCY SESSION OR IF THE SESSION WAS
TRUNCATED DUE TO PATIENT INTOXIFICATION.**

1. Was this a core or elective session?

- 1 = Core
- 2 = Elective

2. What session topic was covered this week?

- | | |
|----------------------------|------------------------------------|
| 1 = Introduction | 8 = Enabling |
| 2 = Step 1/Acceptance | 9 = Emotions |
| 3 = People, Places, Things | 10 = Moral Inventories (Steps 4&5) |
| 4 = Surrender | 11 = Clean Living |
| 5 = Getting Active | 12 = Conjoint Session 1/Enabling |
| 6 = HIV Risk Reduct | 13 = Conjoint Session 2/Detachment |
| 7 = The Genogram | 14 = Termination |

Approximately how many minutes of this session were devoted primarily to discussion of the manual session topic for this week? ___ ___ minutes

3. Did you check completion of last session's recovery tasks?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

4. How many 12-Step meetings (any type) did the patient attend since the last session?

___ ___ sessions

5. Did the patient make journal entries since last session?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

6. Did the patient read suggested 12-Step literature since last session?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

If so, from what source(s)?

- 1 = Big Book(s)
- 2 = 12 x12
- 3 = Living Sober
- 4 = Other: _____

7. To what extent did you review the patient's **REACTIONS TO LAST SESSION'S RECOVERY TASKS** (e.g., 12-Step meetings, suggested readings, obtaining a sponsor, using the telephone to contact 12-Step peers, written assignments)?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
8. Did you suggest **RECOVERY TASKS** for next week?
 1 = No
 2 = Yes
- If so, please describe:* _____
9. To what extent did you discuss the patient's acceptance of his/her disease, it's implications, it's symptoms, or discuss the **DISEASE CONCEPT OF ALCOHOLISM**?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
10. To what extent did you explore the patient's **DENIAL**/resistance (e.g., avoiding meetings, minimizing negative consequences) **OR** discuss the patient's resistance to the following 12-Step recovery in terms of his/her denial **OR** discuss the need to surrender?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
11. To what extent did you encourage the patient to **BECOME ACTIVE** (e.g., 12-Step meeting attendance, getting a sponsor) **OR** plan specific 12-Step program activities for the week (e.g., speaking or helping at a particular meeting, use of the telephone) **OR** encourage the patient to use 12-Step program involvement as a means of coping?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
12. To what extent did you explicitly refer to **12-STEP RECOVERY** **OR** interpret or explain a particular step to the patient **OR** invoke a particular step concept during the session **OR** discuss the patient's progress through the steps?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
13. To what extent did you explicitly invoke the concept of **SPIRITUALITY** or a **HIGHER POWER** as a source of strength, hope, and guidance in the patient's working a recovery program (e.g., invoking the Serenity Prayer, reference to Steps 2&3)?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively
14. To what extent did you **ASSESS THE PATIENT'S DRUG USE** since the last session?
- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
 Not at all Somewhat Considerably Extensively

15. To what extent did you discuss or address the patient's current **COMMITMENT TO ABSTINENCE**?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

16. To what extent did you discuss, review, or reformulate the patient's **GOALS FOR TREATMENT**?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

12-Step Facilitation Tape Rating Scale/Tape Rater Version:

STUDY: ___ PATIENT ID: ___ ___ ___ DATE: ___ ___ / ___ ___ / ___ ___

SITE: ___ ___ THERAPIST ID: ___ ___ WEEK: ___ ___ SESSION: ___ ___

**PLEASE COMPLETE THE FOLLOWING BASED ON THIS SESSION WITH THE PATIENT.
DO NOT COMPLETE IF THIS WAS AN EMERGENCY SESSION OR IF THE SESSION WAS
TRUNCATED DUE TO PATIENT INTOXIFICATION.**

1. Was this a core or elective session?

- 1 = Core
- 2 = Elective

2. What session topic was covered this week?

- | | |
|----------------------------|------------------------------------|
| 1 = Introduction | 8 = Enabling |
| 2 = Step 1/Acceptance | 9 = Emotions |
| 3 = People, Places, Things | 10 = Moral Inventories (Steps 4&5) |
| 4 = Surrender | 11 = Clean Living |
| 5 = Getting Active | 12 = Conjoint Session 1/Enabling |
| 6 = HIV Risk Reduct | 13 = Conjoint Session 2/Detachment |
| 7 = The Genogram | 14 = Termination |

Approximately how many minutes of this session were devoted primarily to discussion of the manual session topic for this week? ___ ___ minutes

3. Did you check completion of last session's recovery tasks?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

4. How many 12-Step meetings (any type) did the patient attend since the last session?

___ ___ sessions

5. Did the patient make journal entries since last session?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

6. Did the patient read suggested 12-Step literature since last session?

- 1 = No
- 2 = Yes
- 9 = N/A none assigned last session

If so, from what source(s)?

- 1 = Big Book(s)
- 2 = 12 x12
- 3 = Living Sober
- 4 = Other: _____

12. To what extent did you explicitly refer to **12-STEP RECOVERY OR** interpret or explain a particular step to the patient **OR** invoke a particular step concept during the session **OR** discuss the patient's progress through the steps?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

SKILL LEVEL:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Poor Adequate Very adequate Excellent

13. To what extent did you explicitly invoke the concept of **SPIRITUALITY** or a **HIGHER POWER** as a source of strength, hope, and guidance in the patient's working a recovery program (e.g., invoking the Serenity Prayer, reference to Steps 2&3)?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

SKILL LEVEL:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Poor Adequate Very adequate Excellent

14. To what extent did you **ASSESS THE PATIENT'S DRUG USE** since the last session?

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

SKILL LEVEL:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Poor Adequate Very adequate Excellent

15. To what extent did you discuss or address the patient's current **COMMITMENT TO ABSTINENCE?**

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

SKILL LEVEL:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Poor Adequate Very adequate Excellent

16. To what extent did you discuss, review, or reformulate the patient's **GOALS FOR TREATMENT?**

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Not at all Somewhat Considerably Extensively

SKILL LEVEL:

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
Poor Adequate Very adequate Excellent