

# JOURNAL

## OF ADDICTIVE DISORDERS

### THE CONVERGENCE OF GROUP PSYCHOTHERAPY AND THE TWELVE STEPS OF AA.<sup>1</sup>

#### ARTICLE

##### Abstract

Alcoholics and other chemically dependent people seem to recover best in group therapy settings. Groups effectively break down the denial process through a combination of identification, confrontation, feedback and support. Every alcoholic/CD should be strongly encouraged to regularly attend AA/NA meetings. Many specialists consider it the single most important aspect of treatment. Formal alcoholism/CD group therapy is also successful. In concert, AA and group therapy are highly successful, constituting one of the strongest forms of treatment available. (Gitlow & Peyser 1980; Pattison & Kaufman 1982; Whitfield 1981 & 1982).

In the past, substance abuse treatment was split between two groups: those who believed in substance abuse recovery programs, typified by AA and other twelve-step self-help programs, therapeutic communities, rehabilitation programs, as well as groups espousing relapse prevention, and the medical/psychiatric community, which has used psychiatric treatment as the means to achieve often similar goals. The former believed that group treatment was effective, abstinence was the goal of treatment, and helping the abuser/addict to relearn more constructive and less self-destructive behavior relating to substances of abuse as well as to interpersonal relationships was the main process leading to recovery. The latter used a variety of forms of psychiatric treatment, including individual and group psycho-therapies as well as psychopharmacologic intervention and were interested in treating comorbid disorders as well. In recent years, there has been a recognition that an integrated treatment program, combining features of both models, is more successful than either approach used alone. In both designs, the use of group treatment has been increasingly recognized as the most therapeutically and economically effective method of reaching out and helping these difficult to treat patients. Group therapy and integrated substance abuse treatment programs have grown rapidly, both as fields of knowledge and in their more widespread clinical applications.(Brook & Spitz et.al)

##### Word identification

Chemical Dependency(CD), Alcoholics Anonymous(AA), Narcotics Anonymous(NA), Self-Help Groups(SHG), Group Psychotherapy(GPT), Group Interpersonal Therapy(GIT), Professionally Directed Groups(PDG).

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### **A Brief History of Group Psychotherapy**

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Most authors trace the origins of group therapy in the United States to the beginning of the twentieth century, when Dr. Joseph Pratt began to conduct health classes for the tubercular patients in Boston. These classes employed lectures as well as self-presentations by recovering patients and supportive group interaction. During roughly the same period, Dr. Elwood Worcester, rector of Emmanuel Church in Boston, established the "Emmanuel Church health classes" or "Emmanuel Movement," using group methods. Worcester and his associate, Samuel McComb, worked with a physician, Dr. Isador H. Coriat, combining medical and spiritual principles. They took an interest in treating alcohol dependence and wrote on the subject as early as 1908. Another member of Emmanuel Movement was Courtney Baylor, who joined the group in 1912. Baylor, a recovered alcoholic, specialized in helping patients with drinking problems and further developed ideas about the interaction of physical and psychological factors in alcohol dependence. The treatment he and the Emmanuel group developed was taught to a line of other recovering alcoholics who became lay therapists, including Richard Peabody and his student, Francis Chambers. Chambers describes the treatment in 1939, however, as depending primarily on individual therapy and training in deep relaxation (Strecker and Chambers 1939). Group methods are not mentioned in his volume. It is interesting, however, that the origins of group therapy and alcohol dependence treatment were so closely linked (Blume 1977).

One of the most important movements to stimulate the use of group therapy in addiction treatment was the so-called "self-help" movement (perhaps better described as the mutual help movement) exemplified by Alcoholics Anonymous(AA), founded in 1935 (Wilson 1945). AA also had its historical analogs.

In Europe, Dr. J.L. Moreno experimented with group methods in his psychiatric practice in Vienna as early as 1910. Moreno coined both the terms "group therapy" and "group psychotherapy" in 1914 (Moreno, 1975). During the early 1920s, Moreno began to develop the technique of psychodrama, a method that has been applied successfully to addictive disorders. In the 1967 textbook on alcohol dependence edited by Dr. Ruth Fox, a psychiatrist and first medical director of the National Council on Alcoholism, Hannah Weiner describes her four years of experience with the "Weiner-Fox group." This outpatient private practice model of alcohol dependence treatment combined or alternated formal group therapy sessions with psychodrama sessions (Weiner, 1967). Weiner was a psychodrama student of J.L. Moreno and, in turn, trained other psychodramatists to work with alcoholics and addicts. Thus, the history of alcohol dependence treatment and that of the group therapies are further connected.

### **Treatment of Addicted Populations Using Group Psychotherapy**

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Within the last thirty years, there have been significant and dramatic changes in the understanding of addiction and its treatment. Foremost among these changes is the utilization of group psychotherapy as an important, if not the most crucial, component of an alcoholic's or substance abuser's treatment regimen. However, as important a development as this has been, the recognition and acceptance of addiction as a disease and a primary disorder that must first be addressed has had more of an impact on the way the addiction is treated. Addiction to chemicals, whether it be to alcohol or drugs, is no longer viewed as a symptom of a more serious core issue. Rather, it is seen as a primary condition that must first be arrested if any progress in treatment is to be achieved and abstinence from all chemicals must be the first goal of recovery. Put another way, substance abusers and alcoholics cannot benefit from psychotherapy as long as they continue to use chemicals. Not only has this stance legitimized the treatment of addiction and created a philosophy of treatment completely independent of the

more classical and traditional approaches to psychological difficulties, but it also raises the question of whether addiction is purely a psychological phenomenon. The disease concept has also lent support to Alcoholic Anonymous's lifelong contention that addiction is a disease and total abstinence is a necessity if addiction is to be treated successfully.

Prior to this shift in treatment philosophy, intra-psychoic conflicts and intra-personal dynamics were usually viewed as the cause of addiction. However, the disease concept stands that view completely on its head. Depression, anxiety, and character pathology are now viewed as symptoms-the result, not the cause-of addiction. Addiction specialists discovered that once they persuaded the alcoholic and substance abuser to abstain from the use of chemicals, these symptoms either completely subsided or at least greatly diminished in many cases. In their classic longitudinal study, Vaillant and Milofsky put a final nail into the controlled drinking versus the disease concept controversy of the late 1970's When they concluded. "Thus, the etiological hypothesis that viewed alcoholism primarily as a symptom of psychological instability may be an illusion based on retrospective study" (1982, p.492). Consequently, Vaillant and Milofsky verified what everyone within the AA community and the addiction treatment field has known for years. Vaillant put it best when he later wrote "Prospective studies are gradually teaching psychiatrists the astonishing fact that most of psychopathology seen in the alcoholic is the result, not the cause of alcohol abuse. Put differently, "alcoholism is the horse, not the cart of mental illness" (1983, P.317).

Not only has the treatment of addiction been legitimized, addiction has become recognized as one of the most significant and major health problems in this country. Previously, treatment for addiction was available only through AA, other twelve-step programs or an occasional obscure hospital or treatment program in some distant part of the country. Now it is rare to find any major metropolitan area that does not have at least one hospital or outpatient treatment program that specializes in addiction treatment. The increases in the need for more treatment facilities is a direct result of the increased use of alcohol and substances in our present day culture. The most crucial precipitating factor in addiction is the degree of availability and access to a particular drug. Thus, no matter how tolerant an attitude for addictive practice society has, or how strong individual personalities or genetic predisposition's are, no one can become addicted unless they have ready access to the drug. Thirty years ago, addiction treatment was less complicated. The addicted person was instructed to stop drinking, then was detoxed if necessary, and was told to start going to AA meetings. Now, it is rare to find an alcoholic, especially one under thirty years of age, who is not also using and abusing numerous other drugs. The concept of cross-addiction, namely, stopping the use of one drug only to become addicted to another, is common practice for most substance abusers and alcoholics. The term "poly-drug abuser" is becoming more of a common diagnosis. It is now necessary to inquire what is the substance abuser's "drug of choice." Certainly, the onset of increased drug use in our culture has complicated the diagnostic and treatment picture.

Increased drug use has also resulted in increased demands for effective treatment for chemical dependency. Consequently, group therapy has also increased in popularity and has become the treatment of choice for all chemical dependencies and substance abuse disorders. Initially, the increased utilization of group psychotherapy may have been due in part to the cost effectiveness of group treatment and the influence of the popular support group format of Alcoholics Anonymous and its twelve-step program. Nevertheless, most professionals who work with substance abusers on a sustained and prolonged basis (Khantzian, Halliday, and McAliffe, 1990; Flores, 1993; Flores and Mahon, 1993; Vannicelli, 1992; and S. Brown, 1985; Brown and Yalom, 1977; Washton, 1992; Matano and Yalom, 1991) now agree that there are far more

important reasons why group therapy is an essential and crucial ingredient in the treatment of addiction. These reasons have to do with a number of important factors, including-but not limited to-the nature of the addiction process itself, which either produces or exacerbates depression, anxiety, isolation, denial, shame, transient cognitive impairment, and character pathology. It is now recognized that many of these issues, whether the person is addicted or not, respond better to group treatment than to individual therapy. There is also an emerging appreciation for the special advantages of group therapy, and it is no longer viewed as a secondary or inferior form of treatment. It is now seen as the source of powerful curative forces that are not typically available for the patient being treated in individual therapy. In the hands of a skilled and well-trained group leader, the forces can be harnessed and utilized in a way that provides a vital and unique therapeutic experience for an individual that would not be possible in individual treatment.

The increased recognition and acceptance of group therapy as a legitimate form of treatment in its own right coupled with the alarming increase of substance abuse in our culture has resulted in an increased demand upon degreed and non-degreed professionals to led groups with these patients. This demand has often been made of group leaders who have not been adequately trained in group psychotherapy and who therefore are forced to apply models of group treatment that are poorly suited to the addicted patient. Since group therapy is an intricate component if not the most crucial element for both inpatient and outpatient treatment programs as well as after care and relapse prevention, it is crucial that a practical and effective model of group therapy be outlined and established if treatment is to reach its full potential.

Group Psychotherapy has long been an essential component of treatment programs, group orientations vary enormously from one setting to another. Nevertheless, most professionals who work with alcoholics and addicts on a sustained basis agree that abstinence is a necessary first step in treatment. Once that is obtained, the consensus is that the therapy group offers chemically dependent individuals unique opportunities to learn about themselves and their addiction. (Yalom, 1975; Brown and Yalom, 1977; Wallace, 1978; Vanicelli, 1992; Khantzian, Halliday, and McAuliffe, 1990; Washton, 1992; Vannecelli, 1988; Flores and Mahon, 1993).

Some of the advantages of Group Psychotherapy:

1. Mutual identification with acceptance from others going through similar problems.
2. Positive role modeling for abstinence and reality testing about chemical use is enhanced because the addicted person has the opportunity to better understand their own attitudes about addictions and their defenses against giving up chemicals by confronting similar attitudes and defenses in others.
3. Confrontation, immediate feedback and positive peer pressure for abstinence.
4. Affiliation, cohesiveness, social support while learning to identify and communicate feelings more directly.
5. Structures, discipline and limit setting while permitting experiential learning and exchange of factual information about recovery and drug use.
6. Installation of hope, inspiration for the future and the pursuit of shared goals and ideas. (Washton, 1992).

Successful group psychotherapy, whether it be with chemically dependent members or non-addicted members, requires that two conditions be adhered to and maintained. First, the group task and structure should fit and be matched with the members' needs. If the leader and the treating institution adhere to the disease model, abstinence must be the goal and the group task

should be structured to accomplish this end. Second, the leader's decision and technique should be adapted so that there is a match to the overall task or purpose of the group. Unfortunately, group goals are often vague or confusing, with not enough emphasis on a systematic plan for accomplishing these goals. Leaders and members often tend to view groups in terms of techniques, or theoretical orientation rather than in terms of a goal or a task to be accomplished. Techniques and theories can become sacred rituals rather than tools for the accomplishment of the tasks that are the specified purpose of the group. In the same vein, a variety of group approaches that emerge to serve special purposes, as in the twelve-step programs and group psychotherapy, are often seen as competing enterprises rather than different modes for achieving similar ends. (Flores, 1997).

According to the results of the last National Drug and Alcoholism Treatment Unit Survey (NDATUS), 944,000 Americans were in treatment in specialty addiction treatment facilities on a single day (October 1) in 1994 (SAMHSA 1996). It is safe to guess that the vast majority of these 944,000 clients were receiving some form of group therapy specifically geared to addiction treatment and were also receiving some form of a twelve step program.

American society in the late 1990s has witnessed the closing or downsizing of many addiction treatment programs, particularly in the private sector. For instance, the National Association of Addiction Treatment Providers, the trade association for most of the freestanding private inpatient addiction programs, reported that its membership had dropped from 400 in the early 1990s to 250 by 1997 (Alcoholism and Drug Abuse Weekly 1997). Managed care, changes in health insurance, and the demand for cost control have been blamed for this downsizing. The influences of managed care and other changes in the rapidly shifting American health care system along with decreases in entitlement benefits for individuals suffering from addictive disorders and the failure of public funding to meet the addiction treatment needs of the uninsured and underinsured, threaten to widen the gap between the treatment requirements of this population and society's ability to provide specific services. However, even in this climate of inadequate support, group therapies continue to thrive.

### **Brief History of Alcoholics Anonymous (AA):**

Historical records show that AA was officially founded in 1935. The 1920s and 1930s witnessed the rise of a quasi-religious evangelical movement, characterized by a group known as the Oxford Group. This group attempted to recapture the spirit of early pietist Christianity and emphasized the importance of confession of and restitution for sins among peers. The Oxford Group counted some alcoholics among its members, including a man named Edwin Thatcher.

Thatcher achieved a period of abstinence with the help of the Oxford Group, particularly from another member who had been treated by the Swiss psychoanalyst Carl Jung, who viewed alcoholism as medically untreatable but perhaps resolved by a spiritual transformation. Thatcher also influenced an alcoholic friend, William Griffith Wilson.

William Wilson (now known as AA CO-founder Bill W.) had drinking problems for a number of years. In late 1934 Wilson had a spiritual experience during a detoxification episode. His interpretation of this experience was shaped by what Thatcher had told him, as well as by his own reading of William James "Varieties of Religious Experiences". Wilson maintained sobriety until, on a failed business trip to Akron, Ohio, his confidence left him. He got in touch with Dr. Robert Holbrook Smith (now known as AA CO-founder Dr. Bob), an Oxford Group member who had also struggled with alcoholism. Their conversation, now recognized as the first AA meeting, had a profound effect on them both. They discovered that they could identify with each other's

stories, and provide each other strength and hope. A key lesson they drew from this experience was that the way for alcoholics to recover was for them to help other alcoholics recover.

Over the next few years, alcoholics held mutual support meetings under the auspices of the Oxford Group. However, the religiosity and rigidity of the Oxford Group led the alcoholics to split off into their own organization, which became public in 1939 with their book *Alcoholics Anonymous* (known universally in AA simply as the “Big Book”). The appearance of AA’s book was followed by positive media coverage, which helped make the 1940s the decade of AA’s fastest growth.

Some aspects of AA, such as the practice of experienced members sponsoring newcomers, were developed specifically to help individual members recover. Others, such as AA’s refusal to take any stand on outside issues, were intended to help the organization as a whole survive and function effectively. Much of what AA members learned and decided in both areas was set forth in 1953 in the second most important book in AA, *Twelve Steps and Twelve Traditions*.

AA has continued to grow steadily from the 1950s to the present day. Today, AA’s membership survey (which Room and Greenfield, 1993), suggest is a conservative estimate of AA’s actual size, records that AA has nearly two million members in over fifty countries. As it has grown in popularity, it has had a substantial impact on the professional treatment system, particularly in the United States. Although consistent with its policy, AA has never taken an organizational stand on professional alcohol treatment service but individual AA members have played key roles in the establishment of the National Institute of Alcohol Abuse and Alcoholism and the National Council on Alcoholism. Further, many treatment programs have adopted parts of AA’s approach, have hired AA members as counselors, and refer their patients to AA as aftercare.

### **The Why and How AA Works**

AA describes its organization as “a fellowship of men and women who share their experience, strength, and hope with each other so that they may solve their common problem and help others to recover from alcoholism” and adds that its purpose “is to stay sober and help other alcoholics achieve sobriety” (*Alcoholics Anonymous*, 1939). Anonymity is required to avoid the possible stigma of membership and possible ostracism of family and friends. Anonymity ensures confidentiality, which permits free and candid discussion of problems and difficulties.

However, the cornerstone upon which the Alcoholics Anonymous philosophy is built remains the recognition and admittance that one has an uncontrollable drinking problem. The members of Alcoholics Anonymous do not pursue or coddle malingering prospects. They make it plain that if the prospects actually wanted to stop drinking, the members would anywhere, anytime, reach out to help them. The program will not work with those who only want to quit, or who want to quit because they are afraid of losing their families or their jobs. AA states that the effective desire must be based upon enlightened self-interest. The alcoholic must be fed up with the stark social loneliness that engulfs the uncontrolled drinker, and they must want to put some order into their bungled lives.

Alcoholics Anonymous is guided by its suggested “Twelve-Steps.” “Suggested” is the word to be emphasized, however, for there are no musts in AA except those that members set up for themselves. Basically, AA will demonstrate that alcoholics can be accepted and loved. Alcoholics who come to AA for the first time, strangers, rejected and lonely, are received as valued members of the human race worthy of being salvaged. Listening to members recount life experiences as dismal as their own, and then observing how they have overcome their drinking

problems, alcoholics are filled with the hope that if the members could do it, perhaps they can also. They become motivated to try.

Alcoholics learn they must live one day at a time without taking a drink. By attending AA meetings and verbalizing problems, they strengthen their resistance to drink and gradually reconstruct their lifestyles to rid themselves of dependency on alcohol. The most crucial concept involves alcoholics recognizing themselves as individuals whose illness is an uncontrollable drinking problem; they must accept the tenet that becomes the foundation of their rehabilitation program: "Even one drink is too many."

Alcoholics, due to the nature of their illness, have established an elaborate denial and rationalization system. These psychological defenses that prevent the recognition and admittance of their illness are as much involved and intricately connected with their disease as alcohol itself is.

Vernon Johnson, (1973) sums up the dynamics of this interplay best:

The primary factor within this primary condition, however, is the delusion, or impaired judgment, which keeps the harmfully dependent person locked into his self-destructive pattern. It must be met and dealt with first since it blocks his entering any therapeutic process at all. The alcoholic evades or denies outright any need for help whenever he is approached. It must be remembered that he is not in touch with reality (p.44).

AA acknowledges this need for recognition (it is the first of its twelve steps), and it can occur only when alcoholics have reached their crisis and at a gut level have surrendered to some Power greater than themselves. The spiritual and religious dynamics at the level of recovery cannot be overstated for alcoholics must confront themselves in their naked existence. The existential overtone to such a crisis is the central psychological factor of the recovery program. Alcoholics are asked simply to exchange the destructive dependence upon alcohol for a constructive Power (steps Two and Three). The important thing is for newcomers to recognize that they have not been able to manage the part of their life that has been affected by drinking. As alcoholics surrender they see that it is possible to risk being themselves, and they move consciously toward deepening their meaningful relationships with others because this will help them recover.

Once this gut-level surrender to some spiritual awakening is accepted, alcoholics must pay a personal cost. The dynamics of forgiveness and restoration are difficult concepts to acknowledge. The wrongs that have been done during the period of illness can never be completely reconciled. This process of reconciliation is part of the monotonous and painstaking road to sobriety. Regardless of what friends and neighbors may think, alcoholics do not necessarily feel happy to wake up in the morning facing life without a drink. Painful hangovers they have experienced previously may seem more tolerable than the gnawing fears and vague anxiety they now feel as they anticipate each day's activities.

The cost is one to be paid in psychological pain. The reward is the sense of forgiveness and the vitality of new interpersonal relationships. The goal to stop drinking is not a totally adequate one. A new way of viewing life, a new sense of self-worth and self-respect, and a new appreciation of one's responsibility and relationships with others are vital to sober living. Often a mature religious faith helps provide a new beginning and emotional help for the trying times facing every alcoholic.

The AA approach is practical and is based on the idea that all problem drinkers at one time or another have gone at least twenty-four hours without a drink. So AA members do not swear off alcohol for life or for any other extended period of time. Alcoholics are made to realize that there is nothing they can do about tomorrow now. AA wants alcoholics to concentrate on staying sober today, during this twenty-four hours. Then when they feel the desire to take a drink, it is accepted simply as something that must be dealt with today. They are taught not to worry about tomorrow's craving but merely to concentrate on postponing taking a drink today.

Regular attendance at local meetings plays an important part in a life of sobriety. Group meetings and relationships provide the testing ground for new ways of dealing with one's emotions and with the problems of living. Alcoholics frequently accept confrontation and support from others who struggle with the same problems as they do, although they may reject similar responses from physicians, ministers, or other professional persons. AA is one of the most successful approaches to sobriety because it practices these principles. AA has the benefit of comradeship and shared problems coupled with the added asset of the emotional objectivity and personal understanding or personality dynamics that others provide.

But the general atmosphere of an AA meeting is one of gaiety and good fellowship. Generally, AA members take their alcoholism seriously, but not themselves. That is another important part of the recovery program.

### **The Convergence of Group Psychotherapy and the Twelve Steps of AA**

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The question begs to be asked:

Why not develop a partnership between Alcoholics Anonymous and professionally oriented treatment approaches and combine the two different sets of knowledge and expertise?

By doing so, the chances are greater of developing an innovative treatment model that may actually help more alcoholics and addicts, rather than continuing the destructive territorial fighting that is presently occurring. This is precisely the aim of this paper.

Those professionals who are suspicious or antagonistic toward twelve-step programs might have something valuable to learn if they were instead to direct some of their energy toward understanding what the programs are about and how they work. More than anything else, AA is a pragmatic program that is less concerned with whys than it is with how. Instead of trying to discredit it or tear it apart, both the professional and the addicted patient would be better served if AA were understood for its results. As new members of the program are often told, "If it's not broke, why fix it?" Those critical of the program only see its spiritual roots and judge it to be a religious organization with an ideology that fosters debasement, compliance, mind control, and dependence. Many critics, whose own ideological beliefs are deeply rooted in Western rational philosophy and the science of psychology, might be more understanding and accepting of AA if they were to recognize that many of the program's historical roots can be traced back to William James, one of the early pioneers of the science of psychology and the philosophy of Pragmatism. James's writings and his classic text, *The Varieties of Religious Experience* (1902), had a profound effect on Bill Wilson, the chief architect of AA, the Big Book, and its twelve-steps and twelve principles. One main tenet for James, as it was for all Pragmatists, was that the process of determining the value and truth of something was closely related to its utility and practical usefulness. If something worked, it was judged to be true. The Pragmatists were far less interested in grand, abstract, and obtuse theories, or what John Dewey came to call

“spectator knowledge,” than they were in the nitty-gritty practical aspects of knowledge that came from the experience of something working after it had been tried and tested.

AA members are told “Utilize! Don’t Analyze; go to ninety meetings in ninety days!” Following James’s recommendation that if you want to change the way you are thinking or feeling, first change the way you are behaving, AA members are told “Take your body to a meeting and your mind will follow.” Nowhere is this pragmatic influence more clearly demonstrated than with Father Martin, a Catholic priest and early AA enthusiast who is the living embodiment of AA and its philosophy. Once, when asked why AA works, Father Martin responded in his own unique style by saying, “AA works because it works!” The utility of teaching the addict or alcoholic to behave according to the principles of the twelve-step program determines its usefulness and its truth.

Professionals see the disadvantages of working against AA and have sought ways of bringing AA and professional treatment programs together. (Minkoff, 1995) for one has suggested the value of a complementary integration of twelve-step and mental health treatment philosophies. He believes there is a need for a “unified conceptual model” of treatment that considers both the disease model of addiction and a disease model of mental illness. While Minkoff is specifically focusing on the dual diagnosis patient who may be psychotic as well as addicted, his attempt to view addiction as a disease that involves two independent and primary but interactive illnesses has merit because he recognizes that the split between the mental health model and the disease model is an unnecessary one. He recognizes that the historical roots of the split originated in the medical establishment’s failure to adequately treat or understand alcoholics. Essentially, modern medicine had turned its back on the alcoholic’s plight, and it was this failure of the medical establishment in the 1930s that forced Bill Wilson and other suffering alcoholics to create their own treatment method. They were more concerned with one that worked and were less concerned with the prevailing beliefs and philosophies of the day that dictated what was properly an illness and what properly constituted treatment.

Minkoff challenges the typical hierarchical medical approach to treatment and its tendency to foster this separation between the mental health model and the disease model. He asks us to consider how ridiculous this situation would be if we were to practice it with other aspects of psychiatric care. Imagine if someone with anxiety could only be treated by an anxiety disorder specialist and if there were any signs of depression, a depression specialist would have to be called in.

Fortunately, there are a growing number of professionals and researchers who are starting to appreciate the advantages of AA and other twelve-step programs. They are discovering that the integration of the two can be quite complementary. For instance, Dodes (1988) commented that based on his experience with more than 500 patients treated with a combination of psychoanalytic psychotherapy and twelve-step programs, he found that “patients appear able to implicitly grasp a dual level of functioning within themselves and therefore to accept the dual level of therapeutics approach” (p.288). In a similar fashion, Brown reported comparable results in her excellent book, *Treating the Alcoholic: A Developmental Model of Recovery* (1985), based on a ten-year study that she conducted on recovering alcoholics who had successfully stopped drinking. While she was primarily interested in identifying what worked for these AA members and why, her other main impetus for the book was an attempt to form a “synergistic partnership between the domains of AA and professional helpers,” because she was acutely aware of the mistrust and competitive animosity between the two. While she states that she is clearly on the side of the alcoholic and that her “book is a challenge to professional helpers and

nonalcoholics from all disciplines to reexamine their own beliefs, values and theories about alcohol and alcoholism," she believes strongly that "the alcoholic badly needs the professional." Her book is one example of a growing number of appeals for a "synergistic working relationship" that is starting to come from the professional community.

Aware of the reasons for the split, Brown cautions the alcoholic about the dangers that are still inherent in the professional community when she writes:

If you are suffering from alcoholism, it is likely that your alcoholism will not be diagnosed by physicians, psychologists, or other helping professionals. If your alcoholism is diagnosed, the chances are good that you will receive an inappropriate referral for treatment. You may be told to "cut down" on your drinking, or you may be sent to a psychiatrist to determine what the real problem is. If you are abstinent and recovering from alcoholism and need professional help for other life problems, the chances are good that you will be too afraid of the professionals to seek the treatment you require. Of course there are many exceptions, but it is a bleak picture.

Brown's conclusions help explain why recovering addicts or alcoholics may be distrustful of professionals. Certainly many members of twelve-step programs have earned the right to be suspicious of "ignorant professionals" who have often misdiagnosed them and offered little help in their struggles with their individual addictions. For example, alcoholics frequently report a personal downward spiral when they were advised "to cut down on their drinking" while the professional sought to get at the "real core" of their problem. One need only attend a few AA meetings to hear the horror stories told by many members. In fact, AA would have never come into existence if it had not been for the kind of help alcoholics desperately needed. AA, as a social phenomenon, is an example of how a certain portion of an afflicted population banded together in a community of help because society's sanctioned mode of treatment was inadequate. Yet the founder of AA himself-Bill Wilson-had no doubts about mutual cooperation of AA and professional help in his own treatment and recovery from alcoholism. He twice returned to long-term individual psychotherapy with his friend and advocate, psychiatrist Harry Tiebout. Research conducted by AA reveals that 60 percent of AA membership has sought some form of psychological treatment in the past and this percentage is increasing each year (Alcoholics Anonymous, 1990).

Most of the criticism of Alcoholics Anonymous in the past has focused on its ideological and religious overtones, with the implication that AA puts pressure on its members to accept the AA belief system and that this pressure harms them in some way. For instance, Tournier (1979) criticized AA's effectiveness because he felt that it was a treatment method that had never been scientifically established and that the fellowship's ideology dominated the treatment field, which resulted in a situation that limited new ideas. Jones (1970) also criticized the AA program as an "acceptance of totalitarian ideology" (p.195). Unfortunately, these types of attacks are short-sighted and reflect ill-informed beliefs about the treatment philosophy of Alcoholics Anonymous.

Chemically dependent individuals would be better served if critics of AA would direct their energies toward understanding the ideological differences that exist between themselves and the AA program. If they would gain a more accurate understanding of AA, they would find that the disparity between their position and AA's is actually not that great. Professionals may actually learn a great deal more about psychotherapy and treatment, not only for the addicted individual, but for the person who does not suffer from an addiction problem. It is within the realm of group psychotherapy that these two opposing views can best be merged into a

supportive approach to therapy. The marriage of the principles of Alcoholics Anonymous and group psychotherapy could result in an exciting and extremely complementary enterprise.

There is one unique aspect involved in preparing the chemically dependent person for group therapy that is usually not necessary for non-addicted members. Most alcoholics and addicts have at some time during their addiction attended meetings of AA, NA, CA. These individuals should be encouraged to continue their participation in these organizations. It would be important to inform them that the psychotherapy group is not designed to treat their addiction or be a substitute for the peer-oriented program. Rather, the group can support or complement such peer-oriented programs. In some cases, if the person does not have enough sobriety, group therapy may be contraindicated, especially if the group leader is unfamiliar with the treatment format of these programs.

Both professionally oriented groups and peer-oriented groups(AA, NA, CA) should be considered active treatment groups designed to facilitate recovery and abstinence from alcohol and illicit drugs. A critical difference exists, however, between the professionally oriented and peer-oriented group. The professionally led therapy group emphasizes the use of specific behavioral and psychological prescriptions and techniques that are applied to a global, generalized, symptom reduction effort. In comparison, the AA format focuses on a specific, regimented approach addressing one specific, component of recovery (i.e., abstinence).

The core content of the professionally oriented group should consist of the attempt to facilitate gradually increasing introspection and compliance through the use of group confrontation, discussion, and education. In contrast, the peer-oriented group is almost entirely supportive, fostering a degree of dependence on the acceptance of a specific and limited treatment approach focused entirely on compliance and abstinence from alcohol and drugs. (Flores-1997).

### **These are Eight Divergent Elements that Peer-Oriented Groups have in common with Group Psychotherapy**

Peer Oriented Elements:

1. Treatment goal will focus specifically on abstinence.
2. Emphasis on the "how" of abstinence and recovery.
3. Opening of group with readings of the AA "Big Book" and the Twelve Steps of Recovery
4. Structured use of life histories dealing specifically with personal history of alcoholism and recovery.
5. Didactic format by group leaders to impart AA principles.
6. Emphasis on the first four steps of AA's traditional twelve steps with less emphasis on feelings and emotions.
7. More democratic group leadership with members taking a more active role in the group discussion.
8. Group discussion focused on ways to remain abstinent.

Professionally Oriented Group Elements:

1. Treatment goals will be individually determined by the person, which requires that social, psychological, physical, and drinking-related behavior be examined and evaluated.
2. Emphasis on the "why" of abstinence and recovery.
3. Development of group cohesiveness and traditional group processes.

4. Verbal reports of general progress without notation and rigid format.
  5. Mobilization of group support and feedback.
  6. More emphasis on group discussion of feelings and emotions.
  7. More traditional role of group leader in the group process.
  8. More confrontation and exploration of resistance.
- (Flores-1997-adapted)

These specific treatment procedures should be developed and monitored in their application throughout the course of treatment in order to ensure that the treatments offered (professional vs. peer [AA]) are both clinically meaningful and discriminately different. In this way, maximum benefit can be realized by the group leader by contrasting different types of therapy with the identifiable characteristics of certain alcoholics and addicts.

The Common Elements of both Professionally Directed Groups and Peer-Oriented groups:

1. Group Discussion.
  2. Correct misconceptions about addiction.
  3. Impart information on addiction and need for compliance.
  4. Formulation of treatment issues.
  5. Group support at the beginning.
  6. Aim to reduce patient complaints and behavior that interfere with alcohol and drug abstinence.
  7. Attempt to involve and change family environment.
  8. Search for continuing causes of abstinence difficulties.
- (Flores, 1997).

### **Similarities and Differences for each groups Modalities**

How Self Help Groups(SHGs) Differ From Professionally Directed Groups(PDGs):

There are four specific areas that help the clinician separate SHGs from PDGs. Aside from some obvious differences, professionally led groups have a designated trained leader, offer services for a fee, and are often marked by a clear beginning and end of service.

- 1.) The Helping Group as a Social Microcosm.

All group psychotherapists view the group as a social microcosm: a small, complete social world, reflecting in miniature all of the dimensions of real social environments. This aspect of the group-its reflection of the intrapersonal issues that confront individuals in a larger society-is most highly prized as a group property linked to an individual's change. Underneath all group activities lies the assumption that change is based on the exploration and reworking of relation that change is based on the exploration and reworking of relationships in the group. SHGs develop a rather different stance to the issue of the group as a social microcosm. The interaction among members as a vehicle for change is de-emphasized. AA has a specific negative sanction for this type of behavior. The group is a supportive environment for developing new behavior, not primarily within the group, but outside. The group may become a vehicle for cognitive restructuring, but analysis of the transaction among members is not the basic tool of change.

## 2.) Psychological Distance/Closeness Between Helper and Helpee.

Located at one extreme, many professionals, both through special training and manipulation of symbols and settings attendant to professionalism, increase the psychological distance between themselves and the patient. Of all help systems, SHGs achieve the greatest psychological parity between the helper and those being helped. Not only are helpers frequently similar in social background but, more important, they share the same condition as those seeking help. Client control of the organization also erases psychological distance.

## 3.) Specificity/Generality of Help Methods.

The help provided by nonprofessional therapists and peer counselors tends toward the general. High specificity characterizes self-help groups. (Antze's, 1976) study of self-help organizations demonstrates how they develop specific ideologies about the nature of the problem and tailor appropriate help methods to the specific afflictions they address.

## 4.) Differentiation versus Nondifferentiation Among Participants.

It is easier for SHGs to stress identity with a common core problem than it is in psychotherapy groups. Although it is typical for a psycho-therapeutic group to go through a period of time in which similarities are stressed, this is usually an early developmental phase, and represents an attempt of the group to achieve some form of cohesiveness. It is not the *raison d'être* of the group as it may be for a self-help group. In fact, some evidence demonstrates that psychotherapeutic group participants who remain committed to a sense of similarity are less likely to experience positive change. The potency of SHGs, on the other hand, appears to stem from their continued insistence on the possession of a common problem; the members believe themselves to derive support from their identification with a common core issue. (Brook & Spitz, 2002).

Matano and Yalom also address some of the sources of potential conflict between AA and psychotherapy. They present helpful suggestions on how these differences can be resolved or how these differences are sometimes induced by others' misperceptions. They conclude that these differences need not interfere with the establishment of a healthy, working alliance between twelve-step programs and the professional community:

It is important to resolve these perceived areas of incompatibility between AA and psychotherapy. We believe that AA and psychotherapy are not competing forces that threaten the survival or efficacy of the other, but are mutually augmentative. Their goals are similar, and they share more common methods than generally thought. It must be remembered, however, that both psychotherapy and AA are diverse entities, containing a wide range of practices and interpretations of theory and traditions; there will, unfortunately, always be AA "hard liners," openly antagonistic to the idea of therapy, as well as psychotherapists who scorn AA (1991, pp. 248-285).

There is a class, however, of group psychotherapy, labeled by (Weiner, Williams, and Ozarin, 1986), as homogeneous group therapy, whose members are united by their struggle with a common problem. This is a parallel development in group psychotherapy, and represents properties and characteristics shared between more traditional group psychotherapy and self-help groups.

In summary, most SHGs are low on using the group context as a social microcosm, and low on differentiation. They are high on specificity, and low on psychological distance. Traditional dynamic group psychotherapy is high on social microcosm, and moderate on specificity, and high on psychological distance and differentiation.

### **Economic Trends Bring Group Psychotherapy and Alcoholics Anonymous To the Fore Front of Addiction Treatment**

The past decade has been witness to a virtual revolution in the field of health care. Driven by concerns over costs of medical and mental health services, government, insurers, and others involved with the financing of health care have focused on creating ways to establish cost-containment while still providing high quality patient care. The implications of these changes are profound.

Optimists feel that radical change is inevitable in order to prevent the system from going out of control. To accomplish this goal, changes in conventional methods of health care delivery are inevitable. A wide range of alternatives have been proposed and instituted as experiments designed to stem the tide of runaway costs. These systems are broadly subsumed under the rubric of managed health care. Pessimists fear that we are seeing the "corporatization" of medicine and the end of psychiatric therapies as now practiced. The principles and language of business and economics threaten to shatter the cornerstones of practice, such as the doctor-patient alliance and patient confidentiality. With financial profit as the goal, many believe that quality care will inevitably suffer.

Although health care reform affects all segments of medicine, it does not affect them equally. Specifically, mental health services are treated as carve-outs in many managed care systems (Galanter et al., 2000). Furthermore, substance abuse and alcoholism treatment risk being adversely impacted by those programs that preferentially reimburse treatments which are brief, documentable, and able to be conducted by the least skilled practitioners whose fees are less than those of practitioners who characteristically provide these services.

These changes have shifted the patterns of practice of many mental health and substance abuse practitioners. The increased value placed on brevity of treatment has resulted in an expansion of the use of short-term psychiatric interventions. The concern here is not with the broader use of brief therapies, since that has led to greater clinical and research understanding in the appropriate applicability of short-term methods. The view of brief therapy as a panacea is dangerous. This view may lead to misplacement of patients into treatments that make good economic sense but may be harmful to seriously impaired patients.

Despite the conflicts between the economic and therapeutic agendas involved in patient care, there are economically prudent ways to provide quality care for substance-abusing patients. The increased use of group psychotherapy is a prime case in point. When clinicians are skilled, many people, formerly relegated to expensive, long-term, inpatient or outpatient therapies, can be seen in a group setting. Short-term, symptom-focused groups emphasize specificity of treatment focus, teach skill acquisition, and disseminate accurate information about issues shared by group members. Moreover, with the increased enthusiasm for short-term therapies, a renewed appreciation for the effects of treatment over the course of a patient's life has emerged. Participants learn to identify when they are in need of psychological help and to seek treatment at the earliest possible stage in that process, thereby further reducing potential treatment costs by that process, thereby further reducing potential treatment costs by supplying a mechanism for relapse prevention and earlier intervention should symptoms recur.

When group therapists share their expertise with those in managed care circles who are receptive to group therapy, then the gap between a managed care perspective and therapeutic considerations can be narrowed. Managed care professionals need to be informed about the flexibility and diversity of group experiences. Group therapist strongly believe that there is hardly a psychiatric, medical, and/or social condition for which a constructive group experience cannot be created. The advances found in group therapy with substance abuse patients offer a prime example of the confluence of the psychological, physical, and social needs of patients addressed simultaneously in one form of treatment. This model is not merely cost-efficient, it makes for high quality treatment with high degrees of patient specificity. Also, included in the package of change is the use of twelve-step programs as an adjunct to formal treatment programs. It is assumed by the managed care health providers that since all twelve-step programs are free, and readily available, the use of these programs is of course essential to their bottom line costs. Of course economics play a huge role in the bottom line of treatment programs all across America, the thought of addiction treatment without the help of AA, NA, CA, has brought these organization to the top of treatment inclusion, along with group psychotherapy, as the leading components in addiction treatment. (Spitz, 1996; 1997).

### **Group Psychotherapy and Alcoholics Anonymous Working Together Enhance Spirituality**

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A central stumbling block and opportunity during recovery is surrendering to God's will for us. Thurston (1984) and others describe various stages of human will and its growth and development.

O.) The beginning stage of the human will is (0) the start of human understanding. Our will is "asleep", we are controlled by others, our ego/mind controls our life. At this level we are physically ill and in chronic distress. We believe that we are the "victim" of life's twist and turns.

1.) Stage one is our earlist awakening, it is the beginning of self-reflection. We are still rebellious against life. We are angry, but we are becoming aware of our self-worth. At this stage we are now questioning lives realities.

2.) Stage two is the adult realization of introspection, We express our vulnerability and hurt. Now the expression of feelings starts to rise from our inner spirit. We become flexible, kind, cooperative, understanding of our fellows.

3.) Stage three is where we find true compassion for our fellows. We start to detach from people, places, and things that are meaningless for spiritual growth. We start making quality choices in our lives, letting go of the past, moving forward to greater awakenings in our lives.

4.) Stage four is the new beginning of lives journey from a new perspective. We now have a spiritual conscious with our Higher Power. We understand God's will for us from an intuitive nature inside ourselves. We understand what unconditional love is for ourselves and others. (Compiled from Thurston, 1984; Ouspensky, 1949; Assagioli, 1969).

Since God created us, a central part of its will for us is that we become and be who we are as individuals, i.e. "for me to be me" as a unique, complete and whole being. This wholeness includes our being in community with other men, women and children. A key to loving ourselves is to celebrate who we are as a total human being. However, it can be risky to fully be

ourselves. Perhaps some major meanings of the Twelve Steps are described in AA's "Just for Today" and "Twelve Promises". These describe who we already are and how we can live in our wholeness (AA 1976). Indeed, not limited to alcoholics, the physical, mental and spiritual recovery program of AA is a "way out" of needless suffering for all of humankind.

In 1975 a new self help group came into being on the East Coast of America. It's name is Women for Sobriety. This organization adopted "Thirteen Statements of Acceptance". Please notice that the majority of statements listed are also used in women's group psychotherapy sessions by seasoned therapist:

1. I have a drinking/CD problem that once had me.
2. Negative emotions destroy only myself.
3. Happiness is a habit I will develop.
4. Problems bother me only to the degree I permit them to.
5. I am what I think.
6. Life can be ordinary or it can be great.
7. Love can change the course of the world.
8. The fundamental object of life is emotional and spiritual growth.
9. The past is gone forever.
10. All love returns two-fold.
11. Enthusiasm is my daily exercise.
12. I am a competent person and have much to give to others.
13. I am responsible for myself and others.

(Kirkpatrick, 1984).

Group therapy works well in concert with and is complimentary to recovery in self-help groups. The two are compatible. Therapy groups refer many people to self-help groups who otherwise would not attend them. At the same time, group therapy differs from self-help groups in several ways, some of which are that one usually pays a fee for it, with the same group of about eight to twelve people meeting weekly with the guidance of one or two group leaders or facilitators. There is more confrontation and feedback than in self-help groups, and there is much caring and support for each group member's getting well and staying well. Since alcoholism/CD are illnesses or isolation and alienation, which only aggravate our suffering, being in a group specifically addresses the person's isolation and alienation.

Being in such a group forces the person to confront a fundamental spiritual necessity: relating to self, others and eventually the universe. It takes the person out of his or her own narrow existence, stuck in the lower self, and gently and sometimes somewhat more forcefully encourages communicating, risking, feeling, trusting, being assertive, and caring for fellow members. Over a period of about two years of active working in a well-conducted chemical dependence therapy group, the person undergoes a series of transformations that begin to fill the suffering and feelings of emptiness with a sense of hope and positivity about their ability to stay well and to grow. (Whitfield, 1988).

### **Conclusion**

Difficult as it is to predict the final outcome of the many drastic changes taking place in the provision of health care, it is safe to prophesy that the need and demand for addiction treatment will not go away. If for no other reason than the burden placed on the health care system by the serious physical consequences of alcohol dependence and other addictions (APA, 1995), and the comorbidity with other psychiatric disorders (Kessler et al. 1996), addiction treatment will survive. Shrinking resources allocated to addiction treatment will require that such treatment be

provided in the most cost-effective manner possible. This need makes the group therapies seem even more attractive. However, several important factors must be considered.

The first is if self-help, either in the form of twelve-step programs or other alternatives, can be substituted for professional treatment. Asked another way, is AA a group therapy? If the answer is yes, can a self-help group referral, at no cost to the insurer, be considered adequate treatment? In 1983 a business group made this proposal to the New York State Commission for Alcoholism. It was called the "alternative state budget proposal" this proposal removed all state funding for alcohol dependence treatment. The report stated that since AA was the best "treatment" for alcohol dependence and AA was free, the millions of dollars allocated for treatment could and should be discontinued. Similar arguments are still being made (Bower, 1997).

Self-help fellowships are an important adjunct to professional treatment. Voluntary AA participation has been shown to reduce health care costs for alcoholic patients (Humphreys and Moos, 1996), so that the combination of treatment and self-help makes good sense. However, we should be clear in our own thinking that although they function through group meetings, self-help fellowships are not group therapies, and should not be substituted for professional treatment.

Second, we should reexamine the use of mandates or requirements for group participation in treatment. A review of the confidentiality considerations should remind us that group s cannot be looked upon as a "one size fits all" treatment for addictive disorders. The U.S. Supreme Court ruled in 1997 that alcoholics in the criminal justice system cannot be mandated to attend AA or denied privileges if they refuse to attend, based the religious/spiritual nature of the program (Project MATCH Research Group 1997). No similar ruling has been made concerning the privacy issues involved in AA or in mandated group treatment. However, in 1996 a man was found guilty of homicide based on testimony from fellow AA members that he had confessed to the crime at meetings. The defendant's claim of privilege for material discussed at AA meetings was not accepted by the court.

It is clear that group psychotherapy and twelve-step programs, can and do work well together to help in the recovery process of suffering alcoholics and addicts. It is also clear, that economics will play a great role in the treatment process of chemical dependence in the future. What must be made very clear, to all concerned in policy making at the local, state and federal levels of government, is that total reliance on twelve-step programs by governmental agencies is absolutely ludicrous. There is no substitute for trained professionals to lead group psychotherapy, which in the authors opinion, is one of the intricate keys to success of addiction treatment.

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