

A REVIEW OF THE 'ANONYMOUS' SELF-HELP GROUPS AND THEIR UTILISATION IN PROFESSIONAL SETTINGS

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Over the last 35 years there has been an enormous increase in the number and variety of self-help groups, fellowships and organisations which play a very large part in today's caring society. Many talk about the self-help movement and some describe us as "moving towards a self-help society (Bradford 1975)". It does not, however, require experts and professionals to tell us that people who have similar problem can give each other help and support. This has been going on since time immemorial. But it is probably only in recent years that the self-help movement has become structured and organised.

The 50th Anniversary of Alcoholics Anonymous provoked widespread admiration and congratulations from all media and this leader article in the Times is an example of that. (Table 1)

Alcoholics Anonymous has been one of the most an 1 treatment approaches for alcoholism: it is also the model for other successful self help movements (Zimberg 1987). Let us therefore look more closely at Alcoholics Anonymous. The latest survey was carried out on January 1st 1995 and it can be seen that for the first time the membership has exceeded two million members world-wide. They operate through over 80,000 groups in 115 countries. 'Mere are in addition over 2,000 groups in prisms and other correctional facilities. The basic text is the book "Alcoholics Anonymous". This was written by the first hundred members. It is known affectionately as the Big Book and the three English editions have sold 15 million copies. In addition it has hem translated into 30 languages. The latest, Nepali is due off the press in a few weeks. The rate of growth of AA since 1992 has been 4% per annum. For general interest from the 1992 membership survey the average length of sobriety of members is more than 5 years and the table also shows a split between male and female under and over 30 years of age. From the 1992 survey it was discovered that 35% of arrivals at Alcoholics Anonymous came from either treatment facilities or the medical profession. This was the largest referral source, although a significant number, 34%, were attracted by an AA Member and 21 % were influenced by their family.

After arriving at Alcoholics Anonymous 56 of those in the 1992 survey received some type of treatment, counselling or medical, psychological and/or spiritual help. Moreover 87% of those members who had received such treatment or counselling said that it played an important part in their continuing recovery from alcoholism- There is a saying in Alcoholics Anonymous which has been

turned into the title of one of their pamphlets - "Let's be friendly with our friends." Obviously with so many people arriving at Alcoholics Anonymous from outside agencies and then going on to receive professional help whilst they are also benefit from the self-help groups this friendship from their friends is of crucial importance.

Nowadays AA has come to work closely with most other agencies that treat alcoholics and in most alcoholism treatment units members of AA who come to visit are introduced to patients who are interested and may even conduct meetings. AA is now regarded as a partner in treatment, not a rival. Equally AA has come to accept that medical and other services may have a valuable role that it cannot itself perform (Kessel & Walton 1989).

AA, which is essentially a self-help group, presents its philosophy in the twelve steps and twelve traditions. the recovery process involves not taking any alcohol for "one day at a time", and active attendance at AA meetings.

The primary objective of the membership is to stay sober and help the still actively alcoholic. Not only do members stay sober but they display marked attitudinal and behavioural change. This is of crucial significance since detoxification from alcohol may be relatively simple but achieving comfortable and permanent abstinence will require considerable work for many years.

Clinics in Britain which utilise AA as an adjunct to therapy have developed a co-operative relationship with the organisation. Since AA is a non-professional group it does not seek to compete with any therapeutic approach but as an independent organisation it has over the years developed a very active participation with treatment clinics. In the United States there are over 2,000 private clinics which have integrated AA principles into their programmes and more than 1,000 clinics permit the running of an AA meeting on the site. AA strongly encourages its members to assist the professional in the field. In the UK there is ready access to members who are established in their recovery and willing to assist in a volunteer capacity. Such arrangements are made through local groups or intergroups. The majority of the treatment clinics in the UK employ AA's 12 Step programme.

SPECIALISED ALCOHOLISM TREATMENT

While the treatment of alcoholism has evolved diverse orientations, the specialised facilities incorporate the components considered necessary for effective treatment. These include (a) complete medical evaluation and differential diagnosis (b) full psychological evaluation (c) group therapy (d) individual therapy (e) alcoholism education (f) family therapy (g) AA meetings (h) continuing care. The treatment philosophy considers that alcoholism is a primary and usually progressive disease (Gitlow, 1988) which can be successfully treated, provided that a comprehensive approach is used. this philosophy is compatible with the view of AA which considers alcoholism to be a disease which is not only physical in nature but also exhibits mental and spiritual disturbance.

At one of the specialised units, Castle Craig which I founded seven years ago, the treatment programme has four major elements.(McCann P. 1988)

It is firstly necessary to intervene directly in the primary dependence state by focusing specifically on the ingrained habit of maladaptive use of alcohol.

This corresponds with the 1st step of the AA programme. It is of course necessary also to initiate a resolution of other major problems resultant from or contributing to his illness such as marital difficulties.

The second element is the creation of a therapeutic community which permits an intensive approach and is a powerful catalyst to behavioural change in the patient.

A third element is the use of a multidisciplinary team comprised of doctors, nurses, psychologist, social worker, pastoral counsellor, and trained alcoholism counsellors.

Fourthly if we accept that AA's philosophy is worthy of regard and that successful recovery is more likely if AA attendance occurs, a fundamental premise was the need to incorporate these principles into a professional programme and transmit them to the Patient. is achieved in a variety of ways which we describe.

CLINICAL STAFF

The clinical staff play a key role in introducing patients to AA concepts. It is fortunate that many alcoholics undergoing in facilities in Britain are either inadequately educated about AA or are not properly introduced to their meetings. As Edwards puts it "It is a dereliction of duty if patients go through treatment without AA even being mentioned or worse still if they are deflected from AA involvement by some negative statement". If the doctor or therapist is prejudiced against AA his bias will won be perceived by the patient who will find justification for not investigating AA and what he considers an easier but perhaps less effective alternative.

The consistency of the therapeutic milieu then is reinforced by the contribution from the clinical staff all of whom are required to be conversant with how AA operates and have no reservations about the validity of number of AA meetings in order to learn of the various activities. The employment of professional staff who are themselves recovered alcoholics is a considerable advantage since they become particularly expert at conveying the ideology of AA in a manner that is both factual and inspiring, Phrases which are used constantly at AA meetings such as "developing openness and honesty, becoming willing & letting go", become part of the language of therapy. Acting as role models they reflect that a fulfilling and productive life through AA fellowship is possible. As in AA staff and patients address each other by first names only, and staff will often appropriately disclose aspects of their own recovery. Patients in this way become less suspicious of staff and less defensive. While all staff are trained to be non-judgemental and caring blend of recovered alcoholics into the staff team has a marked effect on the climate of trust and open-ness.

The selection of such staff will involve, apart from other relevant qualifications, consideration of the quality of their own recovery, of the ability to detect repressed feelings and demonstrate empathy. The staff must be supported in their roles by all departments of the organisation. According to Sobbel and Sobbel (1987) for example, 72% of the professional counsellors working in more than 10,000 substance misuse treatment centres in the United States are recovered alcoholics and Bradley (1988) estimates that as many as 60% of all alcoholism treatment professionals in the United States are AA members.

The United States is the undisputed leader in the process of translating the 12 Step AA ideology into a product for professional treatment markets, (Maykella 1993). The first attempts to make such a translation started in the early 1950's, but not until 1970's and 1980's did 12 Step treatment become a dominant part of the professional treatment system in North America (Anderson 1980: Cook 1989).

THE THERAPEUTIC COMMUNITY

The ethos of the therapeutic community is compatible with AA's ideology and its momentum directs the patient towards AA's unequivocal goal of abstinence. AA meets certain needs of the alcoholic. It

firstly provides hope where only despair prevailed. Secondly it restores self-esteem through its uncompromising acceptance of him as a person. Thirdly, it enables him to recognise his problem through the process of identification, Within the milieu of the clinic these same characteristics are found. Hope abounds. There is the continuous exposure of ex-patients, reunions, which are part of the continuing care programme and where several hundred ex-patients and their families actively pursuing the AA way of life return to the centre. Furthermore patients who have been engaged in therapy for a few wren will speak of the profound alterations in perception of their condition. the new patient's expectations are raised that change is possible, and that its counterpoise, a new order of firmer stability, can be attained Secondly the new admission to the clinic is at once made to feel welcome and accepted by the peer group who invite him to join their informal activities, offering him a cup of tea, putting a supporting arm around his shoulder and supporting him throughout his detoxification period. A genuine esprit de corps prevails where mutual concern and respect is evident and the entree to the group is to simply state "and I am an alcoholic" as AA members do at a group meeting. Gradually the alcoholic's interpersonal relationships, which had suffered serious disruption and become at most only superficial begin to improve. The intense peer inter-action also counteracts the loneliness and isolation and fosters the AA characteristics of fellowship, a sharing relationship with other suffering alcoholics, and communication of the joys and discoveries of sobriety. Thirdly he is enabled to recognise his own problem through listening to the stories of older patients, as they share frankly about their careers and the cycle of identification continues.

The environment of the centre can be adjusted to reflect aspects of AA thinking included in AA ideology are a number of aphorisms which indicate some basic coping skills for new comers. These are inserted into the treatment setting through the use of framed pictures on the walls. Clinical staff will explain the significance of such sayings to patients in the course of therapeutic encounter. In this way it is possible to raise the consciousness of patients to the application of a new way of thinking and managing life's realities. Thus the patient who cannot adjust to living without alcohol for the rest of his life will be advised to consider the saying "One day at a time". In this way a more realistic short term goal is substituted for life long abstinence. The AA aphorism "Think, Think, Think" will remind him to beware of impulsive drinking or other impetuous actions, to apply restraint in response to life's challenges and introduces alternative constructive behaviour.

Following initial admission to the clinic and during therapy patients are provided with therapeutic reading material. this will include literature published by AA such as the book entitled "Alcoholics Anonymous", which contains an amount of how AA works, and also a book entitled "Living sober", which provides many practical suggestions on how to live a fulfilling life without alcohol. the patient's therapist will prescribe sections to be read which are of general or particular relevance to the treatment plan.

A wide range of didactic material is provided through lectures and video recordings. the topics are diverse and include such ones as "The disease of alcoholism", "Self Esteem" but there are also lectures on the steps of AA and many lectures point to come aspect of the AA experience.

It is a practice of the treatment programme to ensure that patients are properly introduced to AA meetings. Apprehensions can be allayed by adequate prior explanation of the activities and philosophy of AA This will apply even to those who have had previous exposure since prejudice abounds and many have them misinformed. There will be a natural reluctance initially from some patients to engage on AA meetings. It may be rationalised by some that its apparent religious flavour is unacceptable. It is often then reassuring to be informed that it is not a religious organisation although there is a spiritual dimension to the programme, that the patients do not have to speak at meetings and that those who avail themselves of all the therapeutic resources will have the best prognosis. Patients are informed that a more objective opinion may be formed following exposure to a number of meetings, when they will have the opportunity to meet other alcoholics who are recovering, When one is suffering from a disease which is associated widely with a poor outcome and which brings so much

despair, the impact of meeting recovered alcoholics who are living sober and fulfilling lives cannot be underestimated. The newcomer will realise profoundly that if they can recover, so can he. Orientation to the AA programme is provided by professionals who are AA attendees. Members are invited to conduct a weekly meeting in the centre at which attendance by all patients in the clinic is exceedingly popular. Transport is arranged to ensure that patients view a number of meetings outside the clinic. members of AA are also encouraged to visit the clinic by arrangement, for more informal contact.

PHASES OF TREATMENT

The twelve steps of AA now form the foundation of the treatment programme. (McCann M A 1992) Patients are helped by staff to gain an understanding of, and complete the first five of these. This is a dynamic process and must not be viewed as an intellectual exercise. It therefore requires to be accurately monitored by staff with constant feedback during group therapy from peers. As always, it is easier for staff to make judicious assessment of progress based on specific and observed attitude and behaviour change rather than upon the patients' declarations of intent.

The initial phase of treatment corresponds to completing step one of the AA programme. This step reads "We admitted we were powerless over alcohol - that our lives had become unmanageable". During this phase it is necessary for the patient to begin to relinquish some of his unconscious defence mechanisms. This is helped by the realisation that he has a disease there is initially a lack of awareness of the extent of his uncontrolled drinking and the ensuing problems. There is also denial of other conflicts, feelings and problems. Group therapy which is a cornerstone of treatment greatly assists providing a continuous confrontation with reality. In order to increase awareness of his problem he will be expected to record at length specific data related to his drinking and its consequences. This may include, for example, a detailed account of occasions when he suffered blackouts, a description detail of his preoccupation with alcohol, or specific examples of alcohol related destructive behaviour. His peers will be asked to review these acknowledgements of his powerlessness over alcohol and at the same time he will look for evidence of insight into his condition, a genuine awareness that he needs help and is prepared to face it and a diminution of the alcoholic's characteristic grandiose defiance. This phase will usually take two to three weeks but it is a process with its own tempo. As repressed material is uncovered and shared with his peer group and as the process of mutual identification and acceptance develop there is a reduction of shame which itself assists in the release of repressed material.

Having completed step one the patient moves into the next phase of therapy corresponding to completion of step two and three. The second step reads "Came to believe that a Power greater than ourselves could restore us to sanity", and the third step reads "Make a decision to turn our will and our lives over to the care of God as we understood him".

While major elements in the recovery process during the study of step one included self disclosure and acceptance of his illness, the elements that emerge during this phase include movements from futility to hope, from distrust to trust and from isolation to integration with his peers. The patient may given a questionnaire designed to help focus on the meaning of these steps, or he may be asked to study some relevant literature. Alternatively through other assignments partly written, partly involving interaction with peers he is assisted in focusing on a number of spiritual values such as development of personal responsibility or gratitude. He attends a special group therapy session once a week which discuss these steps. The concept of a High Power remains a flexible yet personal one. The agnostic is told that he can utilise these steps by accepting the group as a "Higher Power".

The next stage in treatment corresponds with completion of the fourth and fifth steps. the fourth step reads "Make a searching and fearless moral inventory of ourselves" and the fifth step states "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs". Elements in his

recovery during this phase include a development of greater responsibility and self-discipline, and increased self understanding a prerequisite to improvement in these areas of his life where change is necessary. The objective of these steps is to also remove any distress concerning the past and this restores much peace of mind. The patient is involved in preparatory interview with the trained pastoral counsellor. A special guide to the fourth step available and with access to expert patterns of behaviour that have characterised his lifestyle. The implementation of step five is in the form of a highly confidential interview using trained listeners preferably a minister or someone with a long experience of AA

DISCHARGE

A treatment facility can only provide initial intervention in the disease of alcoholism and temporarily arrest its progression. It is now necessary sustain the therapeutic benefits of inpatient care by active support and monitoring of recovery in the community. Alcoholism is a major cause morbidity and mortality, has usually resulted in serious disruption of social functioning for the individual, and has a high potential for relapse. It is the circumspect to consider that recovery must be regarded as a long term process and that alcoholics will need to depend on some agency for an extend period. This long term maintenance programme of recovery is most efficiently provided by AA at no cost to the individual.

Toward the end of treatment therefore careful preparations are made for the patients' discharge back to the community. A detailed continuing care plan is devised for each patient which will not only include in-patient follow-up with individual and group counselling but will continue to emphasise importance of applying AA principles within the person's new lifestyle. Leaving the stabilising environment of the facility is somewhat stressful but engaging in advance the support of some of his local AA membership a smoother transition back to community living is made. Prior to discharge patient will then be expected to establish contact with a local AA person. The member, often an ex-patient and someone established in his own recovery will act as a temporary sponsor providing guidance and a degree of availability should advice be required. In a practical sense he will usually offer his telephone number and introduce the patient to the local AA made contact with AA - A list of ex-patients who are willing to under take the role of sponsor and are now involved with the fellow ship is accessible to staff. Each patient will be given a list of AA meetings in his locality and will be encouraged make a commitment to attend a number of these immediately after discharge.

While most return home, certain patients such as those with little family support and no immediate prospects of employment are referred for residential aftercare in halfway houses. Those facilities to which we refer all have the same goals of abstinence and promotion of involvement.

RELATIONSHIP OF PROFESSIONALS WORKING IN THE FIELD WITH THE ANONYMOUS SELF-HELP GROUPS

If a treatment facility wishes to involve the Anonymous organisation or 12 Step organisations in its activities it will be employing a very powerful asset in the recovery of its patients. Individual members and groups can play an important part during the treatment programme but even more so in the support of patients after they leave the direct care of the treatment facility. It is vital therefore that professionals in the field must study die constitution and traditions of AA and its offspring and thoroughly acquaint themselves with the local membership, inter groups, regional representatives and the nearest national headquarters. (Grune and Stratton. 1988) Out of courtesy it is always advisable to inform the national headquarters and other representative sections of any significant changes in the treatment centres own organisation. Early discussions are advisable to see what extent the help of AA can be enlisted- Considerable help can be obtained at this stage especially in obtaining contacts with established stable members of the organisation.

It is always a measure of a professional ability in this field on how their relationships develop with outside bodies and the relationship with the Anonymous self-help groups is no exception. During treatment it is advisable to introduce patients to AA meetings, and it can be a considerable asset if an in-house AA meeting is held on the premises of the treatment unit. Usually members of Alcoholics Anonymous, through their inter group or the local group will leap at the opportunity to start up a meeting in a treatment facility. This can take various forms and advice can be sought on this from the Fellowship. It is important that once established the staff do not interfere in any way with the group. This is essential and I personally consider that once a person is stabilised following their detoxification they are introduced to AA as soon as possible. On no account must the professional interfere with the running of the group, or try to influence it in any way.

The relationship with outside bodies such as self-help groups is a measure of a professional's ability, and the anonymous self-help groups are no exception, although this professionalism may be tested on occasions. The smooth reeling of this relationship between treatment centre and self-help organisations requires tact, patience and understanding. For their part members of these self-help groups will not interfere in the treatment of the patients. Occasionally an over zealous member of the Fellowship perhaps new in their own recovery, may transgress this. It has happened that members have queried medication being received by patients. (McCann M G 1993). This is against the guidance issued to members and if transgressed a discreet discussion with the group leader, or if necessary the National Office, will soon put the matter right. As pointed out by Lewis he had encountered a degree of rigidity amongst AA members. This rigidity is changing and more characteristic of the 70s than the 90s. The earliest leaders of AA notably Bill Wilson at a talk before the New York Medical Society in 1958 said "AA will always stand ready to co-operate".

The membership of AA can be of enormous assistance, providing contacts after a patient has left treatment and this help should be sought and cherished.

CONCLUSION

My own experience of having directed the treatment of many patients over the past 12 years has led to great optimism. Unfortunately not all alcoholics will initially recover and many will continue to remain in the same state of abject misery or die, but we are nevertheless encouraged by the steady restoring to health which we see for the majority. It is my opinion that this recovery would not be as substantial as it is without the healing influence of the AA programme. Alcoholism results not only in physical illness but also in fragmentation of the mind and spirit and for a treatment programme to be effective it must pay attention to this spiritual dimension. Jung spoke of the necessity for the alcoholic to undergo a total rearrangement of attitude and mind, "in short a genuine conversion" and that all his patients a "spiritual or religious experience" had been necessary. Griffith Edwards has described basic treatment as "an alliance with the natural possibilities for recovery". Incorporating AA principles into the multidisciplinary approach of the specialised alcoholism treatment unit ensures attention to the spiritual dimension of wholeness but also permits the individual to discover the pathways he must travel to achieve this healing.

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