Addiction as a Family Disease: Helping Children and Adolescents in Families Affected by Substance Abuse

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Outline of Presentation

- Case discussion
- Epidemiologic issues
- Risk and Protective Factors
- Impact of alcoholism and other drug use disorders on children & families
- Our role as child, adolescent and family health advocates

Case History

- 11 year old male with Type I Diabetes
- Multiple hospitalizations for DKA
- Parent and child sent to intensive educational program
- Admissions for new onset seizures and hypoglycemia
- Parental/family history

Epidemiological Issues

Two Fundamental Questions

- How many COAs/COSAPs are there?
- How many of these children will develop alcohol/drug use disorders?

Epidemiological Issues: How Many COAs Are There?

  - 22 million COAs age 22 and older
  - 6.6 million COAs under age 18
- Eigen LD & Rowden DW, 1988 National Health Interview Survey
  - 11 million COAs under age 18

National Longitudinal Alcohol Epidemiologic Survey - 1992

- Data collected via personal interviews
- Nationally representative sample chosen at random - 48,862 households
- Diagnosis based in DSM-IV criteria

B F Grant, AJPH, 90 (1):112-115; 2000
National Longitudinal Alcohol Epidemiologic Survey - 1992

- 7.4% of adults classified with DSM-IV alcohol abuse or dependence in past year.
- 18% of adults classified with lifetime DSM-IV alcohol abuse or dependence
- 9.7 million children living in households with 1 or more adults who were abusing or dependent on alcohol

B F Grant, AJPH; 90 (1):112-115; 2000

National Longitudinal Alcohol Epidemiologic Survey - 1992

- 1 in every 4 children in the US exposed to alcohol abuse or dependence in the family.
- The number...“defines one of today’s major public health problems.”
- “Children exposed through no fault of their own, are thrust into families and environments that pose extraordinary risks to their immediate and future well-being and threaten the achievement of their fullest potential.

BF Grant, AJPH; 90 (1):112-115, 2000

Estimated Numbers of Children under 18 Years of Age Living with One or More Parents with Past Year Substance Dependence or Abuse: 2002 to 2007

Epidemiological Issues

Two Fundamental Questions

- How many COAs/COSAPs are there?
- How many of these children will develop alcohol/drug use disorders?

Children of Alcoholics: Risk Factors

- COAs appear to be vulnerable to risk for maladaptive behaviors due to a combination of risk factors in their lives
- The single most potent risk factor is parental AOD using behavior
  – biologic factors
  – psychological factors
  – environmental factors

COAs are 4 to 9 times more likely to develop an alcohol use disorder

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Description</th>
<th>Ratio</th>
</tr>
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<tbody>
<tr>
<td>Goodwin, et al.</td>
<td>Copenhagen: 5,485 non-family cases, 1924-47</td>
<td>3.6:1</td>
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<tr>
<td>Cloninger, et al.</td>
<td>Sweden: 862 males adopted by non-relatives (Type I)*</td>
<td>4.4:1</td>
</tr>
<tr>
<td>Cloninger, et al.</td>
<td>Sweden: 862 males adopted by non-relatives (Type II)**</td>
<td>9.4:1</td>
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<tr>
<td>Bohman, et al.</td>
<td>Sweden: 913 women adopted by non-relatives</td>
<td>3.5:1</td>
</tr>
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</table>

* Type I (milieu-limited): Mild parental alcoholism, mild parental criminality
**Type II (milieu-limited): Early onset severe alcoholism and serious criminality
Children of Alcoholics: Risk Factors

- COAs are considered to be at high risk because they have a greater likelihood of developing alcoholism compared to others.
- Research on risk factors suggest that while certain risk factors are associated with increased risk, they do not necessarily indicate a causal relationship.

Concepts and Issues in COA Research

- Although investigators agree that COAs are at higher risk for developing alcohol use disorders than others, problems with alcohol are not an inevitable consequence of COA status.
- Recent research has identified numerous bio-psycho-social factors associated with a family history of alcoholism that may play a role in determining whether COA’s will develop an alcohol use disorder.

Dynamic Diathesis-Stress Model

Multiple factors influence the onset of alcohol use disorders - Windle

Alcohol Specific Family Influences Affecting Development of Psychopathology in COAs

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Research Findings</th>
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<tr>
<td>Modeling of drinking behavior</td>
<td>COAs are more familiar with a wider range of alcoholic beverages at a younger age and develop alcohol use schemas earlier</td>
</tr>
<tr>
<td>Alcohol expectancies</td>
<td>COAs have more positive expectancies regarding the reinforcing value of alcohol</td>
</tr>
</tbody>
</table>

Ellis DA, Zucker RA, Fitzgerald, AHRW; 21(3):218, 1997

The Primacy of the Family in the Social and Cognitive Development of Children

Two relevant conclusions from the literature

- All familial variables that can, will affect child outcomes
- The parent-child interaction is characterized primarily by two major dimensions:
  - Nurturance (i.e., warmth and support)
  - Control (i.e., supervision and discipline)
Families

Children of Substance Abusing Parents

• May lack consistency, stability, or emotional support due to chaotic family environment
• May be physically and emotionally traumatized due to accidental injury, verbal abuse or physical abuse due to parental drinking/drug use
• May encounter:
  – poor communication - neglect
  – permissiveness - undersocialization
  – violence

Family Disease Model
The Alcoholic Family System

Don’t Talk
Don’t Trust
Don’t Feel

Rigid Rules
Rigid Roles
Defense Mechanisms
Isolation

Disease of Alcoholism

Oddly, the majority of COAs go undetected.

Detection of Alcoholism in Hospitalized Children and Their Families

Duggan AK, Adger H, McDonald EM, Stokes EJ, Moore R
AJDC, 145:613-617, 1991
Comparison of Parents by Household Screening Status

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total % (N=147)</th>
<th>Positive (N=22)</th>
<th>Negative (N=125)</th>
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<tr>
<td>Mean Age</td>
<td>36</td>
<td>36</td>
<td>36</td>
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<tr>
<td>Sex, Female</td>
<td>99</td>
<td>100</td>
<td>98</td>
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<tr>
<td>Race, White</td>
<td>76</td>
<td>73</td>
<td>77</td>
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<tr>
<td>Employed</td>
<td>59</td>
<td>68</td>
<td>57</td>
</tr>
<tr>
<td>Income &lt;$20,000</td>
<td>30</td>
<td>46</td>
<td>27</td>
</tr>
<tr>
<td>Education &lt;HS</td>
<td>15</td>
<td>18</td>
<td>15</td>
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Comparison of Adolescents by Household Screening Status

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<th>Characteristics</th>
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<th>Positive (N=10)</th>
<th>Negative (N=59)</th>
<th>p-value</th>
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<tr>
<td>Has been troubled by a parent’s drinking</td>
<td>5</td>
<td>23</td>
<td>2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Has used drugs</td>
<td>5</td>
<td>23</td>
<td>2</td>
<td>.07</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>8</td>
<td>10</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>Depressed &gt; 2 wks in past year</td>
<td>39</td>
<td>50</td>
<td>37</td>
<td>.69</td>
</tr>
</tbody>
</table>

Despite feeling a responsibility to inquire about AOD in patients and families there appears to be a cultural ambivalence and a lack of skills in doing so.

• 0% Recognition by housestaff
• 1 Positive case identified by faculty
**Practical Issues: What is our role as child, adolescent and family health advocates?**

**Children of Alcoholics**

*Hidden Problems Hidden Costs:*

For Each 1,000 Subscribers
- 24.3% Greater rate for inpatient admissions
- 28.8% Greater length of stay
- 61.7% Greater rate for hospital days used
- 36.0% Greater rate for hospital charges

Children of Alcoholics Foundation, 1990

**Role of Health Professionals**

- Develop a sense of optimism, responsibility and confidence in clinical skills
- Take advantage of windows of opportunity
- Learn how to intervene and address the issue in a sensitive and caring manner
- Take an active anticipatory role in:
  - guiding patients and families to resources
  - helping to educate patients and their families
  - providing support and validation of concerns

Adger, McDonald, Wenger. *Pediatrics*, 103; (103); 1083, 1999

**Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents Affected by Substance Abuse-Level I**

- Be aware of medical, psychiatric, and behavioral syndromes and symptoms
- Be aware of benefit timely and early intervention
- Be familiar with community resources
- Include appropriate screening for family AOD use
- Determine family resource needs and services being provided
- Communicate appropriate concern and offer information, support and follow-up

Adger, McDonald, Wenger. *Pediatrics*, 103; (103); 1083, 1999

**Screening for Alcohol and Drug Use Concerns in the Family**

The Most Important Question Some Never Ask

Have you ever been concerned about someone in your family who is drinking alcohol or using drugs?
Screening for Alcohol and Drug Use Concerns in the Family


- Parents who screen positive preferred pediatrician to initiate additional discussion about drinking and effect on child, give educational material and present options for referral. Wilson, et. al., 2009.

What Children and Families Need to Understand and Hear From Us

- You are not alone.
- It is not your fault.
- Your concerns are valid.
- Help is available.

www.nacoa.org

Teen Talk

- Positive peer oriented groups.
- “Doing the Right Thing is Cool”

SUMMARY

- An estimated one in 4 children in the US grow up in households with parents affected by alcohol abuse or dependence and countless others grow up in homes with parents affected by other drugs.

- While the majority of them will grow up to lead healthy and productive lives, many will not.

- The challenge before us is to identify them early and intervene in a timely and meaningful manner.
Long Term Sobriety in Alcoholics Anonymous

Michael Anthony, PhD, LPCS, CRC
Introduction and Goals

- Alcoholism and AA
  Every clinician needs to be thoroughly familiar with the work of the 12 step self-help programs. 12-step programs in conjunction with psychotherapy produce the best outcomes.

- Research results regarding member long term AA participation
  To learn what members with substantial sobriety (20 years or more) in the AA program have to say by analyzing themes that arise from long-term member experiences.

- Stage models of recovery from alcoholism
  To learn how to better assist our patients (and ourselves) in obtaining and maintaining permanent sobriety through the AA program.
Alcoholism and AA

- Alcoholism: Disease or Dilemma?
- What is AA?
- Benefits of Group Therapy for Alcoholics
- Difficulties in Researching this Population
Alcoholism: A True Disease

It has only been within the last quarter century that the affliction of alcoholism has reached widespread acceptance as a true disease by both medical professionals and the general public.

- 1956 AMA declares the affliction an illness.
- 1967 AMA declares alcoholism is indeed a bona fide and complex disease.
- 1992 The National Council on Alcoholism and Drug Dependence (NCADD) and the American Society of Addiction Medicine formed “Joint Committee to Study the Definition and Criteria for the Diagnosis of Alcoholism,” reached the following definition for this devastating disease: Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.”
- 2000 DSM-IV-TR While stopping short of labeling the condition a disease, the manual does, however, note the strong genetic as well as the environmental components of the malady.
- 2005 Medical practitioners and researchers alike continue to call for “the re-conceptualization and treatment of addiction as a chronic medical illness” (NCADD).
- Owen and Sheehan provide an excellent discussion of the rationale and history of the disease model of alcoholism treatment, tracing the roots of the evidence that the illness qualifies for this classification status. Interestingly, they cited research that compared alcoholism to diseases like hypertension and heart disease that are not solely biological in nature, but rather interface with environmental risk factors for onset and progression. According to the researchers, factors such as personality, lifestyle, and genetics all contribute to the onset of alcoholism. Moreover, the biological etiology for alcoholism, like most chronic diseases, remains idiopathic. As a result, they advocate for the expansion of the scope of treatment for alcoholism to multimodal approaches. To bolster their conclusion that a disease designation is absolutely correct, they cite additional research that states emphatically that alcoholism is a brain disease that markedly impairs a person’s ability to control alcohol seeking behavior, the end result being molecular changes in the brain from chronic drinking.

WHERE DOES A GUY LIKE PACMAN JONES GO INTO REHAB?

SPORTS PACMAN TO GET HELP

VIDEO GAME CHARACTERS ANONYMOUS

2000 12-Step programs Today
2000 12-Step programs Today

Hey, where's my watch?! That's IT, Manto! ..you're going NEXT-DOOR!
What is AA?

Much to the rest of the groups horror Bob had completely misunderstood the concept of Alcoholics Anonymous.
Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, multiracial, apolitical, self-supporting in that it does not accept any money for its services nor any contributions from non-AA sources, and is available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem. AA members share their experience with anyone seeking help with a drinking problem; they give person-to-person service or “sponsorship” to the alcoholic coming to AA from any source. Alcoholics Anonymous also prohibits certain practices. AA does not furnish initial motivation for alcoholics to recover; it does not solicit members, nor does it follow up or try to control its members by, for example, keeping attendance records or case histories. AA does not engage in or sponsor research, nor does it participate in “councils” or “boards” of social agencies. AA does not provide medical services to include detoxification services, hospitalization, drugs, or any other medical or psychiatric treatment to include psychological diagnoses or prognoses. AA is not a religious organization or a social agency. Thus, it does not offer or endorse services engaging in education about alcohol abuse; neither does it provide any of the following: housing, domestic or vocational counseling, food, clothing, jobs, money, or any other welfare or social services, letters of reference to parole boards, lawyers, court officials, social agencies, or employers.

(Alcoholics Anonymous, 1984, 2006)
What is AA?

- Every clinician interested in the treatment of alcoholism should be familiar with the genesis of this the major self-help movement of the twentieth century, or arguably of all time. In short, “because of its size, its organization, and its influence on society, AA has been described as a full-blown social movement, akin to the women’s liberation and civil rights movements.” Nowinski, J. (2003). Self-help groups. In J. L. Sorenson, R. A. Rawson, J. Guydish, & J. E. Zweben (Eds.), Drug abuse treatment through collaboration: practice and research partnerships that work (pp. 55-70). Washington, DC: American Psychological Association.

- The AA movement “provides healing without healers (professionals), spirituality (faith and hope) without religion (institutions), and solidarity and community without organization and bureaucracy” . . . “following Jung, clinicians and researchers need to recognize the strength and hope of AA and other 12 step programs as legitimate sources of knowledge and scholarship.” . . . The willingness of AA to remain open-minded when investigating spiritual experience, and its encouraging its members to do the same, is what distinguishes AA’s voice from most other theories and methods.” Diamond, J. (2000). Narrative means to sober ends: Treating addiction and its aftermath. New York: Guilford Press.


- President Obama’s comments
So, Who was this "Doctor Bill" guy?
• Approximately 3% of the adult population of the United States has at some time attended an AA meeting. Over one million people attend an AA meeting annually.

• AA remains the number one solution for those recovered from an alcohol addiction regardless of length of sobriety. It is estimated that there are more than 100,000 groups and more than two million members in 150 countries. Since the book’s publication, close to 22 million copies have been sold. AA now distributes more than a million copies each year worldwide in English alone. The nearly 600-page volume has been published in 43 other languages, including Arabic, Croatian, Hindi, Mongolian, and Punjabi. A translation into Simplified Chinese to be used throughout the People’s Republic of China is currently underway (Alcoholics Anonymous, 2006).

• The modern era of substance abuse treatment actually began with the founding of AA. Today, 93% of all treatment centers in the United States incorporate a 12-step treatment approach.

• According to the most recent survey of AA members conducted by the organization’s WSO in 2004, the average age of AA members currently is 48 years of age, and nearly three quarters of members (approximately 73%) are over the age of 40. Furthermore, the average length of continuous sobriety of members is more than eight years, with 36% of members having achieved more than 10 years of continuous abstinence from alcohol. So, as the AA movement matures, so does its membership. The dynamics of AA’s exploding elder population, which continually boasts more and more members with 20 years or longer of continuous sobriety, are such that not even the AA organization itself tracks its senior membership (20 years and longer).
Why Group Therapy WORKS!

McHumor.com by T. McCracken

“You think YOU have peer pressure!?”
Therapeutic Factors of Group Therapy

1. Imparting information
2. Installation of hope
3. Universality
4. Altruism
5. Corrective recapitulation of the primary family group
6. Enhances socialization techniques
7. Behavior modeling
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

Benefits of Group Therapy for Substance Abusers

1. Participants can see the progression in themselves and others;
2. Participants can practice new behaviors and explain slips and lapses in an understanding and supportive environment;
3. Participants gain credible identification;
4. Participants enjoy isolation reduction;
5. Participants receive caring confrontations;
6. Participants establish healthy recovery patterns;
7. Participants enjoy denial reduction;
8. Participants gain positive peer pressure; and
9. Participants gain increased motivation.

Difficulties in Researching this Population

1. Only more sociable and affiliative people will become long-term AA members.
2. No definitive causality between meeting attendance/outcomes has been established.
3. The composition of AA membership is constantly changing.
4. The heterogeneity of addictive disorders.
5. AA’s tradition of anonymity.
6. The impossibility of experimentation with components of the program.
7. The self-selection factor in affiliation.
8. The lack of appropriate controls of the individual groups.


Morgan (1992) completed a dissertation on long-term sobriety in AA, interviewing 15 male AA members who had achieved a decade of sobriety. Morgan sought to determine the nexus between the development of spirituality and the attainment of long-term sobriety, and concluded that the spiritual element was indeed a critical factor for the attainment of long-term sobriety for this population sample. Sommer did the same, but with alcoholics less than 8 years sober.

Introduction and Goals

- **Alcoholism and AA**
  
  Every clinician needs to be thoroughly familiar with the work of the 12 step self-help programs. 12-step programs in conjunction with psychotherapy produce the best outcomes.

- **Research results regarding member long term AA participation**
  
  To learn what members with substantial sobriety (20 years or more) in the AA program have to say by analyzing themes that arise from long-term member experiences.

- **Stage models of recovery from alcoholism**
  
  To learn how to better assist our patients (and ourselves) in obtaining and maintaining permanent sobriety through the AA program.
Research Participants

- What are the most important things they have learned through their participation in AA?

- Why do they still attend meetings regularly after 20 years or more of AA participation?

- How do these recovered alcoholics who continue with their long-term participation in AA fit into the existing models of long-term recovery from alcoholism?
## Participant Demographics (General)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Marital Status</th>
<th>Children</th>
<th>Education</th>
<th>Religious Affiliation</th>
<th>History of Alcoholism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chuck</td>
<td>68</td>
<td>M</td>
<td>2</td>
<td>MS</td>
<td>Unity/Buddhism</td>
<td>Y</td>
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<tr>
<td>James</td>
<td>73</td>
<td>M</td>
<td>2</td>
<td>MSW</td>
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<tr>
<td>Joy</td>
<td>54</td>
<td>M</td>
<td>2</td>
<td>BA</td>
<td>Lutheran</td>
<td>Y</td>
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<tr>
<td>Julie</td>
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<td>M</td>
<td>4</td>
<td>H.S.</td>
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<tr>
<td>Kurt</td>
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<td>S</td>
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<td>2 yrs. College</td>
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<td>Mohandas</td>
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<td>D</td>
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## Participant Demographics (AA Related)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Meetings Weekly</th>
<th>Years Sober</th>
<th>Years Drink</th>
<th>Has a Sponsor</th>
<th>Sponsors Others</th>
<th>Psy. Diag</th>
<th>Meds Therapy</th>
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</tr>
<tr>
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<td>18</td>
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<td>Y</td>
<td>Y</td>
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</tr>
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<td>17</td>
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<td>Y</td>
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<td>Y</td>
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<tr>
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<td>23</td>
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<td>Y</td>
<td>Y</td>
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<td>5</td>
<td>25</td>
<td>11</td>
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<td>Y</td>
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<td>Y</td>
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<td>5-9</td>
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<td>N</td>
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<td>N</td>
<td>N</td>
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<tr>
<td>Walter</td>
<td>5</td>
<td>24</td>
<td>25</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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Emergent Themes From Long-Term Recovery in AA

1. Drinking Career
2. Long-Term Sobriety
3. Medical and Therapy History
1. Drinking Career

- Family Alcoholism
- Lost in the Wilderness
- Severity of Bottom
- Spiritual Experience
Family Alcoholism

My life is not unmanageable.
I got a nice room in my mom's basement.
Family Alcoholism

Most participants could point toward feelings that developed early on in their family-of-origin home environment, which they could and would later identify as the primary culprits that fueled their drinking. These included feelings of difference, feelings of living a dual life, and feelings of being separate or apart from. Another factor that often began early on included, predictably, low self-esteem. And finally, many of the participants identified conflicts with their religious upbringing that would later play a major role in their descent into alcoholism.
Lost in the Wilderness

As the descent into alcoholism began to steam ahead like a racing juggernaut, each of the participants expressed their helplessness at halting the disease's inexorable progression.

"I owe my life to crack cocaine. It got me to the program a lot quicker."
Severity of Bottom

My only requirement was a federal court order.
Severity of Bottom

Finally, in each of the participants’ lives came the time when they could no longer drink without paying a price which they eventually became unwilling or unable to pay. Bottoms vary in Alcoholics Anonymous as people have different tolerances for psychological pain. Nevertheless, as the participants’ stories showed, all alcoholic individuals who are able to escape the tragic ends of the untreated disease can usually point to a time when they had to concede to their innermost selves that regardless of the consequences, they could no longer drink. This phenomenon which leads many alcoholics to change their lives, has been referred to as “the continued viability of the elemental self.” People in advanced stages of addiction when they are confronted with the prospect of relinquishing their drugs, or whatever substance or experience their addiction has coalesced around, must reach this point where healing may start if their problem is to be not merely managed but transformed.” (Diamond, 2000).
After awhile, Starbucks and yoga just ain't enough!
Bill Wilson’s Spiritual Experience

In his helplessness and desperation, Bill cried out, “I’ll do anything, anything at all!” He had reached a point of total, utter deflation — a state of complete, absolute surrender. With neither faith nor hope, he cried, “If there be a God, let Him show Himself!” What happened next was electric. “Suddenly, my room blazed with an indescribably white light. I was seized with an ecstasy beyond description. Every joy I had known was pale by comparison. The light, the ecstasy — I was conscious of nothing else for a time.” “Then, seen in the mind's eye, there was a mountain. I stood upon its summit, where a great wind blew. A wind, not of air, but of spirit. In great, clean strength, it blew right through me. Then came the blazing thought ‘You are a free man.’ I know not at all how long I remained in this state, but finally the light and the ecstasy subsided. I again saw the wall of my room. As I became more quiet, a great peace stole over me, and this was accompanied by a sensation difficult to describe. I became acutely conscious of a Presence which seemed like a veritable sea of living spirit. I lay on the shores of a new world. ‘This,’ I thought, ‘must be the great reality. The God of the preachers.’ “Savoring my new world, I remained in this state for a long time. I seemed to be possessed by the absolute, and the curious conviction deepened that no matter how wrong things seemed to be, there could be no question of the ultimate rightness of God’s universe. For the first time, I felt that I really belonged. I knew that I was loved and could love in return. I thanked my God, who had given me a glimpse of His absolute self. Even though a pilgrim upon an uncertain highway, I need be concerned no more, for I had glimpsed the great beyond.” Bill Wilson had just had his 39th birthday, and he still had half his life ahead of him. He always said that after that experience, he never again doubted the existence of God. He never took another drink. (Pass it On, 1984, pp. 120-21).
Spiritual Experience

Apocalyptic variety - A rather rare phenomenon in AA whereby alcoholics experience a sudden and powerful spiritual transformation for which they often credit the loss of the desire to return to drinking.

Educational variety - The more common process of spiritual transformation in AA whereby alcoholics through the process of “working the steps” and applying the AA program to their lives achieve resolution of their drinking problem. Most alcoholics are unaware of this transformation except in hindsight.

- In my study, for some recovered alcoholics, the event was more of a process, as with Richard and Mohandas, who realized that they did not want to lose their families. For others, like James, a specific event triggered a desperate attempt to again seek help. For still others, the life-changing spiritual experience was similar to Wilson’s, an apocalyptic revelation that inexorably altered the course of their lives. These receivers of Grace can recount with uncanny precision their exact moment of redemption.

- In all, 5 participants discussed a spiritual experience in AA that transformed their lives. The importance of the spiritual experience or transformation for the alcoholic cannot be overstated. For many, it is the defining moment of their lives. Fully one third of the participants in this study experienced at least a form of the apocalyptic transformation - in that in a moment they knew that their lives had changed forever. Patricia was praying at an International AA convention in Montreal when she had hers. Steve was sitting in his local AA meeting in Oakland, California. Chuck awoke to consciousness out of a blackout to hear a voice say that it was over. James in a similar blackout state, realized that his drinking had to end right then and there. For Thomas though, it was just a feeling that came over him on a crisp, clear December night on the front porch of the man’s home who would become his sponsor.
Sylvia Cary wrote an entire book, *Jolted Sober*, on this topic. She discusses “the moment of clarity” experience, a psychological phenomenon experienced by many long-term members of AA, which may manifest itself in individuals differently, but is essentially an epiphany of one form or another “that their addictive behavior has to end.”

For others, who have experienced the more common educational variety of spiritual transformation, like Walter and Susan, it was the gradual result of working the steps and applying the principles of the AA program to their lives that changed them forever.

Regardless of the seed from which the existence-changing tree of life sprang for these participants, for each of them this positive “event” has matured into a guiding force that many of them allow is closer to me than my next breath. Patricia says that now she “believes in Grace … people are channels for it…. It doesn’t matter what happens, God will carry me through it and I will return to peace.” Walter exclaims, “I used to think people were crazy when they talked about God … Protestants, Geeez! Long story short, my faith has gotten me through little and big things over the years.”

No longer embarrassed by discussing either religion or spirituality today, these participants reveal that, unlike AA members early in recovery, as has been commonly reported in studies on early sobriety, they no longer suffer from shame when discussing matters spiritual or religious. Not only do they openly discuss and usually attribute their long-term sobriety to these factors, they, as Zemore and Kaskutas (2004) have found, associate their increase in spirituality with giving back, with if you will, Erickson’s generativity. Most current research continues to show that the continued growth and evolution of members’ spirituality remains a paramount consideration for long-term success in AA.
Emergent Themes From Long-Term Recovery in AA

1. Drinking Career
2. Long-Term Sobriety
3. Medical and Therapy History
2. Long-Term Sobriety

- Commitment to Meeting Attendance
- Importance of Relationship with Higher Power
- Sponsorship/AA Service/Giving Back
- Changes Experienced in the AA Program/Elder Statesman
- Social Life, Addiction to AA
Meetings, Meetings, Meetings

Bless me Father, for I have sinned.
It's been more than a month since my last meeting!

ASHLEY
Two meetings per week remains the standard for members (2004). Research continually shows that meeting attendance and outcomes are correlative, even in longer-term sobriety. That is to say, for alcoholics fortunate enough to find AA, the greater the severity of their alcohol dependence and alcohol-related problems, the more likely they will stick with their participation in 12-step programs.

Research group averaged 5 meetings a week.

Younger participants make slightly fewer meetings per week.

Older members that make more meetings may be retired, consequently having much more leisure time. Nonetheless, it begs the question, since the drinking problem has long been solved, why spend much of your time in self-help group therapy? Chuck’s reason was that meetings “keep things in perspective,” while Thomas felt that “they provide the opportunity for service.” The evidence suggests that those who participate in AA activities (meetings, studying AA literature, and social activities) are more apt to maintain their sobriety. In addition, they achieve healthier coping strategies generally, and are much less likely to use psychological medications or outside counseling to maintain their abstinence.
Relationship With A Higher Power

Just a sign, God! .... Anything!!
AA’s cofounder, Dr. Robert Smith (1950), presented his last major talk at the first International Convention of AA just prior to his death in 1950. From the podium, he pronounced that the 12 steps of AA were derived from the Sermon on the Mount (Matthew 5–7), 13 Corinthians, and the Book of James, and yet, hardly any of the participants defined themselves as Christians.

Most participants talked freely and openly about their conception of “God” or a higher power in their lives today. Every participant suggested that the power they know and believe in today is vastly different from the concept they had while drinking. Yes, eight of the 12 participants listed a Christian denomination on the demographic “form,” but through the clinical interviews, it became clear that few would actually identify themselves as Christians today. Patricia raised Catholic, now believes in the “Power of Benevolence.” Steve responded, “I suppose I lean toward Christianity … but none really.” Thomas stated, “I believe in God, I am Christian, I just don’t think much about it…. Keep the God thing in reserve, mostly.” Kurt notes that, “I have Christian values, but I am not dogmatic.” Then later, in explaining his decision-making processes today, he added: “What would Jesus do?” Further, 10 of the participants, such as James, state flatly that they are not religious. “Spiritual, not religious” is a common refrain heard at AA meetings around the world. Members often have an antipathy toward organized religion, and often this feeling tends to linger. This phenomenon may help to explain why so few members want to be labeled “Christian,” yet in their responses, they clearly articulate a Christian philosophy.
CALL Your Sponsor

I pray every day God.....
Why don't you answer?
Of the participants, 10 still had a sponsor or sponsors and 10 also continued to sponsor multiple individuals themselves. Kurt, with 23 years sober, felt that his participation in this area has really increased. “In the last eight years, I have had more intense sponsor relationships…. more involved now than ever … more than 10 years ago.”

Most participants talked about how sponsorship has changed. Joy, for example, stated that she is “no longer on an ego trip when I sponsor … it’s not about me or them, but a sacred responsibility and a privilege.” Steve and Patricia both indicated that they have become much more compassionate in later sobriety. Patricia reflected that “at 10 plus years of sobriety, I sponsored heavily, yeah, 10 to 20 years has been my heaviest.” For many though, sponsorship has been consistently “heavy” all the way through.

Patricia’s description of her history was typical: I sponsor six people right now. I’ve cut back the last seven or eight year, before that at ten years plus, I sponsored heavily. Then, I worked a lot for the gay group locally got burned out. I had several special needs sponsees with disabilities. Tough job, sometimes. I took a sabbatical quit sponsoring for a year, a few years ago. I started back up again, though. Also, I have attended Al Anon the last six years. The last two years, I’ve really slacked off. From 10 to 20 years was my heaviest service. My last treasurer job ended last summer. My lowest amount of service came at five to eight years, after a really busy first five years of service in sobriety.

For many, sponsorship has become more of a relationship of equals not so in the earlier years. “Today, it’s about sharing humanness with my sponsee, not perfection. The relationship is a friendship, an important responsibility. I have learned to be more tactful, not blunt or brutally honesty. Some moments call for that, but I prefer to be gentle. The metamorphosis really started at 10 years sober when I was a teacher in AA. Suddenly, I lost my job and became a student of my sponsees, who taught me how to live and get through those tough times. I have softened over time, learned more about compassion, become more compassionate.

Several participants – Walter, Chuck, and Thomas – shared that their need for sponsorship has decreased over time.
Sponsorship and Erickson’s Generativity

In considering AA sponsorship in terms of Ericksonian thought, it seems that the process that has matriculated in AA completely encompasses Erickson’s generativity. Care, is a widening commitment to take care of the persons, the products, and the ideas one has learned to care for. All the strengths arising from earlier developments in the ascending order from infancy to young adulthood (hope and will, purpose and skill, fidelity and love) now prove, on closer study, to be essential for the generational task of cultivating strength in the next generation. For this is, indeed, the “store” of human life. Extrapolated to AA, this is exactly what happens in the AA sponsorship process.

Ritualization: “In accordance with our promise, we must also allocate to each stage a specific form of ritualization. An adult must be ready to become a numinous model in the next generation's eyes and to act as a judge of evil and a transmitter of ideal values. Therefore, adults must and do also ritualize being ritualizers; and there is an ancient need and custom to participate in some rituals that ceremonially sanction and reinforce that role. This whole adult element in ritualization we may simply call the generative one. It includes such auxiliary ritualizations as the parental and the didactic, the productive and the curative…. Genuine generativity, of course, includes a measure of true authority.

Put simply then, “generativity involves the concern for establishing and guiding the next generation … in mentorship … guiding and helping them … passing down of traditions, rites, and customs to the next generation”

Criticisms: Some may suggest that because many very long term AA members do not feel the need to practice their generativity outside the AA fellowship, they are indeed “stagnant.” That is to say, they are not truly generative in the Ericksonian sense. If they were, they would be more integrated into broader society, dissenters may argue. As has been shown in this research, many very long timers in AA have performed community-based initiatives throughout their sobriety (e.g., work in prisons and hospitals). Moreover, they have certainly completed the “tasks” associated with Erickson’s penultimate stage of psychosocial development, to include raising families, completing careers, and so on. In addition, they have in many cases, achieved ego integrity or wisdom. And finally, most continue to sponsor, to mentor individuals in the most important learning roles of their lives.
Service to Others

Hey, isn't that your sponsor?

BAD BOYS
BAD BOYS
Whatcha gonna do when they come for you

COPS

D.E.A.
Other types of service:
Three participants, Walter, James, and Steve, indicated that they worked extensively in jails and prisons for much of their sobriety. Chuck has helped to start groups, as has Kurt. Chuck is now writing a local history of AA. Still, sponsorship remains probably the most visible element of AA service which most very long-term members participate in.

Research contradicted:
Two thirds of the very long-term members in this study, however, seem to require little outside AA to fulfill this need. Just as does Julie, eight participants essentially identify AA as their church. “I have no need to get involved outside in the community, I am performing my service work right here,” Julie stated. Patricia, with 20 years sober, reflected: “I was a user of the AA program in the beginning, but the program has gained my respect. I use the people, the literature now, but now it’s more about giving rather than taking, I have found more balance in my later years. Glad I have become more of a giver in the last ten years.” Chuck, Walter, and Thomas perform no community service now nor does James except for the various boards he sits on. Patricia stated that she had volunteered at a children’s hospital from 10-15 years sober, while Mohandas had worked with the homeless in Chicago at six to eight years sober, but neither do anything now. Susan still does “lots of stuff” she said, mainly through her position at a public institution. For both Joy and Thomas, their church provides all the extracurricular service activities they need.

“Thus, the fruits of middle age, according to Erickson, are found primarily in relationships based upon generativity.”
There are only two things alcoholics don’t like - the way things are and change.

Alcoholism
Patricia has been able to discover and become comfortable with her true sexuality, as a lesbian. She has also dealt with a homeless and mentally ill mother and extreme vocational struggles.

James, Joy, Richard, and Walter all have learned to overcome disabilities – legal blindness, cognitive and learning disabilities, and severe physical spinal cord injury.

Patricia sees herself as an elder, but maintains that “I have learned to rely on the group conscious rather than my own opinion.” Joy who has gone from a totally dependent blind person to become a successfully married entrepreneur said simply that she is still “just a child of God.” Richard too, today is humble, “just another alcoholic doing the best I can.”

Julie sees herself as an elder now. Semi-retired, and with her four children grown, she finally found the courage to divorce her husband at 20 years sober. Regarding the designation of AA elder, some were averse to wear the laurel wreath, as it were. Many of the participants made self-effacing comments regarding their elder status. For example, James decried being an elder statesman, as did Chuck. This negation might be better understood when one understands that in AA it is a faux pas to appear “unhumble.” Yet, it was clear to this researcher that these participants as a group feel that they are authorities on very long-term issues in AA.

Steve developed an eating disorder at 15 years sober, which he still struggles with. He believes that he became an elder in AA at about 17 or 18 years sober “when I started sponsoring others with long-term sobriety.” He added that “I am a better person today than I have ever been because of AA, God, psychotherapy, people, things I’ve learned in AA … because of all of it.”

Chuck speaks more of the internal changes that have occurred in his life, especially in the last few years, the loss of fear, the no longer feeling apart from or separated from God that has slowly taken place over his long haul in sobriety.

James, who reported that he was a taker his first six or seven years sober, now exclaims that today “I learn as much as I teach.”
Dating within the fellowship can be problematic. You both can't be the center of the universe!
All participants expressed a powerful engagement with the AA fellowship, which has continued throughout the present day.

Sommer in 1992 suggested an interesting explanation:

“While recovering alcoholics in some ways do long to be “normal” or to know what “normal” is, in some ways not being “normal” and maintaining the identity of a “recovering alcoholic” is self-protective. This label justifies ongoing participation for life in a program of recovery. Participation in AA is a form of social support and validation. The program of AA provides a forum to be educated about how to be in the world on a daily basis. The program of AA offers tools to cope with anxiety and stress. The question has also been raised as to whether at some point recovering alcoholics might outgrow AA. I ask grow into what? The goal of recovery is not to outgrow AA, but to integrate the principles of the program into a normal way of life. “

Thus, the social network AA members form is vital to ongoing recovery as many researchers have observed (Bond, Kaskutas, & Weisner, 2003; Emrick 2004). James put it simply enough: “I just like the people I hang with … we have meaningful conversations, unlike so many that you have with non-AA folks … superficial junk.”
<table>
<thead>
<tr>
<th>Participant</th>
<th>Percentage</th>
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<td>Thomas</td>
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<td>Mohandas</td>
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<td>Walter</td>
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<td>Chuck</td>
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<td>Joy</td>
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<td>Julie</td>
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<td>Susan</td>
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2. Long-Term Sobriety (cont.)

- Maturity
  - Productivity/Creativity
  - Community Involvement/Church Attendance

- Most Important Things Learned
  - Self-Authorship and freedom
  - Responsibility for self
  - God consciousness
  - Service to others
“Still looking for your inner-grown-up, Harold?”
Sommer (1992) noted the maturational process in AA:

“Several members referred to this feeling of “growing up” in the program. They joked about being “four years old, or five years old,” etc. There is a shared feeling among members that developmentally, they are behind their non-alcoholic peers; that drinking “stunted” their emotional growth and that they are just now “catching up.”

None of the participants were able to articulate the maturational process in AA very well, if at all. Many of the participants are highly educated, several with master’s degrees and one with a doctorate. One would think that they could be more adroit at determining critical points in their recovery. Indeed, the older the participant, the less likely it was that he or she could define when things changed in their sobriety. Moreover, the older segment of the participants was less likely to be able to hang a specific year on any developmental process. Of those who could venture a guess (approximately one half of the participants) as to when they had become mature in AA, even those participants could articulate substantially nothing further regarding the process. For a good number of the participants, it is just as if it has always been that way.

Patricia stated that she “feels like I grew up in AA. My sense of self, I gained really after 10 years … only now am I contemplating a career.” Neither Mohandas nor Joy could articulate in any way when they felt that they had matured in AA, though both allowed that they had, in fact, matured. Steve and Chuck responded similarly, with Chuck adding that in terms of spirituality he had matured, but again, he could not say when. James and Kurt were able to estimate their becoming mature at around 15 years of sobriety, while Susan, Richard, and Julie felt that the transformation occurred as they approached 10 years of sobriety.
God had done for them what they could not do for themselves. Eventually, they realized that through their application of the steps, their lives and hearts had changed. Kurt actually took a hiatus from AA from eight to 10 years sober. He came back though to get more involved than ever in his second and now third decade in sobriety:

Most of them allowed that the first decade was really one of just trying to survive, trying to acquire Maslow’s basic needs for physiological security, safety, belonging and love. Patricia put it this way, “After 10 years, I started becoming a whole person, really just dryness prior to that.”

Becoming skilled at relationships, learning to become a good employee, and so on, are activities that most of the participants achieved well into their second decade of sobriety.

Today, in the 20 years plus category, the attainment of the principles of integrity, honor, ethics, service, in short, wisdom, has happened for many, if not all, of these participants.

Some research suggests addiction to AA: “A very worthy question,” Patricia advised. “No, AA is a choice. I would say that with true addiction, there is no choice, and I freely choose to come here, so therefore I am not addicted.” Julie illustrated the contradiction, as she stated flatly that she is “not addicted, not recovered, only recovered from a hopeless state of mind and body. But to answer your question, really at around 25 years sober.” Joy said, “skip the semantics, yes.” Chuck responded similarly. Steve is diplomatic, “I am not addicted, dedicated. I subscribe to the recovering [ongoing] theory. I must continue to grow … uncover, discover, discard.” Walter quips, “Yeah addicted, probably drink without it, but not immediately” Chuck and James had essentially the same response. Chuck also pointed out that “I haven’t recovered, if you don’t come to meetings, you forget … length of sobriety does not change this.” Mohandas is convinced that he will not drink again no matter what. Richard also thinks that he wouldn’t drink without AA, “but I don’t need to test that model,” he states. He adds that “Yes, I am recovered.” On the other hand, Thomas maintains that “yes, I am addicted to AA, and I would drink again without it. You never recover.” Susan claims that today she is “not addicted … I wish I were completely recovered, but I don’t think I have recovered from the isms … still selfish and so on.”

Thus, as can be seen, the debate over recovered versus recovering continues on in AA and probably always will, with members expressing often conflicting and ambivalent sentiments regarding this issue. Less contentious, perhaps, but nevertheless perennial, is the debate over the nature of AA attendance. As is demonstrated above, members do not care whether they are labeled as “addicted” to AA or not. They are much too grateful to AA to be concerned with any negative stereotypes.
Maturity and Erickson’s Generativity

- In Ericksonian terms, maturation involves certain acts: “Generativity encompasses procreativity, productivity, and creativity”

Personal Achievement

- In an effort to understand more about maturation in AA and when it occurs, the participants were queried, and responded to probes concerning this issue. Patricia responded that she had “founded women’s groups.” Upon further reflection, she also noted that she had matured as a writer. She observed that earlier in her sobriety, she had written novels and poetry, while in her later sobriety, she gravitated more toward epistles and essays. Pointing to another achievement in her maturation, she noted that she quit smoking at 10 years sober, which she credited with changing her life more positively than anything she has ever done, after quitting drinking. Kurt also quit smoking five years ago, at 18 years sober. Joy finished her undergraduate degree at 14 years sober, while Julie maintained that one of her greatest achievements was finding the courage to divorce her husband at 20 years sober. Just this year, Steve started performing vocals in a band that plays retirement communities.

Work-Related

- Seven participants related the increase in productivity that they had experienced in their sobriety to their vocational situations. Walter related just about everything to his work, especially after he celebrated 10 years of sobriety. Chuck and Richard started their own businesses at 12 years sober each, while Thomas was 26 years sober when he started his own business. Chuck and Richard also credited their sobriety with seeing them become better authors, as both write recreationally now. For 12 years, from years 12-24 in sobriety, James served as the chairman of a very large nonprofit organization locally. Susan observed that she became much more productive in her research after 10 years sober. And finally, Kurt started running triathlons at 15 years sober, and eventually became president of the local organization.
And More Service . . .

Sure, I told him to call every day, but I didn't think he would!
Most important things learned

- Most common theme: Self Authorship
  Five participants: Patricia, James, Chuck, Mohandas, and Walter. Summing up the collective sentiment on this issue, Patricia averred, “I am the author of my own experience, I am free to choose, I don’t have to act impulsively.” Walter stated that he figured this out after about 15 years sober. Thus, all feel that each individual is his or her own driving force or *primum mobile*.

- Other themes included: God consciousness, Acceptance, Freedom, Service
  Richard and James both interjected that they were sober about 15 years before they “got it about God.” Another common theme was acceptance, which seems to have come to four of the older participants only relatively recently. James, as did Chuck, said he was 20 plus years sober when he finally achieved this principle. Mohandas also stated the same time line, but with the addition of freedom. Susan stated assuredly that “God can do anything.” Joy pointed to the principles of “integrity, spirituality honesty, and open-mindedness.” Julie said, “Never to have to drink again, but also that the principles are portable, you can carry them with you.” Like Julie, Thomas asserted that “you never have to take the first drink.” For Steve and Kurt, it was about the principles and service.

  “The absolute power in service to others and giving to others. The fact that that is really the root of human happiness … the ability or the willingness maybe to serve others without expectation of return. You and I know to do that … you know that from that stems all the things that we hold most dear … which is almost the polar opposite of trying to seek out those things that will please me … be it money, women, be it fame, fortune … all those things that we scramble to get. I think that the awareness that we are looking for really comes more through commitment and service to others. And that is a hard thing to unlearn.”
2. Long-Term Sobriety (cont.)

- Fulfillment of the Promises
- Mortality
Ask not what your homegroup can do for you, Ask what you can do for your homegroup!
The promises are achieved much later than the literature suggests:

Six of the 12 participants experienced the true beginning of the “promises” at 10 years and after, while one third allowed that fully 15 years of sobriety were necessary for their fruition. The remaining participants related that the “promises” did not fully materialize for them until after 20 years of sobriety.

In discussing the “promises” of the AA program with the participants, the researcher was struck by the candor with which they offered their experience. Both Patricia and Steve allowed that the “promises” started to come true for them after 10 years sober when they started working on their childhood issues. For Joy, 10 years or so was also the magic number, as it was for Richard, Mohandas, and Susan. Susan stated that she “started to get less self-centered before then, maybe after five years, but it was at least 10 years before caring for others really started.”

For others, the fruition of the “promises” came later still. James and Kurt feel that they were at least 15 years sober. For Chuck, “I was at least 20 plus years sober before “I learned to be okay, when things are not okay.”
Mortality

Listen, only us oldtimers can introduce ourselves with both first and last names in meetings!
One might conjecture that a mature and truly wise person does not fear death. Rather, he or she sees it as part of the inevitable ebb and flow of life. When a person has reached a mature sobriety, or Erickson’s final stage, “death is not feared but accepted as one among many facets of one’s existence”

Five participants expressed no fear regarding their eventual death. Two expressed some trepidation, as did one of these for deeds left undone, a sure sign of wisdom, according to Erickson.

Regarding his mortality, Steve expressed only gratitude for a life well-lived.

As one might expect from our resident Eastern mystic type, Mohandas suggested: “Embrace it! If I am afraid of death, I am stupid!”

Practical 85-year-old Thomas allowed only that “all the arrangements are made, might be a good solution … no more pain or burden to anyone.”

Another war veteran, Richard, put it this way, “I have been close to death … I’ve run around the smell of death, I have no fear of it. I want to know what chapter of your book I am going to be in.”
Emergent Themes From Long-Term Recovery in AA

1. Drinking Career
2. Long-Term Sobriety
3. Medical and Therapy History
3. Medical and Therapy History

- Psychological Diagnoses/Medications
- Relationship with Therapy
Methadone is very effective. He hasn't made a move towards the drugs, or anything else for that matter, in days!
The founders of Alcoholics Anonymous learned very early on that one of the major barriers to alcoholics seeking recovery outside AA is that they do not normally listen to anyone who is not an alcoholic (Alcoholics Anonymous 1957, 1980). More recent research confirms that AA members early in the recovery process remain suspicious of outside therapy and psychotropic medications (Cheever, 2004).

All of the participants in this study thought little of any diagnoses that they had received for hospitalizations or other treatment prior to getting sober. They dismissed them as ill informed, generally.

Eleven participants also eschewed psychotropic medications in their recovery. Three had used them briefly, some with great success, but all save one now seek to solve their cognitive/emotional problems without the aid of prescribed medication. Walter’s response was enlightening: “I take no meds … some people need it, okay for them … but I feel most meds unnecessary … get off your goddamn ass and do something…. My only diagnosis has been: lazy.” Kurt was somewhat more diplomatic, “I don’t believe in medications that much. They are usually counterproductive.” At least three participants, like Julie and Steve, choose to defer to expert medical advice. Patricia used antidepressants for one year at nine years sober and she credits them with having saved her life, though she feels that she has not needed them since. Richard, the only participant to use psychotropic medication throughout much of his recovery also is very satisfied with the result of his use of psychiatric medications. Steve used antidepressants briefly at 15 years sober to get over a suicidal stint, but has used none since. “Today,” he says, “I enjoy digging into my psychological conditions, I enjoy processing them.” Steve, like Patricia, has been a periodic user of therapy all the way through his recovery. Today, he feels that because it has worked for him in the past, it will work for him whenever he may need it again. Currently, he believes that he may be about to lose his job through a layoff, but because of his past positive experiences with outside therapy, he has no fear of depression. “My past experience will help me to grow even further,” he says.
Recovery is about Learning to Love Yourself!
All participants were believers in outside therapy, though some more than others. Nine have had nothing but positive experiences with it. Gone is any trepidation toward therapy that is normally a significant factor in early sobriety.

Most participants felt that counselor competency is the major factor in choosing a good therapist, not AA affiliation. Indeed, Kurt and James expressed reservations about seeing a therapist who is in the AA program for various reasons. The majority of participants do feel that a good knowledge of AA, if not actual participation in the program, to be vital to a quality therapy experience, however. Two participants suggested that therapy very early in recovery is not only a waste of time, but may actually be counterproductive. This is in concert with the literature. In the formative years in AA members need to bond with the program. Further, they reported that outside therapy interferes with this process. Because longtime members’ bonds are already secure, they tend to do better with outside therapy. Kurt put it adroitly: I think that therapy is a waste of time in early recovery, because the primary task at that point in time is to get them stable off their disease, and engaged in the process of not being drunks anymore. And getting them involved in a life of sane and happy usefulness to use a cliché. But I think that therapy is invaluable and mandatory, if you will, as people start entering middle recovery, and they start entering the seven to ten year period where the “rah rah” wears off, and the running around at night to Jim’s drinking coffee wears off … been through the steps a couple of times, and had this that and the other. I think at that point absolutely, and that they should engage in it if it is available to them. I wish I had had the insight to do that.

Zweben observed that for the client already participating in AA, the therapist’s interest in both the AA program and the client’s attendance at AA meetings assists both client and clinician. The alcoholic will generally more rigorously attend to his or her AA program, and the therapist’s knowledge of how to treat this population will be continually improved. Brown (1985, 1988, 1993, 2003) continued to develop and refine a model of recovery that suggested a model of treatment for alcoholism that integrates therapy with the AA program of recovery.
Historically, recovering alcoholics seem to have become less antagonistic toward therapy.

As early as 1984, a survey of Alcoholics Anonymous members found that 40% reported using professional help after being in AA. Moreover, of this 40%, four out of five stated that professional help had played an important part in their recovery. This would suggest that nearly one third of the entire sample obtained important supplementary help from some non-AA professional source after being in AA.

This trend continued for the remainder of the century. According to the 1992 AA member survey, 80% felt that counseling or treatment was instrumental in directing them toward AA. By 2004, according to the latest AA survey of members available, 65% of members report that they have received some type of counseling after coming to AA, with 84% of those reporting attributing an important role of this treatment in their recovery from alcoholism (Alcoholics Anonymous, 2006). Thus, needless to say, the correlation between AA participants and therapeutic interventions remains high.

And finally, Zackon noted that outside therapy is a key element for success in later sobriety. Nevertheless, research shows treatment options for the long-term AA population remain limited.
• Alcoholism and AA

   Every clinician needs to be thoroughly familiar with the work of the 12 step self-help programs. 12-step programs in conjunction with psychotherapy produce the best outcomes.

• Research results regarding member long term AA participation

   To learn what members with substantial sobriety (20 years or more) in the AA program have to say by analyzing themes that arise from long-term member experiences.

• **Stage models of recovery from alcoholism**

   To learn how to better assist our patients (and ourselves) in obtaining and maintaining permanent sobriety through the AA program.
Stage Models of Recovery from Alcoholism

- Little has been written about the experiences of recovered alcoholics beyond the early to middle years of sobriety, particularly as concerns academic research; little clinical attention has been paid to the population that enjoys the most successful remission from the disease—those who have achieved very long-term recovery, especially the population that has done so utilizing the self-help group therapy movement known as Alcoholics Anonymous.

- Stage models suggest that the process of recovery begins before alcohol use is moderated or terminated and that, while linear movement through particular stages is possible, the more common experience is a recycling through these stages before permanent recovery is achieved. In assessing any stage of human development in individuals or in people collectively, there will always be variations among the stage members depending first upon their history and second upon their level of involvement in their own developmental processes.

- Stages of change models are very popular among addiction professionals, but have come under attack for the lack of empirical evidence supporting them.

- Tri Stage models most popular among theorists - approximately 50%.

- The major problem with all of these models is that they are too general and few offer any meaningful time line for their completion. Further, all models fail to offer developmental tasks to be completed in any meaningful way, beyond continued spiritual development, which most maintain must be of a perpetual nature. In most academic studies long-term recovered alcoholics are very loosely defined. The relative lack of detail in defining long-term recovery is significant considering how catastrophic a lapse in sobriety can be to the alcoholic. Encouragingly, some studies that address the early years of recovery for alcoholics do define the event of recovery from alcoholism as a lifelong process.
Erikson's Eight Psychosocial Stages

1. Basic **trust** v. **Mistrust**. *Birth to 1 year*. From warm, responsive care infants gain trust or confidence that the world is good.

2. **Autonomy** v. **Shame** and **Doubt**. *1-3 years*. Children start to use new mental and **motor skills**, and want to choose for themselves. Autonomy is created when the parents allow reasonable freedom and don't force or shame the child.

3. **Initiative** v. **Guilt**. *3-6 years*. Children use **play** to experiment with what kind of person they might become. If the parent demand too much **self-control** the child might become insecure with who they are.

4. **Industry** v. **Inferiority**. *6-11 years*. Children learn to work and cooperate with others. Negative experiences may lead to feelings of **incompetence** and inferiority.

5. **Identity** v. **Confusion**. *Adolescence*. The adolescence tries to discover 'Who am I, and what is my place in society?' The resolution (or not) of this will result in your views on your future adult roles.

6. **Intimacy** v. **Isolation**. *Young adulthood*. Young people work on establishing intimate ties with others. Because of early disappointments an individual may not be able to form lasting relationships.

7. **Generativity** v. **Stagnation**. *Middle adulthood*. Generativity means giving to the next generation through work, children, or caring for other people. Failing to do this can make you feel that your life is meaningless.

8. **Ego integrity** v. **Despair**. *Old age*. In this final stage, people reflect on what type of life they led. If they are not happy with their life, they feel despair and fear death overmuch.
Maslow’s hierarchy of needs is predetermined in order of importance. The lowest level is associated with physiological needs, while the uppermost level is associated with self-actualization needs, particularly those related to identity and purpose. Deficiency needs must be met first. Once these are met, seeking to satisfy growth needs drives personal growth.
# Stage Models of Recovery from Alcoholism*

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th># of Stages</th>
<th>Stages</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>Bean</td>
<td>3</td>
<td>Acute/Early/Ongoing</td>
<td>None, but perpetual</td>
</tr>
<tr>
<td>1977</td>
<td>Taylor</td>
<td>3</td>
<td>Drinking/Dry/Sober</td>
<td>None, but perpetual</td>
</tr>
<tr>
<td>1977</td>
<td>Brown **</td>
<td>4</td>
<td>Drinking/Transition/Early Recovery/Ongoing recovery 0-1 year /1-3 years /3-5 years /5+ years with Sp. growth</td>
<td></td>
</tr>
<tr>
<td>1981</td>
<td>Rosen</td>
<td>4</td>
<td>Detoxification/Giving up Drinking/Obtaining and Maintaining Personality/Value Difference Emergence</td>
<td>2+ years for 2\textsuperscript{nd} stage only</td>
</tr>
</tbody>
</table>

*Note: ** indicates additional or relevant information.*
Bean
- recovery model from alcoholism involving psychodynamic stages.
- model called for the development of self-esteem improvement and the increased acquisition of defense mechanisms by the recovering alcoholic.
- was also among the first to realize that recovery in AA was an individual affair.

Taylor
- expanded on Bean’s findings in recognizing that, as recovery becomes long-term, recovery processes might vary with the individual.

Brown
- among the first to offer a time frame for recovery in AA
- hypothesized that each stage involves development on both “behavioral” and “socio-psychological” levels.
- emphasized the role of increased spiritual growth in the recovery process. This process, which according to Brown, perpetually occurs during the final stage of development is comorbid with the alcoholic’s development of a solid self-identity.

Rosen
- looked at what AA members in the first few years of sobriety bring to the outside therapy table. As with most researchers who have studied AA, Rosen concluded that a combination of AA and therapy provide the best chance for an alcoholic’s success in maintaining sobriety.
### Stage Models of Recovery from Alcoholism (cont.)

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<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>Melvin†</td>
<td>3</td>
<td>Starting Over/Reality/Reaching out and Sharing the Growth</td>
<td>0 - 18 months/None/None</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Trust vs. Mistrust, Autonomy vs. Shame, Initiative vs. Guilt</td>
</tr>
<tr>
<td>1985</td>
<td>Whitfield</td>
<td>5</td>
<td>Entry Point/ Awakening /Exploration/Integration/Being</td>
<td>Stages 1 to 4: 0-5 years, Stage 5: 5+ years with Sp. growth</td>
</tr>
<tr>
<td>1985</td>
<td>Larsen</td>
<td>2</td>
<td>Abstinence/Recovery</td>
<td>None</td>
</tr>
<tr>
<td>1986</td>
<td>Zackon</td>
<td>2</td>
<td>Primary Recovery/Secondary Recovery</td>
<td>None</td>
</tr>
</tbody>
</table>
Melvin summarized the very early stages of sobriety (first 18 months) in Ericksonian terms, providing a strong argument for the Ericksonian developmental model as adapted to recovery in Alcoholics Anonymous.

“the newly sober person, like the infant, is confronted by an essentially new world”. From this vulnerable and less protected space, they are as Erikson describes it, “a simple receiver of support and nurturance.” … Their prime modality, he says, is to get, “not in the sense of go and get, but in that of receiving and accepting what is given.” … The newly sober persons in this study were nearly adopted by people in AA whose message was to listen and attend.

as their fog lifted, they became more “active and incorporating.” … All the participants spoke of following all the directions they received at AA in their struggle to remain sober, much like Erikson said the developing child will “grasp objects and follow them.” … As all the participants regarded their initial decision-making skills to be poor, they relied heavily on their sponsor or A.A. friends for guidance. Therefore, their social modality, especially in A.A. became one of “taking and holding on to things.” … The results from this dependency for all the participants was a belief that the people helping them were trustworthy. It is from this trust that the “capacity for faith and hope” comes. This is an essential belief for continued sobriety and the beginnings of personal and interpersonal growth. From these dyadic interactions and self-absorption comes the foundation for movement into the next stage.

as the participants entered the second stage, here called reality and by Erikson, Autonomy, they moved from getting to participation. They began to “gain the courage to be an independent individual who can choose and guide his own future.” … They began a process of retaining concepts of staying sober and also learning to let go of stresses and anxieties. They also began speaking at A.A. meetings, contributing their energies to their group; many volunteered at social service agencies. Several of the participants spoke of the fine line between depending on their sponsor and making their own decisions, reflecting the balance between needing direction and doing it on one's own that Erikson addresses. … As the stage ended, many participants noticed a diminishing degree of anger and rage, a significant feature in Erikson's second stage. “Being firmly convinced that he is a person on his own, the child must now find out what kind of person he may become.” … A whole self now emerges to be involved in a world of people. Infused with new energies, the participants spoke of feeling more comfortable with themselves, what Erikson phrased “more himself, more loving, more relaxed and brighter in his judgments.” … Partially as a result of this new confidence and comfort, the maintenance of sobriety became less of an issue. The recovering person can “forget that he is doing the walking (abstinence) and instead find out what he can do with it. Only then do his legs (sobriety) become part of him instead of an ambulatory appendix.” … All the participants also spoke of goals arising, of being more interested and invested in their world. Many began to imagine and construct new futures. They felt infused with a new energy to reach out to others and to explore themselves. As this vision of the future crystallized, many felt that they could “be what I (they) can imagine I (they) will be.”
Melvin (cont).

- perhaps the most important researcher of the 1980s
- in analyzing her research about participants’ adaptation process to AA, the author concluded: “The goals, issues and problems in the sobriety stages as described by the participants often paralleled the Eriksonian stages. At some points, the participants’ quotes were synonymous with Erickson’s statements”
- the implications of Melvin’s research are clear. If the early stages of the adaptation process in AA are indeed synonymous with Erickson’s psychosocial model of development, then might the latter stages correspond to Erickson’s final stages?

Whitfield

- performed research leading him to conclude that the primary mechanism for the recovery from alcoholism was spiritual in nature, a conclusion not at all opposed to AA doctrine. “When the spiritual malady is overcome, we straighten out mentally and physically” (Alcoholics Anonymous, 1939, p.77).
- described the recovery process as a spiritual transformation and concluded that a discernible time frame exists for spiritual development in AA; recognized that his final stage might continue for a lifetime, as spiritual growth is ongoing in recovery.

Larsen

- abstinence is only the first stage of recovery. Real recovery, begins when the alcoholic has begun the rebuilding process by adopting the philosophy of AA to his or her daily life.
- emphasized the importance of learning to maintain healthy relationships as one of the primary tasks of the newly sober alcoholic.

Zackon

- prescribed outside therapy as a key element in the prosecution of the secondary phase or longer term sobriety in AA.
### Stage Models of Recovery from Alcoholism (cont.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th># of Stages</th>
<th>Stages</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>Hutchinson</td>
<td>3</td>
<td>Surrendering/Accepting /Committing</td>
<td>None, but perpetual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>Van Wormer</td>
<td>3</td>
<td>Early Recovery: Denial vs. Identity</td>
<td>0 - 6 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Middle Recovery: Anger vs. Acceptance</td>
<td>.5 - 1 year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ongoing Recovery: Isolation vs. Intimacy; Rigidity vs. Flexibility</td>
<td>1 - 3 + years</td>
</tr>
<tr>
<td>1987</td>
<td>Zweben</td>
<td>6</td>
<td>Transition and Crisis</td>
<td>30 days - 2 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Breaking the Drug Dependence Cycle</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Establishing and Consolidating Abstinence: Creating New Life Styles</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Addressing Psychological Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Long-term Psychological Exploration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Integrating the Spiritual Dimension</td>
<td>Min. of 2+ years</td>
</tr>
</tbody>
</table>
Hutchinson
- outlined specific developmental tasks.
- suggested that the process of recovery envisioned in her model was “never-ending”

Van Wormer
- agreed that recovery is a lifelong process
- group work in conjunction with AA attendance
- as have most stage recovery theorists, Van Wormer identified certain developmental tasks to be completed in each stage. Unlike other researchers, however, she suggested a termination point – at least in part as the group work lasts only one year – provided abstinence has been achieved. After that, she encouraged AA attendance for ongoing recovery.

Zweben
- offered one of the most complex stage model of recovery
- just as did Van Wormer (1987), Zweben proposed his model within the context of group work
- was also a strong advocate of therapy in conjunction with AA attendance.
<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th># of Stages</th>
<th>Stages</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>Sommer</td>
<td>5</td>
<td>Early months of recovery: Trust vs. Mistrust, Physiological Needs Zero to two years ± Safety, Belonging, and Love Needs Autonomy v. Shame Two to four years ± Initiative vs. Guilt, Industry vs. Inferiority (Child to Teen) Four to seven years ± Identity vs. Confusion, Intimacy vs. Isolation Self-esteem, Self-actualization (working on) (Young Adult to Adult) Seven to ten years (hypothetical) Generativity vs. Stagnation Integrity Vs. Despair (approaching) Self-actualization (approaching) (Adulthood to Old Age)</td>
<td></td>
</tr>
</tbody>
</table>
Sommer

- Quite progressive as a stage model theorist. In reviewing her speculations concerning the proposed developmental tasks, she was essentially correct. They just appear to take a little longer than she postulated. The results of my study suggest that the developmental stages leading to adulthood as espoused especially by Erickson and Maslow take considerably longer for the recovering alcohol addict to accomplish than has been previously conjectured. In reality, AA members are still very much working on achieving the pre-adulthood tenets of the developmental theorists specified well into their first decade of sobriety.

- Maslow’s struggles: the struggle for hope, a sense of will, a sense of purpose, competence, and fidelity and love, are all very much typically achieved tenuously at best by alcoholics, certainly until they near 10 years of sobriety.

- According to Sommer, “the integration of the recovering alcoholic identity into the person may take many years.”
## Anthony Tri-Stage Model of Recovery from Alcoholism

<table>
<thead>
<tr>
<th>Year</th>
<th># of Stages</th>
<th>Stages</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Nascent</strong>&lt;br&gt;Generativity vs. Stagnation. (Adulthood)&lt;br&gt;Self-esteem Needs/Self-actualization Needs</td>
<td>10 - 20 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maturation</strong>&lt;br&gt;Integrity vs. Despair. (Old age)&lt;br&gt;Self-actualization Needs (ongoing)</td>
<td>20 + years</td>
</tr>
</tbody>
</table>
Incunabula Stage (0-10 years)

- Incunabula stage alcoholics have been described as “neurotics, like the young children described by Erickson, helpless and dependent needing structure and routine, very insecure.”

- As my research shows, struggles of the participants (e.g. financial) in the zero to 10 year range of sobriety cause great concern for safety and physiological needs. Indeed, probably the majority of alcoholics truly surrender to the AA program only after they have become “unemployed and unemployable.” Steve was dying on the streets of Oakland when he surrendered. Often the road to normal adult functioning vocationally – is a slow process. A full 20 years of sobriety has Patricia reached the place in which she feels confident in the selection of a career, her first. Similarly, learning the ability to love and be loved in a healthy and non-dysfunctional manner is a complex and long process for those who have more often than not come from such dysfunctional and emotionally scarred backgrounds: Patricia and the fiascoes with her lover in her early years of sobriety; Chuck and his multiple marriages that continued to mount for a time in sobriety; and Kurt and his sexual fiascoes, and those at 15 plus years of sobriety. Healing can be a continuous process, but as any member of the very long-term recovery population will attest, it is many times a “one step forward, two steps back” process in recovery; especially, during the early years of sobriety, say years one through five at least, when the person is, as it were, from the cradle (incunabula), only just beginning to learn to crawl in AA. For the alcoholic to learn to walk is another matter entirely.

- According to Cary, there is something akin to a “developmental leap” which occurs around 10 years of sobriety. This is reflective of the participants’ experiences, eight of whom ascribe this time period to many of their most significant breakthroughs. The development of humility and of acceptance in terms of God, relationships, life, and the meaning of their past struggles all begin to cause a true identity codification, if you will, as the nascent stage of recovery nears. Additionally, according to Erickson true altruism now starts to become possible - the incunabula-nascent stage alcoholic may be said to be truly on his or her way to really becoming a leader not only in AA, but often in their communities as well.
### Anthony Tri-Stage Model of Recovery from Alcoholism

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>3</td>
<td>Incunabula 0 - 10 years Trust vs. Mistrust, Autonomy vs. Shame, Initiative vs. Guilt</td>
<td>0 - 10 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Industry vs. Inferiority, Identity vs. Confusion, Intimacy vs. Isolation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiological Needs Safety Needs Belonging, and Love Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nascent 10 - 20 years Generativity vs. Stagnation. (Adulthood)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-esteem Needs/Self-actualization Needs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Maturation 20 + years Integrity vs. Despair. (Old age)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-actualization Needs (ongoing)</td>
<td></td>
</tr>
</tbody>
</table>
Nascent Stage (10-20 years)

- To sum up, the issues that the would-be recovered alcoholic faces typically cannot be resolved in a truly enduring fashion with a few years of sobriety. For the nascent (i.e., emerging, coming into existence) alcohol addict, who in the 21st century often arrives at AA suffering from multiple addictions, after years, if not decades, of active alcoholism, it is the second decade of sobriety that often offers the true entry into what might be described as adulthood.

- The elusive achievement of a decade of sobriety offers for the alcoholic, most for the first time in their lives, a tangible and real underpinning for a developing sense of true self-esteem. By this time, often the vocational picture has improved dramatically. Many participants in this study have shown this to be true, starting their own businesses prior to the end of their second decade of sobriety, which by anyone’s barometer, should surely indicate that a certain level of maturity has been obtained. Furthermore, in the 10 to 20 year sobriety range, recovery from alcoholism is no longer a theory, but has become a reality for those fortunate enough to have made it that far. The expression from the “Big Book,” willing to “go to any lengths,” (AA, 1939, p. 89) has become truly meaningful to this population, as they have now been sober long enough to have faced some real adversities – job loss, relocation, death of a loved one, and so on – to know that they can stay sober regardless of unpleasant life events, which for a considerable portion of their lives, would have sent them straight back to the bottle.

- Following the Ericksonian development model, a sense of identity has been achieved: A sense of identity means a sense of being at one with oneself as one grows and develops; and it means, at the same time, a sense of affinity with a community’s sense of being at one with its future as well as its history – or mythology.
Altruism, or the genuine caring about others, often does not truly manifest itself in any enduring way until the second decade of sobriety has commenced. Nascent alcoholics, having obtained some awareness of the world around them, they now experience a diminishment of the complete egocentrism and self-centeredness which has characterized them for the most part until now. Having solved some of the issues basic to sobriety (e.g., physiological and safety needs), they also now truly begin to exhibit caritas more and more as they have formed at least the rudiments of an identity. They can now start to look around and see that there are others in the world, and that they occupy a position of equal importance in the grand scheme of things at least as much as themselves. This a novel idea for the incunabula stage alcoholic, though it may seem elemental to a normally developed non-addicted individual, who is not familiar with the state of mind of the newly sober.

Erickson’s generativity stage is his longest, often lasting 30 to 40 years. During this time, families are born, careers are made, and so on. As the participants have shown, this is precisely what has happened in their lives, described by Erickson as the richest time of life. And, according to Cary, “whatever work the recovering alcoholic man is doing, chances are that by the fifteenth year he’s doing it better than ever.” Richard, James, and Chuck, all of whom started their own businesses at around this time, would no doubt agree.

The recovering alcoholic has by this time normally begun to shed much of the awkwardness regarding his or her relationship with a higher power that is so often a source of personal uneasiness for the alcoholic, particularly in terms of public testimony during the incunabula stage. By now, alcoholics have learned to rely on their higher power in a much more meaningful way than ever before.
## Anthony Tri-Stage Model of Recovery from Alcoholism

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<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Self-actualization Needs (ongoing)</td>
<td></td>
</tr>
</tbody>
</table>
Maturation Stage (20 years and longer)

- It’s about balance at 20 plus years sober according to Cary. Moreover, sticking to the basics, living a day at a time, going to meetings, and working with others will enable very long-timers to “develop over time the most heroic characteristic of all – wisdom.”

- For Erickson, the attainment of wisdom certainly signals that the final stage of psychosocial development has opened. The 20 year plus sober alcoholic in AA has taken care of people. He or she has sponsored many others in their journey of recovery. Typically, he or she has been successful vocationally, in business, in family life, in his or her AA group, in community service, and most importantly, in developing a relationship with self. Erickson calls this development ego integrity:

  “Only in him who in some way has taken care of things and people and has adapted himself to the triumphs and disappointments adherent to being, the originator of others or the generator of products and ideas – only in him may gradually ripen the fruit of these seven stages. I know no better word for it than ego integrity.”

- One cannot help but reflect on the acceptance of their lives that many of the participants suggest has only happened for them in the last few years (e.g., James, Chuck, Thomas, Mohandas, and Julie).

  “It is the acceptance of one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions. It thus means a new different love of one's parents, free of the wish that they should have been different, and an acceptance of the fact that one's life is one's own responsibility. It is a sense of camaraderie with men and women of distant times and of different pursuits, who have created orders and objects and sayings conveying human dignity and love. Although aware of the relativity of all the various life styles which have given meaning to human striving, the possessor of integrity is ready to defend the dignity of his own life style.

- Maslow termed the growth experienced by the recovered alcoholic self-actualization. In fact, many of the participants who expressed true ego integrity and self-actualization traits are sober longer than 30 years. These recovered alcoholics have attained the traits of self-actualizers, namely, honesty, awareness, trust, and freedom.
Maybe these AAs are right?
Conclusion

- The 12-step programs, especially AA, remain the best solution by far for most people suffering from addiction to alcohol and other mood and/or mind-altering chemicals.
- Permanent sobriety is not only possible, but is becoming more prevalent in AA.
- Alcoholics may be better candidates for psychotherapy AFTER their early formative years in sobriety, when their bond with AA has been cemented.
- No formal programs for the treatment of the disease beyond the first year or two of sobriety exist.
- Mental health professionals are often ignorant of the process of long-term recovery in AA. While many professionals may be sympathetic toward AA, encouraging clients to admit to being alcoholic and to go to AA, they continue to have little or no understanding of the reality of AA. Thus, as often as not, they lead their clients to have false expectations of what they will find at AA meetings.
- So, not only because so many clinicians today suggest participation in AA as a therapeutic method for achieving and maintaining sobriety, but also because AA reciprocates and invites its members to seek out qualified therapists when appropriate, clinicians need to become more informed regarding the process of long-term recovery in AA. Therefore, when the alcoholic with a number of years of sobriety shows up for therapy, if the practitioner is knowledgeable about the AA recovery process, about the particular philosophy of living that AA inculcates in its members, the clinician will be in a much better position to assist clients in maintaining successful sobriety.
- Rehabilitation, or more specifically, resocialization of the alcoholic (sans alcohol) is the goal of AA. When new members spend time with other members, they slowly begin to accept their own condition and the idea that perhaps where the AA program has worked for others, it may also work for them. This identification remains a vital process for very long-term recovered alcoholics, as it continually reinforces their belief that they are afflicted with the disease of alcoholism and must perpetually take action to keep their disease in remission. “We keep what we have only with vigilance,” is the mantra of many a member with 20 years or more of sobriety.
Thank you so much for your attention, and I hope today’s training will benefit both you and your practice.

If you would like to comment on the training today or if you would like more information or a copy of today’s presentation or the research study, please contact me at:

manthony5@satx.rr.com
A final thought on meetings

Well, it really has to do with the first Tradition. Every group gets at least one asshole and one drama queen.
And also please remember . . . .

Could you explain exactly what you mean by that?
Solving the Conundrums of Dual Diagnoses

David H Karney, M.D., M.P.H.
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IDAA, San Antonio, August 1, 2009

What is a *conundrum*?

- *Conundrum* ... a logical postulation that evades resolution, *an intricate and difficult problem*.
- ... a riddle whose answer is or involves a pun or unexpected twist.*

* From Wikipedia, the free encyclopedia

What is “Dual Diagnosis”?

- *Dual diagnosis* ... co-occurring mental disorder and substance abuse. For the general definition of any two diagnoses together, see Comorbidity.
- The term dual diagnosis is used to describe the *comorbid* condition of a person considered to be suffering from a *mental illness* and a *substance abuse* problem.

* From Wikipedia, the free encyclopedia

Primum non nocere

- ... a Latin phrase ..* “First, do no harm.”
- ...sometimes recorded as *primum nil nocere*.
- ... to physicians since (at least)1860, the phrase has been a hallowed expression of hope, intention, humility, and recognition that human acts with good intentions may have unwanted consequences.

* From Wikipedia, the free encyclopedia

No-Harm Management of the Dual Diagnosis Patient

( Abbreviated learning objectives)

- Make the right diagnoses/don’t miss diagnoses.
- Treat dually diagnosed disorders correctly, and in the right order.
- Rarely, and cautiously, prescribe controlled drugs to dually diagnosed patients.
- Document all diagnoses, don’t enable.

Make the right diagnoses; don’t miss diagnoses

- Rules of Thumb
  - Have a high index of suspicion as you thumb through your Differential Diagnosis: Psychiatric patients are prone to self medicate with whatever makes them feel better. Thus, they are more likely to abuse substances than the normal population. Hence, they have a higher incidence of substance dependence.
  - Conversely, be equally suspicious of diagnoses of chemically dependent patients, because they have a higher incidence of comorbid psychiatric conditions.
  - *Bipolar II Disorder is psychiatry’s *diagnosis de jour. Consider falling off of the band wagon.*
Bipolar II Disorder and Dual Diagnosis

- Bipolar II Disorder has become psychiatry’s *diagnosis de jour*. It is especially over-diagnosed in substance abusing patients. This results in the misdiagnoses of a major psychiatric disorder with serious disability, that requires lifelong treatment with medications known to cause, in and of themselves, unnecessary morbidity. [Long sentence intended for emphasis]

- Often, the patient’s substance abuse goes unmentioned. Result: Patient is tagged with a disabling psychiatric condition and the substance abuse problem is minimized or remains untreated.

DSM-IV caveat

limits making most psychiatric diagnoses in the presence of substance abuse if the symptoms are due to the the physiologic effects of the substance.

- “The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).” [for Bipolar II Disorder - and for most other psychiatric disorders.]

- “Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.” from DSM IV-TR

Treat dually diagnosed disorders correctly and in the right order.

- Generally speaking, treatment for both the substance use disorder and the psychiatric disorder should be *initiated simultaneously*.

- There are exceptions:
  - Substance use may take priority in cases of severe substance dependence because of medical crisis, intoxication and/or withdrawal, and substance induced phenomena.
  - Suicidal depression, acute mania and psychosis due to psychiatric disorders may delay a patient’s entry into a substance abuse treatment tracks until psychiatrically stable.
  - Use common sense. Treat both. Don’t ignore either.

RX

Rarely, and cautiously, prescribe controlled drugs to dually diagnosed patients.

- Some *risky Rx’s* in Dual Diagnosis Regimens:
  - Opioids
  - Benzodiazepines
  - Other sedative-hypnotic-antianxiety
  - Amphetamines
  - Medicinal Cannabis

- Use of alcohol and the recreational use of controlled prescription and illegal drugs is contraindicated

In order to do well, Dual Diagnosis patients must:

- Take drugs and abstain from drugs!

- i.e., Take [prescribed] drugs and abstain from drugs [of abuse], including alcohol.

So you think you want to treat dual diagnoses?

- Caution: It may be hazardous to your health.
  - Mood Disorders will make you sad.
  - Anxiety Disorders will make you nervous.
  - Pain Disorders will give you headaches.
  - Adjustment Disorders will stress you out.
  - Personality Disorders will drive you up the wall.
  - Substance Abusers have been known to cause one to drink - too much.
Dual Diagnosis: Key Points

(1) It is difficult to make a definitive psychiatric diagnosis in the presence of active substance abuse, because the use of "a substance (e.g., a drug of abuse, a medication, or other treatment)" may produce symptoms characteristic of other psychiatric disorders. "DSM IV TR.

(2) Generally speaking, in a dual diagnosis situation, treatment of both disorders may be initiated simultaneously; however, treatment of the substance dependence may takes precedence over the treatment of other psychiatric disorders, except in severe cases of suicidal depression, acute mania and acute psychosis.

(3) The use of commonly prescribed controlled substances in the treatment of other psychiatric disorders is generally contraindicated in a patient with co-morbid substance use disorder.

(4) Minimizing unpopular and personally embarrassing substance use disorder diagnoses, by covering them with a more socially and culturally acceptable psychiatric disorder with similar symptoms, facilitates denial and rationalization.

Questions

• David H Karney, M.D., M.P.H.
• San Antonio, Texas
Improving Outcomes in PTSD: The Dual Diagnosis Patient

Matthew D. Jeffreys, MD
Crystal Pearson, PhD

Objectives:
- Recognize potential signs of PTSD and make a preliminary diagnosis and referral for treatment.
- Discuss treatment options for patients with PTSD and their effectiveness.
- Discuss the principles of Seeking Safety in treating the dually diagnosed patient with PTSD.

The Emotional Response to Trauma

Described as the “Imprint of Horror” referring to the sights, sounds, and smells recorded in one’s mind during the traumatic experience.

Common Trauma Responses
- Disorientation
- Dislocation
- Fears of death
- Demoralization
- Difficulty coping with demands

Common Trauma Related Disorders
- PTSD
- ASD
- Bereavement
- Substance Abuse
- GAD
- Adjustment Disorder

Post-Traumatic Stress Disorder
- Traumatic event
- Re-experiencing
- Hyperarousal
- Avoidance
**Acute Stress Disorder (ASD)**
- Essentially the same symptoms as PTSD but less than 1 month duration
- Prominent dissociative symptoms
- Duration between 2 days and 4 weeks

**Dissociative Symptoms in ASD (must have 3 or more)**
- Numbing, detachment
- Decreased awareness of surroundings
- Derealization
- Depersonalization
- Dissociative amnesia

**Estimated 1 Year Prevalence of Anxiety Disorders**

![Graph showing prevalence of anxiety disorders over 1 year](image)

**Types of Trauma and Estimated Risk of PTSD**
- Rape (49%)
- Severe Beating (31.9%)
- Other Sexual Assault (23.7%)
- Serious Accident or Injury (16.8%)
- Shooting or Stabbing (15.4%)
- Witnessing Killing or Injury (7.3%)
- Natural Disaster (3.8%)

**Disability and PTSD**
- High utilizers of care
- Lost efficiency at work
- Somatic complaints of unclear etiology
- Increased risk of physical illness

**Why is dual diagnosis so important?**
- It is common in PTSD populations (25% for our program)
- Patients with dual diagnosis have poorer outcomes
- We have begun attempting to treat both at once
Pharmacotherapy for PTSD

- SSRI’s
- SNRI’s (Venlafaxine)
- Other Antidepressants (Nefazodone and Mirtazapine)

SSRI’s

- Sertraline
- Fluoxetine
- Paroxetine
- Fluvoxamine

Efficacy of Paroxetine in Non-Combat Related PTSD

- N = 19

What Next?

- Treating Hyperarousal
- Treating Re-Experiencing
- Treating Avoidance

Hyperarousal Symptoms

- Sleep Disturbance
- Irritability
- Anxiety

Agents to Consider for Sleep Disturbances

- Sedating Antidepressants (Trazodone, Mirtazapine)
- Antihistamines
- Sedative Hypnotics/Benzodiazepines (Not recommended in dual diagnosis patients.)
- Atypical Antipsychotic Agents
<table>
<thead>
<tr>
<th>Agents to Consider for Hyperarousal</th>
<th>Agents to Consider for Irritability</th>
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<tbody>
<tr>
<td>■ Beta Blockers</td>
<td>■ Divalproex</td>
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<tr>
<td>■ Buspirone</td>
<td>■ Carbamazepine</td>
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<tr>
<td>■ Benzodiazepines (Not recommended in dual diagnosis patients.)</td>
<td>■ Lithium</td>
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<td>■ Atypical Antipsychotics</td>
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<th>Additional Agents to Consider for Re-Experiencing Symptoms</th>
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<tr>
<td>■ Intrusive Memories</td>
<td>■ Alpha blockade through agents such as Prazosin and Clonidine</td>
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<tr>
<td>■ Nightmares</td>
<td>■ Atypical Antipsychotic Agents</td>
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<td>■ Flashbacks</td>
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<th>Avoidance</th>
<th>Treatments to Consider for Avoidance</th>
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<td>■ Avoiding Triggers</td>
<td>■ Agents to Decrease Arousal as Above</td>
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<td>■ Avoiding Activities</td>
<td>■ CBT or Exposure Therapy</td>
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<td>■ Avoiding Others/Lack of Intimacy</td>
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Second Line Agents to Consider

- TCA’s
- MAOI’s

Psychotherapy and Behavioral Treatment of PTSD

Some Goals of Initial Intervention

- Safety
- Mourning
- Reconnecting

Supportive Treatment

- Discussion of symptoms
- Treatment of comorbid conditions
- Relaxation techniques
- Sleep hygiene
- Anger management and assertiveness

Trauma Specific Psychotherapy for PTSD

- Exposure Therapy
  - First used with rape victims but found to be effective in other types of trauma as well.
  - Consistently replicated in studies as being superior to wait list or supportive techniques
  - Consists of imagined exposure and in vivo exposure to avoided triggers

Trauma Specific Psychotherapy (Continued)

- Cognitive Processing Therapy (CPT)
  - Type of CBT treating distorted cognitions relating to trauma
  - Patients look at “rules” affected by their traumatic experience such as trust, guilt, etc.
  - Homework assignments to challenge “rules” given in group setting and processed in individual sessions
  - Written exposure may be incorporated into tx as well
CPT Outcomes

- N=91
- Pre-PCLM (mean)=66.0
- Post-PCLM (mean)=53.7

PE Outcomes

- PCLM data available for 44 of 52 patients
- Pre-PCLM (mean)=60
- Post-PCLM (mean)=34

What is Seeking Safety?

- This is a program to obtain sobriety for the dual diagnosis patient.
- It can be used as a bridge between sobriety and PE and CPT.

Seeking Safety (Najavits, 2002)

- Focused on treating both PTSD and substance abuse with an emphasis on the present
- 25 topics covering interpersonal, cognitive, and behavioral domains
- Goals of treatment are to learn new coping skills to manage symptoms and reduce/stop substance use

Principles of Seeking Safety

- Safety is the priority in the first stage of treatment
- Integrated treatment of PTSD and SUD
- A focus on ideals
- Four content areas: cognitive, behavioral, interpersonal, and case management
- Attention to therapist processes

Conducting Seeking Safety

- Focus is present-centered, trauma details not part of therapy
- Substance abuse is discussed in relation to PTSD symptoms
- Each topic is applied to both disorders
- Treatment can be conducted in either individual or group format, using the number of topics appropriate for the setting
Examples of Seeking Safety Modules

- Safety
- PTSD: Taking Back your Power
- When Substances Control You
- Asking for Help
- Recovery Thinking
- Healthy Relationships
- Self-Nurturing
- Coping with Triggers
- Healing from Anger

Format of the Session: PTSD

- Check-in
- The Quotation
  - "You are not responsible for being down but you are responsible for getting up." – Jesse Jackson
- Topic discussion, as it relates to the patient’s experience
  - Facts about PTSD, link between PTSD and SUD
  - Discussion guided by patients’ reactions to the handouts
- Check-out

Benefits of Seeking Safety

- Emphasizes both PTSD and substance abuse and the complex relationship between the disorders
- Patients explore reasons for self-medicating and develop new coping strategies
- Does not punish substance use, allowing patients to be honest about their struggles
- Patients are prepared to move on to more trauma-focused treatment once substance issues are under control

Conclusions

- Concurrent treatment of alcohol and substance problems associated with PTSD is important.
- Treatments are effective.
- We need to better engage patients and their referral sources.