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**Daniel Carlat, MD**
**Editor-in-Chief**
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## IN THIS ISSUE

*Focus of the Month:*
**The Twelve Steps**



**Learning Objectives**

*After reading these articles you should be able to:*

**1.** Explain why it is important for psychiatrists to know about AA and other 12-step programs in treating patients with addiction. **2.** Summarize the Twelve Steps of AA. **3.** Describe the recent renewed debate about AA's efficacy.

# How Psychiatrists Can Use AA to Help Their Patients

*Alison Knopf, is the editor of* Alcoholism & Drug Abuse Weekly *and a freelance journalist specializing in mental health and substance use issues.*

Ms. Knopf has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

**Summary**

- Learning about AA can help practitioners better treat their patients who struggle with alcohol abuse.
- For brief psychiatric visits, it is more time-effective to prescribe some attendance at AA and have patients discuss how they are working the steps during subsequent appointments.
- Psychiatrists need to make patients aware that disclosing medication use runs counter to the abstinence tenant of AA.

The influence of the Twelve Steps recovery program of Alcoholics Anonymous (AA) is pervasive, but many psychiatrists treating patients with alcohol use—or other substance use—disorders may be unaware of exactly how it can help them in their work.

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Q&A With the Expert

## Psychiatrists and the Twelve Steps

## Marvin Seppala, MD

*Chief medical officer at Hazelden Betty Ford Foundation*

Dr. Seppala has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

**CATR: What do you see as being most valuable about the Twelve Steps in your work with patients who are either alcoholics or addicts?**
**Dr. Seppala:** Twelve Step programs help people with self-efficacy, which has been shown in research on addiction to be a primary predictor of positive outcomes.
**CATR: What does self-efficacy mean?**
**Dr. Seppala:** Self-efficacy is a feeling of being able to accomplish something. People who go to Twelve Step meetings say things like, "I see these other people that describe the same thing that I'm going through, and now they are sober for 5 or 10 years, and I feel like I can do that as well." That engenders both a sense of hopefulness and of self-sufficiency. If we were going to design a long-term care system for a chronic illness, this would be the ideal. The meetings are basically free, they are readily available, you can access them easily multiple times a day, and they provide an immediate source of support for people's efforts in remaining abstinent, and there will be people attending that are willing to help them—not just in the meeting but outside of the meeting. They will take a call from them anytime day or night to talk over how to stay abstinent, how to address a certain situation.

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How Psychiatrists Can Use AA to Help Their Patients

Continued from page 1

There are more than 50,000 AA meetings a week nationwide. Meetings are free, easily accessible, and unintimidating (speaking is not required, although eventually it is what works).

However, the Twelve Steps have been controversial recently, with books and articles declaring that they do not represent "evidence-based" treatment. While one can argue that AA is not really treatment per se, there is in fact a body of empirical research demonstrating its clinical utility. The largest trial was Project MATCH, which was a randomized controlled trial funded by the National Institutes of Health. The trial found that 12-step facilitation (TSF) therapy was as effective as cognitive behavioral therapy (CBT) or motivational enhancement therapy for reducing frequency and intensity of drinking. In TSF, a therapist uses a number of strategies to encourage optimal participation in 12-step meetings. (For more on the evidence for AA, see *TCPR,* June 2014).

The Twelve Steps of AA also apply to Narcotics Anonymous (NA), Cocaine Anonymous (CA), and other substance-specific groups; however, AA is the most common of these.

The steps are both actual tasks and a sequence of psychological processes. In AA's terms, this sequence leads to a "spiritual awakening," but one can equally view it as progress in recovery from substances, as well as progress in learning how to live a more satisfying life.

### First 'steps'

"Give it a try," is what psychiatrists might tell their new patients about AA, said John F. Kelly, PhD, Elizabeth R. Spallin Associate Professor of Psychiatry at Harvard Medical School and director of the MGH Recovery Research Institute. "And say, 'Let's talk about it next time.'"

Patients should go to 3 meetings a week, at first, said Kelly. Research has shown that this is the minimum number of meetings associated with abstinence. While the core literature of AA recommends 90 meetings in 90 days, for new members, researchers have found that there are no increases in engagement after 60 meetings—that the benefit plateaus at this point. Empirically, Kelly says, there is not enough evidence to show that 90 meetings in 90 days is beneficial.

The ideal way to introduce a patient to AA, said Kelly, is for the psychiatrist to know someone who is a member, and can take the patient to a meeting. And if the psychiatrist has other patients who are in recovery and going to meetings, those patients would be the best people to do this, he added. "The most sure-footed way to get a patient to a meeting is to have them taken there by a peer who is in recovery." Psychiatrists can accomplish this kind of introduction by asking for an experienced patient's consent to be contacted by patients who are new to AA.

The next best method is to get a list of local meetings and identify with the patient which ones would be most convenient, said Kelly. (To find meetings, go to http://www.aa.org/pages/en_US/find-aa-resources and click on your location.)

### TSF therapy

Over the past 25 years, researchers have consistently found that TSF is effective, said Kelly, who points out that its effects have been shown to be equivalent to CBT, and other modalities. Since the aim of TSF is to encourage regular AA attendance, its benefits may be identical to the benefits of AA, although it is also possible that TSF helps via non-specific aspects of any psychotherapy.

Actually working on the steps will be too complicated for brief psychiatric visits, said Kelly. "It's more important to just prescribe some attendance at AA, and to have the patient come back and discuss their experience," Kelly said. Encourage patients to say something at their AA meeting, if only to say their name and why they're there. "Just talking at a meeting has been shown to increase rates of engagement and better outcomes," he said. It might be something as simple as, "I'm checking it out, not sure if I'm an alcoholic, but I've had a problem and I'm finally doing something about it.'"

### Medications

Psychiatrists need to warn their patients about not disclosing their medication status in AA, said J. Scott Tonigan, PhD, research professor in the Department of Psychology at the University of New Mexico. His advice is: don't tell people, it has nothing to do with AA.

Along with Kelly, Tonigan 10 years ago surveyed AA members' attitudes toward medications, and they found a "mixed bag" of responses (Tonigan JS and Kelly JF, *Alcohol Treat Q* 2004;22:67–78). "While the core AA literature is nonjudgmental, our paper showed that there is a segment of AA members who are hostile to medications, who will say, "You're not sober if you're taking methadone, lithium, Prozac, and other psychotropic medications," said Tonigan. Kelly and Tonigan have sat in on many

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How Psychiatrists Can Use AA to Help Their Patients

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open meetings, and they see no benefit to disclosing medication use. "The psychiatrist needs to tell the patient, 'Your use of this medication is irrelevant to the Twelve Steps,'" said Tonigan.

When getting to Steps 4 and 5, in talking to the sponsor, the patient will have to disclose medications, noted Tonigan. The psychiatrist who is sensitive to Twelve Steps philosophy should prepare the patient for judgmental statements and suggest another sponsor if the patient gets the message that the medications are bad.

**AA for severe alcoholism**

Joseph Nowinski, PhD, author of the *Twelve Step Facilitation Therapy Manual* for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which was used in Project MATCH, said that it's important for psychiatrists to tell patients to just go to some open meetings at first.

The psychiatrist will be addressing Step 1 automatically in the assessment, using *DSM-5*, which separates alcohol use disorders into mild, moderate, and severe. If the patient has mild or moderate addiction, AA might not be appropriate, said Nowinski.

Nowinski has worked on treatment strategies for alcohol-dependent individuals, but there are people who are "almost alcoholic" (the title of a book he co-authored) who may need to get back to less risky drinking. While TSF is for severe alcoholics, there are people who are "high-functioning alcoholics." Imagine a woman who drinks 3 to 4 drinks a day—this is too much, and adversely affecting her health, but AA is not for her. "In that case, the psychiatrist can ask, 'What is your daily drinking routine; how can we change that?'" It may include drink refusal skills, not going out to bars after work as much, or other approaches. "But they haven't experienced the kind of consequence that people going to AA have," said Nowinski. "They might feel that they don't belong there." On the other hand, there are people with moderate (not severe) drinking problems who go to AA because they really do want to stop, he said.

**Abstinence?**

The message at AA meetings is going to be one of abstinence, not cutting back—even though there are clear benefits to drinking less. But for patients who are not committed to stopping altogether, they could practice what Tonigan calls "sobriety sampling," which can help patients who don't really want to be in treatment and don't have an abstinence goal. "We ask them, 'How long could you try being abstinent?' And if they say 1 day, we say, 'Could you try 2 or 3 days?'" Once they try 2 or 3 days, they come back and report that their lives are already getting more stable, said Tonigan. "If you tell them it has to be for the rest of their lives, that's overwhelming." And this is built into the AA philosophy, which has as one of its most beloved slogans, "One day at a time."

People with addiction tend to discount future rewards, researchers have found. While people who are not alcohol dependent could say they don't want that extra drink because they don't want a hangover the next day, the alcoholic would be more interested in the immediate reward. And eventually, that alcoholic would simply drink the next morning as well to feel better, at this point not being able to cut back at all.

For patients who do want to continue to drink, but who want to cut back, Tonigan thinks a group like Rational Recovery, which is more tolerant of ongoing substance use, might be more appropriate.

For patients who have read magazine articles and books denigrating AA, Tonigan, who worked with motivational interviewing founder William R. Miller, PhD, said don't argue. These patients may say, "Why should I go there? It's a crazy society of people who pray to God." The best response, said Tonigan, is "Yes, I understand what you're saying, but on the other hand, some people aren't aware that there are more than 650 empirical studies on 12-step programs, and in general we find people do much better on attending these programs."

**Which steps work?**

For years, Tonigan and co-researchers have been trying to find out which steps AA members have completed. They found that in essence, people were working on parts of the steps, usually without completing all of them. It turns out that the steps people have completed doesn't predict outcome; rather, continuing to work on them on a regular basis is the key. "That's pretty shocking, because the steps are supposed to be the active ingredient of AA," said Tonigan. "But what we do find is that working the steps helps someone have a spiritual awakening, and that is what is mobilizing the change."

Instead of focusing on the steps themselves, psychiatrists can just encourage people to take part in the "prescribed behaviors" of the steps, said Tonigan.

**Joining the human condition**

David Sack, MD, is an addiction psychiatrist who has been in practice more than 30 years, and he has found that 12-step programs help patients with everything that therapy and medications don't address. Most patients with substance use disorders have co-occurring disorders such as depression, bipolar disorder, anxiety, or schizophrenia, he says. One of the biggest problems for people in early recovery is impairments in working memory. "They lose the ability to plan, to remember what they want to do and when they want to do it," he said. "But in the Twelve Step program, the message over and over is, 'One day at a time, one step at a time.'" This is important to these patients because they can become overwhelmed and panic, he said. The Twelve Steps program helps patients develop a strategy around getting back to work and getting stable.

Secondly, the Twelve Steps program is very good at the issue of shame, said Sack, who is also president and CEO of Elements Behavioral Health, an addiction treatment chain. "Most people in early recovery are forced to confront all the things they did when they were using," he said. The fourth step helps them process what they did to their loved ones or their co-workers. "They write it down and tell it to another

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Expert Interview

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**CATR: As psychiatrists, we often refer patients to AA meetings, knowing how good they are for mutual support. But is it also important for psychiatrists to know the specifics of the actual Twelve Steps?**

**Dr. Seppala:** Yes, I think that is important because the Twelve Steps are based on a spiritual foundation and it can be somewhat easy to undermine a person's efforts in the Twelve Steps if you don't really understand what is going on there. For example, you might make the mistake of agreeing with a patient who rejects AA after one or two meetings, rather than using an understanding of the steps to reinforce further attendance.

**CATR: For those of us who are doing relatively brief medication-focused visits, what should we be asking patients to enhance the benefit they receive from AA?**

**Dr. Seppala:** "How often are you attending meetings? Do you have a sponsor? Are you a sponsor? Are you doing service in your meetings (making the coffee, setting up the chairs)? Do you celebrate your sober anniversary date at the meetings you attend? Do you have a home group?" You want to establish that they are interacting with someone individually rather than just with the general group and someone they can work the steps with outside of the meetings. The other thing to ask is, "What step are you working on?" Research has found that these are indicators of involvement in AA, and involvement has been more strongly associated with drinking outcomes than attendance alone (Krentzman et al, *Substance Abuse* 2013;34(1):20–32).

**CATR: Assuming we do have some basic knowledge about the steps, how can we integrate that into the treatment?**

**Dr. Seppala:** There are certain steps that are most amenable to this. For example, patients on Step 4 are doing a moral inventory. And this is a difficult undertaking because it means looking at all these negative events that occurred in the individual's life. That in itself could contribute to depression, and some people really get stuck on this step and feel worse and worse. And so the psychiatrist should be able to say, "Ah, you're on the fourth step; when are you going to complete that step?" It could be helpful to say, "It may be beneficial if you set a date for the fifth step (where the inventory is shared with another person) and carry this out and get it over with and move on to the other steps." It can also be helpful to point out that an identification of one's strengths can also be a part of the fourth step inventory.

**CATR: What other steps might present particular difficulties for some of our patients?**

**Dr. Seppala:** The first step involves admitting that we are powerless over alcohol and that our lives have become unmanageable. Some criticize this as undermining the individual's self-empowerment. But in my view, this is in sync with the *DSM* criteria for alcohol use disorder, which include a loss of control ("powerlessness") over use in the face of very negative effects on relationships, work, and other aspects of life ("unmanageable"). I might say, "Step 1 doesn't mean that you are unable to address your problem or have no responsibility for it; as a matter of fact, quite the opposite: the steps are about you taking responsibility for your own recovery and moving forward."

**"For a patient who feels close to relapsing, it can be helpful to encourage them to go to an AA meeting, raise their hand, and share with the group that they feel like drinking. An act of this nature is viewed in AA as an act of courage and strength, not weakness. It is normal for an alcoholic to feel like drinking."**

Marvin Seppala, MD

**CATR: If I'm encountering a patient who is close to relapsing, are there any specific steps that I could bring up that might inspire that patient at a critical juncture?**

**Dr. Seppala:** For patients who are really having a tough time and are craving, I would go right back to the first step. I would say something like, "Let's just take a look at the first step again and your recognition of the powerlessness and unmanageability of the disease." That helps to remind them of the consequences of using. But for others, who are having some thoughts about relapse, but it's not really imminent, I would emphasize the last three steps, which are considered maintenance steps—the steps that should be continued through the person's life on a pretty regular if not daily basis, more in the realm of spiritual practice than anything else. Prayer, meditation, and self-examination—those would be the steps to use. Of course, for a patient who feels close to relapsing, it can be helpful to encourage them to go to an AA meeting, raise their hand, and share with the group that they feel like drinking. An act of this nature is viewed in AA as an act of courage and strength, not weakness. It is normal for an alcoholic to feel like drinking. A great deal of support from the AA group can follow from such an admission.

**CATR: How would we actually frame those last three steps if we were talking about them?**

**Dr. Seppala:** One way to do it is to say, "Are you using the tenth, eleventh, and twelfth steps on a daily basis?" (Some people in Twelve Step meetings call it daily disciplines.) "What are you doing on a daily basis to support your recovery? You've stayed sober today. How did you accomplish that?" It's helpful to really emphasize *today*. I actually ask people regularly about these daily disciplines and say, "What is it you do in your daily practice to stay sober?" Some people will say, "I attend a meeting every day" or, "I always call somebody else in AA on a daily basis just to check in and discuss things." With some people it is prayer; with others it's meditation. And there are those that do a daily reading from a meditation book or they pull out one of the Alcoholic Anonymous textbooks to do some reading.

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# The Twelve Steps Explained

*Alison Knopf, is the editor of* Alcoholism & Drug Abuse Weekly *and a freelance journalist specializing in mental health and substance use issues.*

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**Step 1: The surrender**
"We admitted we were powerless over alcohol—that our lives had become unmanageable."

The first step may happen on the first day a patient gets into treatment, or it may be what brings the patient to treatment. But much of the time, this step requires help: Someone needs to ask the questions to make the patient understand that repeated attempts to cut down or stop drinking have not worked—that is the "powerless" piece. This is not the same as feeling powerless in general, it is very specific to alcohol. The patient has to understand and believe that there is a connection between his or her drinking and what has brought the patient to treatment, such as financial problems, job loss, family problems, arrest, feeling sick, and so on—that is the "unmanageable" piece. The sense of relief that comes with the admission of powerlessness and unmanageability in terms of alcohol is liberating for patients.

**Step 2: The higher power**
"Came to believe that a power greater than ourselves could restore us to sanity."

Many patients who go to Acoholics Anonymous (AA) talk about a "spiritual awakening," which often occurs very early in recovery. That awakening is often a result of Step 2. While going to AA meetings, patients become engaged in the process of recovery, sometimes for the first time. The act of going to the meeting, and of speaking in a supportive setting, gives the patient the feeling of taking the initiative. It also inspires a sense of hope, which can be experienced so intensely as to seem religious or spiritual.

**Step 3: The decision**
"Made a decision to turn our will and our lives over to the care of God as we understood Him."

Again, this step is not necessarily about religion, but about being willing to trust the process of AA. The patient emerges with a stronger sense of self-efficacy.

**Step 4: The self-assessment**
"Made a searching and fearless moral inventory of ourselves."

Psychiatrists can be very helpful in this step because it can lead to guilt, shame, and anger. In fact, the purpose is to acknowledge the sources of those feelings and then to improve problem areas by having patients understand them. This in turn reduces the likelihood of relapse, which these triggers, when unrecognized, can lead to. The therapeutic value of this step lies in the patient's ability to have better insight.

**Step 5: The sponsor (or psychiatrist)**
"Admitted to God, to ourselves, and to another human being the exact nature of our wrongs."

The psychiatrist may not have the time it takes to go through this step with patients, and many patients end up just relying on their AA sponsor. But it's not an easy task to be this listener. The goal is to reduce shame and guilt by talking to another person. The advantage of sharing these confessions with a sponsor, rather than with a therapist, is that the patients can see they are not the only ones with these problems, and can get a better and more balanced view of themselves. Therapeutically, this step has the result of reducing shame and guilt.

**Step 6: Readiness to change**
"Were entirely ready to have God remove all these defects of character."

It can take days or weeks to get to this step, which is a recognition that what has been learned in the assessment phase needs to be dealt with, or relapse can follow. Whatever the problems are that contributed to the drinking, the patient admits that they need to be fixed.

**Step 7: Humility**
"Humbly asked Him to remove our shortcomings."

Similar to and closely tied to Step 6, this humility means the patient accepts the need to stop whatever behaviors led to drinking and could lead to relapse.

**Step 8: Taking responsibility**
"Made a list of all persons we had harmed, and became willing to make amends to them all."

Patients make a list of people whom they have harmed, and also list whether they feel harmed by those people. Forgiveness of perceived harms is required so that honest amends can be made in the next step. Together with step 9, this process helps the patient achieve peace of mind.

**Step 9: Restitution and amends**
"Made direct amends to such people

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**A Twelve Steps Mnemonic**

**by Daniel Carlat, MD**

Since I can never seem to remember the Twelve Steps, I created this silly rhyming mnemonic for myself. I figured there might be some readers out there who would find this helpful. So here it is, take it or leave it!

1. One, one, alcohol's no fun.
2. and 3. Two, three, a higher power than me.
4. Four, four, take an inventory like a store.
5. Five, five, by revealing I'll survive.
6. and 7. Six, seven, ready to change and make life heaven.
8. Eight, eight, I'll make a list and I won't wait.
9. Nine, nine, I'll make amends then I'll feel fine.
10. Ten, ten, every day do it again.
11, 12: Eleven, twelve, say my prayers and try to help.

## How Psychiatrists Can Use AA to Help Their Patients

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person, and then they see that the world doesn't end," he said. "The fourth step has tremendous curative power." That shame, when not released, is one reason that people relapse early on in recovery, said Sack. "They're frightened, they don't think they can join the human condition."

AA meetings can be remarkably helpful in teaching patients how to imagine something good in the future, which can help forestall relapse and strengthen recovery. Sack related the story of one patient who was dutifully going to AA but didn't feel it was helping him much—something happened at a meeting that changed everything. "He told me, 'I'm sitting in this room, I don't know why I'm there, and I'm listening to these stories, and one day my ears perked up. I was listening to this guy who sounded just like me—drinking, cocaine, shooting up, detox—and then at the end of his sharing, he said that then he got clean, and he has a house, a car, and his car sounded great, and he has this wife and she loves him and they have dinner together—and I wanted those things too. I didn't really care about being sober, but when I heard that, I said that's what I want.'"

That "sharing," as telling your experience in AA is called, is what allows new patients to see that things can get better, which can decrease their impulsivity, said Sack.

Finally, it's important to know that nobody has to say anything at a meeting. "You watch other people say things, and they get a round of applause," he said. "The meeting shows it's safe to share."

Of course, it's also safe to share in the psychiatrist's office. But Twelve Step 5 groups and AA members are there the rest of the time, even at 2:00 in the morning when your patient may need support. This is a free resource with some good evidence to back it up. The TSF prescription may be just what many patients need.

For the *Twelve-Step Facilitation Therapy Manual*, go to: http://pubs.niaaa.nih.gov/publications/ProjectMatch/match01.pdf

For more up-to-date information, go to: http://www.aa.org/pages/en_US/information-for-professionals

## Expert Interview

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**CATR: How do you respond when patients say they are put off by the references to God or to a "higher power" in AA?**
**Dr. Seppala:** The founders of AA recognized this issue, and they didn't want to exclude anyone from AA attendance in spite of spiritual, religious, or other beliefs. In the Alcoholics Anonymous textbook, there is actually a chapter that is titled "We Agnostics." Almost any AA group will have people who are atheists and agnostics, and in fact, there are agnostic meetings and atheist meetings in most cities. If a patient attends a meeting where the treatment of spirituality does not make them feel comfortable, he or she should certainly find a different meeting. And they should know that many people in meetings struggle with this issue and that they will get a lot of support if they raise the question.
**CATR: Some patients are quite resistant to AA. How can we convince patients to at least give it a try?**
**Dr. Seppala:** Three things come to mind. The first is that I acknowledge that meetings might be difficult, and that almost everyone dislikes going initially. Not many people feel comfortable sharing significant problems with a group of strangers. That is a very difficult task. I say this to normalize that experience so that they'll be prepared. Secondly, I describe some of the research. There's been good research that has shown that extensive involvement in AA, especially at the onset, does result in better outcomes. I emphasize that it isn't just a matter of believing the glowing things that people say at meetings, but that multiple studies have shown that AA attendance—and usually the suggestion is at least 3 meetings a week—does result in remarkably better outcomes (Moos R and Moos B, *J Clin Psychol* 2006;68(6):735–750) and deeper AA involvement results in even better outcomes (Krentzman, Cranford, & Robinson, 2013). And finally, I make sure they know that they need to find the right meetings. A stark example would be if I have a physician who wants to go to a Twelve Step meeting; I probably wouldn't suggest attending a biker meeting downtown. So it's important to find a group where you feel socially and philosophically comfortable. Most major metropolitan areas will have detailed descriptions of their meetings online. So that is really another helpful piece for psychiatrists to know. Also, it might be worth the investment of time to read *Twelve Steps and Twelve Traditions*. This is one of AA's central texts and devotes one chapter to each step. The steps are covered in the book's first 125 pages. This short read will go far in helping psychiatrists to improve knowledge of the Twelve Steps, and your patients will be able to tell that you truly understand the program. This can go a long way toward your credibility and ability to form an empathic bond, which can make all the difference.
**CATR: Thank you for your time, Dr. Seppala.**

## CE/CME Post-Test

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*Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.*

1. 12-Step programs assist people with _____, which is a primary predictor of positive outcomes in addiction. (Learning Objective #1)
   [ ] a. emotional security [ ] b. self-confidence [ ] c. resilience [ ] d. self-efficacy

2. According to the outcome of Project MATCH, what is the clinical utility of AA in reducing frequency and intensity of drinking? (LO #3)
   [ ] a. Twelve-step facilitation (TSF) therapy is as effective as cognitive behavioral therapy (CBT) but not as effective as motivational enhancement therapy (MET)
   [ ] b. Twelve-step facilitation (TSF) therapy is as effective as motivational enhancement therapy (MET) but not as effective as cognitive behavioral therapy (CBT)
   [ ] c. Twelve-step facilitation (TSF) therapy is as effective as cognitive behavioral therapy (CBT) or motivational enhancement therapy (MET)
   [ ] d. Twelve-step facilitation (TSF) therapy is not as effective as cognitive behavioral therapy (CBT) or motivational enhancement therapy (MET)

3. Which of the Twelve Steps in AA involves patients making direct amends to people that may have been negatively affected by their drinking? (LO #2)
   [ ] a. Step 9 [ ] b. Step 8 [ ] c. Step 7 [ ] d. Step 6

4. What is the minimum number of meetings associated with the highest abstinence rates for people first starting AA? (LO #1)
   [ ] a. 2 meetings/week [ ] b. 3 meetings/week [ ] c. 5 meetings/week [ ] d. Daily meetings

5. Which of the Twelve Steps in AA is associated with recognizing a higher power? (LO #2)
   [ ] a. Step 1 [ ] b. Step 2 [ ] c. Step 3 [ ] d. Step 4

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## The Twelve Steps Explained

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whenever possible, except when to do so would injure them or others."

When making amends would harm the other person, it should not be done—sometimes just contacting the other person would cause harm. But patients should make direct amends whenever possible; the process of doing so leaves them with peace of mind.

**Step 10: Balance**

"Continued to take personal inventory and when we were wrong promptly admitted it."

This step shows that some of the work of AA members is far advanced from where many patients are in their lives. A form of self-regulation, it involves watching oneself on a daily basis and making sure any new problems that arise are corrected quickly.

**Step 11: Connectedness**

"Sought through prayer and meditation to improve our conscious contact with God, as we understood him, praying only for knowledge of his will for us and the power to carry it out."

Like "God" in the other steps, "prayer" and "meditation" are vaguely defined, mainly according to the patient's own faith or spiritual sense. The point is to have some regular method of keeping balanced emotionally.

This step helps patients' awareness of themselves and improves well-being.

**Step 12: Helping others**

"Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs."

This is a unique aspect of mutual support groups based on the Twelve Steps, in which part of continuing recovery for the patient—usually a former patient by this point—includes helping other alcoholics.

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*This Month's Focus:*
**The Twelve Steps**

**Next month in *The Carlat Addiction Treatment Report:* Substance Abuse Treatment and Families**

## The Twelve Steps Explained

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**The Twelve Traditions: A how-to guide for AA meetings**

AA's Twelve Traditions are less well-known, but constitute a sort of manual for how meetings should operate. For example, one tradition involves eligibility—the only requirement for AA membership, which means attending meetings, is "a desire to stop drinking." All AA groups must be self-supporting, can collect donations from members but nobody else, and must not own any property. Money, according to AA tradition, just distracts from the primary purpose—"helping alcoholics achieve sobriety." Another tradition is that AA doesn't take any positions on anything. Finally, AA members are supposed to be anonymous and not disclose their relationship to the media. This is not the same as people disclosing that they are in recovery.

Meetings usually last about an hour, start with a reading from the "Big Book" (the main AA text), and usually have a member talking about his or her experiences.

"Open" meetings are for anyone, including people who have no desire to stop drinking; "closed" meetings are only for AA members or potential members. Family, friends, students, professionals who are curious, and others can go to open meetings—and it's recommended.

Source: The information for the therapeutic effects of the Twelve Steps comes from *Twelve Step Facilitation in Non-Specialty Settings* by John F. Kelly, Ph.D. and Barbara S. McCrady, Ph.D.

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