



TWELVE-STEP FACILITATION

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The 12-step approach is among the oldest and most widely practiced models of addictions intervention and treatment (Fisher & Harrison, 2013). As practiced today, the 12-step approach has its roots in the early models of mutual-help groups such as Alcoholics Anonymous, Narcotics Anonymous, and other 12 step-based fellowships. Several unique aspects of 12-step theory distinguish it from the other approaches to addictions counseling reviewed in this book. These include a focus on spirituality as an essential component of treatment, adherence to the disease model of addiction, necessary acceptance of and surrender to alcoholism and drug addiction as a prerequisite to recovery, and a focus on altruism and helping others as part of the treatment process.

In this chapter the 12-step approach to addictions treatment is explored. The history of the 12-step movement is examined and its impact on 12 step-based treatment approaches is discussed. Etiology of addiction, recovery, and methods for practice based on the 12-step model are also reviewed. The chapter ends with a discussion of Gabriel's case and the application of the 12-step principles to Gabriel's current situation. In recent years, as several research-focused approaches have been developed, it has become popular to discount the effectiveness of 12 step-based treatment (Dodes & Dodes, 2014; Fisher & Harrison, 2013; Glaser, 2015; Miller, 2008; Peele & Bufe, 2000; Sack, 2012). As a result, the reader is encouraged to look at this approach with openness, objectivity, and a keen eye for the intricacies of the model.

BASIC TENETS OF THE THEORY

In order to effectively practice 12 step-based treatment, clinicians must have a solid understanding of the model's historical roots and basic tenets. Because Alcoholics Anonymous (AA) is the oldest and most widely recognized 12-step fellowship, the discussion here focuses mainly on the history and impact of the AA fellowship. As we begin this review, it is important to note that the 12-step movement was developed as a theoretical foundation for mutual-help groups and fellowships and not as an approach to treatment (Alcoholics Anonymous, 2001; Borkman, 2008a; Slaymaker & Sheehan, 2008). As the addictions counseling field developed, however, the 12-step philosophy was integrated into addictions treatment approaches. Accordingly, the history and impact of AA and the 12-step movement as they pertain to 12 step-based treatment are outlined briefly next.

BOX 14.1 The Twelve Traditions of Alcoholics Anonymous (Short Form)

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues, hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

concepts reviewed also hold true for 12-step mutual-help group participation. Concepts reviewed later in the chapter include the disease model of alcoholism and addiction,

The origins of the 12-step movement can be traced back to the establishment of Alcoholics Anonymous, popularly known as AA (Alcoholics Anonymous, 2001). Alcoholics Anonymous was created by Bill Wilson and Dr. Robert Smith (more commonly known as Bill W. and Dr. Bob), with the first documented AA meeting occurring on June 10, 1935. As stated in their literature, AA is a worldwide fellowship of persons working together to confront their addiction (Alcoholics Anonymous, 1981).

Similarly, Nace (2011) stated that the fellowship of AA is structured to introduce and assist with the maintenance of abstinence and recovery among members. According to the AA literature, the only criterion for acceptance into the AA fellowship is a desire to stop drinking (Alcoholics Anonymous, 1981). Similar to AA, the only criteria for acceptance into Narcotics Anonymous (NA) is a desire to stop using mood-altering substances (Narcotics Anonymous, 2008). The governing principles of the AA fellowship are outlined in the 12 Traditions of Alcoholics Anonymous (Alcoholics Anonymous, 1981) and presented in Box 14.1. Narcotics Anonymous and other 12-step fellowships have similar governing principles based on the AA doctrine.

Recovery through AA is facilitated by working through the 12 steps, which were established soon after the first edition of *Alcoholics Anonymous* (the Big Book) was published by AA in 1939. The 12 steps of AA are listed in Box 14.2. Alcoholics Anonymous was the first of many 12-step fellowships and has served as the model for other mutual-help groups operating from a 12-step philosophy such as Narcotics Anonymous, Overeaters Anonymous, and Gamblers Anonymous (Kingle, 2013; Laudet, 2008). As Kingle (2013) stated, the 12 steps are sequenced in a way that reflects the recovery process: Steps 1 through 3 prompt preparation, Steps 4 through 9 encourage action, and Steps 10 through 12 are concerned with recovery maintenance.

Later in this chapter several important aspects of 12-step theory are outlined as they pertain to treatment and recovery. Whereas this discussion centers on 12-step theory related to treatment, the

spirituality, acceptance and surrender, working the steps, making amends, forgiveness, and altruism.

Research on 12-Step Mutual-Help Group Attendance

Research on the effects of 12-step fellowship participation on recovery is difficult to accomplish. By their nature, 12-step fellowships are anonymous, making it difficult to identify research participants (Kaskutas, Ye, Greenfield, Wirtz, & Bond, 2008). Despite this difficulty, several researchers have indicated that attendance at 12-step mutual-help groups such as AA or NA can be positively correlated to success in recovery (Kingle, 2013; Morgenstern, Labonté, McCrady, Kahler, & Prey, 1997; Worley, Tate, & Brown, 2012). Moos and Moos (2004), for example, found that persons who took part in AA for at least 4 of the first 12 months after entering treatment had better success than did those who did not participate in AA at this frequency. McKellar, Secrest, and Humphreys (2003) found similar benefits of 12-step attendance on alcohol use and related problems. One issue with research methodology pertinent to both the Morgenstern et al. and McKellar et al. studies was that all participants in the studies were also enrolled in treatment at some point. Accordingly, little is known about the effectiveness of 12-step fellowship participation as a singular intervention without participation in some other form of treatment or intervention.

Issues With Diversity

Whereas AA and other 12-step fellowships exist worldwide, there appears to be a lack of diversity within 12-step fellowships (Fisher & Harrison, 2013; Laudet, 2008). Proponents of 12-step fellowships indicate that anyone is welcome at 12-step mutual-help group meetings so long as he or she is ready to quit drinking and/or using drugs. Despite this, 12-step fellowships in Western cultures tend to attract a large number of persons from similar backgrounds. Laudet (2008) reported on separate surveys of AA and NA members indicating that 89.1% of AA members and 70% of NA members identified as Caucasian. In the same surveys, 65% of AA members and 55% of NA members identified as male. Average age of AA members was reported to be 48 years old and average age of NA members was reported to be 48 years old.

Based on these statistics it appears that the average 12-step fellowship member is generally a middle-aged Caucasian male. This, in turn, may lead persons from other racial/ethnic

BOX 14.2 The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whenever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. 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 that out.
12. 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.

groups, ages, and genders to feel less accepted at 12-step fellowship meetings. Karkuzas et al. (2008) reported that the demographics of AA membership show increasing diversity. Data reported by these authors, however, also indicated that the overwhelming majority of AA members were still Caucasian middle-aged men. At the same time, anecdotal data suggest that some individual 12-step meetings may be more diverse than others, which could depend on geographic location or other such factors. As such, practitioners working from the 12-step perspective should discuss issues of diversity with their clients in order to ensure client comfort and success in 12-step mutual help groups.

PHILOSOPHICAL UNDERPINNINGS AND KEY CONCEPTS OF THE THEORY

All 12-step models of addiction treatment describe addiction through the lens of the disease model (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). The disease model of addiction was first introduced by Jellinek in the 1950s and 1960s (Fisher & Harrison, 2013). Prior to the introduction of the disease model, addiction was viewed as a moral problem with alcoholics and addicts lacking the willpower to control their drinking and drug use. Jellinek's work challenged this notion and offered a medical framework for understanding the disease of addiction.

Proponents of the disease model view addiction as a primary, enduring, and progressive disease that may include genetic susceptibility to addiction (Fisher & Harrison, 2013). As a primary disease, addiction is understood to be a disease in and of itself and not the result of some other condition. In the disease model, addiction is also considered to be a physical disease much like heart disease or diabetes. And, like heart disease and diabetes, if left unchecked the disease of addiction will most likely lead to disability or death. Consistent with the disease model, Narcotics Anonymous (2008) defines addicts as persons who experience life problems as a result of drug use. Within this definition, NA also endorses the idea that addicts may be predisposed to addiction and therefore powerless over drugs even prior to their first use.

From the perspective of the disease model and 12-step approaches, the symptoms of addiction are many (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). These include the presence of life problems due to the use of alcohol and drugs, loss of ability to control alcohol and drug use, unsuccessful attempts at cutting down on drinking and drug use, persistent use to the point of intoxication, lack of insight into the effects of alcohol and drug use (i.e., denial), and general disinterest and nonparticipation in life activities that do not involve alcohol or drugs. These and other behavioral and emotional indicators endorsed by AA and NA are the primary mechanism for recognizing alcoholism and addiction.

Within the disease model it is purported that there is no cure for the disease of addiction (Kringler, 2013). Rather, the alcoholic or addict must learn to live with and manage his or her disease in an effort to prevent the worsening of symptoms. This process is similar to the way a person with diabetes might control his or her disease with lifestyle changes and medication. Because the disease of addiction is thought to be incurable, addicts and alcoholics are never cured or recovered from their addiction problem. Instead, within the disease model and 12-step framework, addicts and alcoholics are viewed as being *in recovery* from the disease of addiction. In this sense, the disease of addiction is still present even

when the outward signs and symptoms of the disease are not observable or descriptive of the alcoholic or addict's current behavior.

From the 12-step perspective, because there is no cure for the disease of addiction, abstinence from alcohol and drugs is viewed as the only viable option for recovery. Moderate use of alcohol and drugs is not an option for the true alcoholic or addict. Living with alcoholism and addiction is seen as a two-solution proposition. Either the alcoholic or addict (a) quits using alcohol and drugs and enters into recovery or (b) remains entrenched in alcohol and drug use thereby running the risk of death, disability, or some other undesirable outcome (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008).

Recovery and the 12 Steps

Sobriety through the 12-step model is achieved through several mechanisms. Descriptions of the change-inducing mechanisms within the 12 steps are outlined in individual chapters within the AA and NA basic texts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). In reviewing the influence of 12-step fellowships on recovery, Donovan and Floyd (2008) suggested that, for successful recovery, simply attending 12-step meetings is not enough. Rather, the person entering recovery must be fully engaged with the fellowship program in order to increase the likelihood of success. The concepts, goals, and activities described next are important areas of engagement for those seeking recovery through a 12-step model.

Spirituality

One aspect of 12-step models that differs from other mutual-help (e.g., rational recovery) and treatment approaches is a focus on spirituality (Nowinski, 2013). A common misconception about AA and other 12-step fellowships is that they are religious organizations (Alcoholics Anonymous, 2001, 2014). This mistaken belief can be reinforced by the fact that many AA groups begin or end with a prayer and may be held in church basements or similar settings (Alcoholics Anonymous, 2014). The use of the term *God*, commonly associated with Christianity, within several of the 12 steps and other AA literature may further this misconception. For example, God is referenced in the Serenity Prayer that is regularly recited at 12-step fellowship meetings (Narcotics Anonymous, 1986, 2008). The Serenity Prayer is presented in Box 14.3.

Spirituality within the 12-step philosophy is seen as both the foundation for and driving force behind successful recovery. According to Nowinski (2013), spirituality provides guidance and direction to those in recovery and can lead to positive changes in personal goals and objectives. A focus on spirituality is the cornerstone of 12-step approaches to recovery with the goal of membership in the fellowship being a spiritual awakening (Alcoholics Anonymous, 2001). A spiritual awakening equates to learning a new way of living and functioning without alcohol and drugs. During a spiritual awakening, beliefs and values consistent with the precovery lifestyle are devalued and replaced with a new ideology more consistent with abstinence and recovery.

The 12 traditions and 12 steps reference aspects of spirituality often, and a reliance on a higher power is

BOX 14.3 Serenity Prayer

God grant me the serenity
To accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.

deemed necessary in order to successfully enter recovery. For example, Tradition 2 in the 12 Traditions states, "For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern" (see Box 14.1). Spirituality is also referenced in several of the 12 steps (see Box 14.2). For example, Step 2 directs persons entering recovery to discover and accept a higher power to lead them into recovery. Likewise, in Step 3 fellowship members are directed to turn their lives over to that higher power as an avenue to successful recovery. A reliance on spirituality is also referenced in Steps 5, 6, 7, 11, and 12 (Alcoholics Anonymous, 1981).

The focus on spirituality and the use of the term *God* has led many away from 12-step fellowships such as AA. To combat this, AA makes a point in many of its publications (e.g., Alcoholics Anonymous, 2014) to communicate that all are welcome to become fellowship members so long as they desire to stop drinking. Additionally, in the early history of the 12 steps AA members decided to add the phrase "as we understood Him" to qualify the use of the term *God*. The addition of this phrase was intended to portray AA as more open and accessible to persons from all backgrounds, not just those affiliated with organized religion or other groups with an already conceived notion of God (Alcoholics Anonymous, 2001). Tolerance and acceptance are highly regarded values in AA, and persons from all faiths and denominations are encouraged to take part (Alcoholics Anonymous, 2014). This message is further delineated in Chapter 4 of the Big Book (Alcoholics Anonymous, 2001) titled "We Agnostics" wherein the differences between organized religion and a nonaffiliated higher power are outlined.

Acceptance and Surrender

With all 12-step fellowships, the first step toward entering recovery is to complete Step 1, admitting powerlessness over alcohol and drugs (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Until Step 1 is completed, individuals will be unable to effectively work the remaining steps in a beneficial manner. In essence, this involves confronting and overcoming any denial the individual has about his or her addiction. The concepts of acceptance and surrender are key here (Connors, Wallerstein, & Tonigan, 2008; Pearce, Rivinola, & Koenig, 2008). With Step 1, the individual entering recovery must accept that willpower alone cannot create sustained sobriety in recovery. After accepting the presence of addiction in Step 1, fellowship members must then surrender to a higher power, be willing to take action, and use the 12 steps to guide them in recovery (Nowinski, 2006). In Steps 2 and 3 individuals must accept the existence of a higher power, surrender to that higher power, and give control of their lives to the higher power of their choosing. Taken as a whole, Steps 1 through 3 are known as the surrender steps (Connors et al., 2008).

Following Step 3, and the acceptance and surrender implied therein, fellowship members are able to engage their recovery in a more active manner by moving through the remaining steps. Without acceptance and surrender, though, working the remaining steps will be fruitless. By the end of Step 3 individuals should have a firm understanding of their higher power and the ways in which they will rely on that higher power for support. As well, individuals completing Step 3 should also be actively and consistently engaging in activities such as attending 12-step meetings, engaging with 12-step literature, creating

new relationships both within and outside 12-step communities, and giving up old habits associated with addiction (Nowinski, 2006).

Group Attendance

To be successful in recovery, regular attendance at 12-step meetings is essential (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Attendance at these meetings is vital for a variety of reasons. First, research has demonstrated that regular attendance at 12-step mutual help group meetings can lead to protective and positive influences in the life of the addict or alcoholic (Kelly, Hooper, Stout, & Pagano, 2012). Attendance at meetings can also be correlated to increased psychological health, reductions in impulsivity, and decreases in drinking and drug use (Kelly, Stout, Magill, Tonigan, & Pagano, 2010).

In addition to these overall positive effects of group membership, attendance at 12-step meetings is also crucial to the work associated with recovery. Through attendance, group members come to recognize that they are not alone in their struggles with addiction and that others have experienced similar problems as a result of their addiction (Alcoholics Anonymous, 2001). This outcome of group attendance, also known as universality in the group counseling literature (Yalom, 2005), is one of the main catalysts for recovery in the 12-step model.

Finally, attendance at group meetings provides members with an open and accepting forum in which to discuss addiction-related issues (Alcoholics Anonymous, 2001). Meetings are seen as a mechanism for encountering recovery-minded individuals with whom the trials of addiction can be shared. Additionally, by attending different meeting formats (e.g., step meetings, speaker meetings), members are encouraged to examine their recovery from different perspectives and through different lenses. Meetings can also provide an ever-present system of support to be called on in times of need. Finally, attendance at group meetings can fill the gaps in daily schedules that were once occupied with drinking and drug use.

Working the Steps

Engaging and following through with activities specified in the 12 steps is commonly known as "working the steps" or "step work" and is essential to the recovery process. As mentioned previously, dividing the 12 steps into sequential categories can be helpful to persons working through recovery. As stated previously, Steps 1 through 3 focus on preparation for recovery (including acceptance and surrender). Steps 4 through 9 highlight specific recovery activities, and Steps 10 through 12 center on maintaining gains in recovery (Kingsley, 2013). This conceptualization of the 12 steps mirrors the stages of change model developed by Prochaska and DiClemente (1984), which is reviewed in Chapter 10. These similarities are illustrated in Box 14.4.

The purpose of step work is to help the addict or alcoholic become less self-centered and more focused on surrendering control to his or her higher power (Borkman,

BOX 14.4 Stages of Change and the 12 Steps

Stages of Change	12-Step Perspective
Precontemplation	Pre-Step 1 (Denial)
Contemplation	Steps 1 and 2
Preparation	Step 3
Action	Steps 4 through 9
Maintenance	Steps 10 through 12

2008b). In general, the steps must be worked sequentially. For example, one cannot turn his or her life over to a higher power (Step 3) before accepting the existence of said higher power (Step 2). Likewise, one cannot make amends to those he or she has wronged (Step 9) prior to taking an inventory of those persons harmed during active addiction (Step 8). It is common for those in recovery to want to skip steps or work through them too quickly. Alcoholics Anonymous warns about this and offers numerous perspectives on how to avoid this potential pitfall (Alcoholics Anonymous, 1981, 2001, 2014). For example, addicts and alcoholics can rely on their sponsor or a group they attend to stay on track in their sequential step work.

Making Amends and Forgiveness

After working Steps 1 through 7, persons in 12-step recovery programs are prompted to make amends with those whom they negatively impacted during active addiction (Alcoholics Anonymous, 1981, 2001, 2014; Narcotics Anonymous, 2008). In Step 8, the person in recovery is directed to make a list of persons whom they harmed during their active addiction. Following this, in Step 9, recovering persons are tasked with making direct amends to those persons identified in Step 8 except in situations when to do so may cause more harm to the wronged party. Finally, with Step 10, recovering persons are expected to continue with their personal inventory and promptly make amends when necessary (Alcoholics Anonymous, 1981).

The process of making amends is aimed at creating inner- and intrapersonal peace (Alcoholics Anonymous, 1981). When creating a list of those who have been wronged, the recovering person is engaging in personal and relational introspection. The intent is for the recovering person to gain more insight into past actions, take responsibility for harmful behaviors, and seek forgiveness from those who have been harmed in the past. Within this process, it is also expected that the recovering person engage in self-forgiveness. The practice of making amends and seeking forgiveness can assist recovering persons in forming healthy, new, and lasting relationships free from drugs or alcohol (Connors et al., 2008).

Altruism

The final area of 12-step engagement to be discussed in this chapter is that of altruism. For 12-step fellowship purposes, altruism is defined as an intentional action that is of benefit to others and where no reward or reciprocation is expected (Zemore & Pagano, 2008). Alcoholics Anonymous (1981, 2001) suggests that recovering persons engage in altruistic acts later in their recovery when lifestyle changes are more consistent and entrenched. This is evidenced by the placement of altruism in the 12th step. The two main altruistic activities recommended in 12-step fellowships are service and sponsorship.

Service in 12-step fellowships most commonly refers to activities aimed at helping other addicts, whether those addicts are in recovery or not (Zemore & Pagano, 2008). This can include such activities as offering contact information to others in recovery, helping with meeting setup and cleanup, providing transportation to and from meetings, and numerous other activities that can benefit other fellowship members or persons not yet in recovery. Research on altruistic service supports the theory that one can gain personal benefit from helping others who either suffer or are in recovery from addiction (Zemore & Pagano, 2008). As such, completing altruistic acts may serve the secondary function of benefiting the addict or alcoholic involved in 12-step service activities.

A second and more specific form of altruism is sponsorship (Borkman, 2008a; White & Kurtz, 2008). In 12-step fellowships, sponsors are persons who are well-established in their recovery and, as a result, can serve as mentors, models, and guides to those whom they sponsor (Kelly & McCrady, 2008). Newcomers to 12-step fellowships are encouraged to seek out established fellowship members (i.e., sponsors) who can assist them in acclimating to fellowship activities and the world of recovery. Once fellowship members are firm in their recovery, providing sponsorship to newer members can further encourage the sponsor in his or her recovery and provide personal feelings of satisfaction and pride when helping others.

HOW THE THEORETICAL APPROACH IS USED BY PRACTITIONERS

Over the past two decades the addiction treatment field has experienced a movement toward professionalization (Fisher & Harrison, 2013). During this time, several states have adopted licensure standards for addiction practitioners. With this professionalization, addictions treatment has become more science based and theory driven (e.g., cognitive behavioral therapy, motivational interviewing) (Borkman, 2008b). At the same time, Alcoholics Anonymous and other 12-step approaches to recovery, which were designed for use in voluntary self-help fellowships rather than methods of formalized treatment, continue to flourish (Borkman, 2008b; Fisher & Harrison, 2013). Despite differences between mutual-help groups and treatment, addictions practitioners frequently adopt the 12-step philosophy in their treatment settings and use the related principles in their work with clients (Sljymaker & Sheehan, 2008). As a result, the literature on 12 step-based treatment approaches continues to expand (Galanter & Kaslunas, 2008). One of the most widely practiced models of 12 step-based treatment is the structured approach of Twelve-Step Facilitation (TSF), which is explored next.

Twelve-Step Facilitation

Twelve-Step Facilitation was developed as a model of treatment designed to support 12-step fellowship involvement and was one of the treatment modalities examined in Project MATCH (Kingsley, 2013; Longabaugh & Wirtz, 2001; Nowinski, 2006, 2013; Nowinski, Baker, & Carroll, 2007). As Ries, Galanter, Tonigan, and Ziegler (2010) noted, TSF is not a 12-step fellowship nor has it been formally endorsed by any 12-step groups (in accordance with Tradition 6 of the 12 Traditions of AA). Instead, TSF is a professionally developed approach to addictions treatment that relies on the skills of competent and trained clinicians for delivery of treatment interventions. Nowinski (2006) stated that TSF is completely compatible with the 12-step philosophy and is based on the same values and principles. As such, the TSF practitioner should be well versed in the 12 steps and related concepts. Likewise, the TSF practitioner should also work through any negative reactions or beliefs he or she has about the guiding principles of the 12-step approach. In other words, to be successful with this approach, addictions practitioners must be fully versed in the 12-step model of addiction and recovery and be open to all philosophies, concepts, interventions, and activities suggested therein.

The TSF model is generally categorized as a manualized and structured approach designed to be used to complement 12-step mutual-help group attendance. Whereas generally

thought of as a model for group counseling. TSF can also be applied in individual, couples, and family formats of treatment. The overarching goals of TSF are (a) increasing abstinence from alcohol and other drugs and (b) increasing participation with 12-step fellowship and mutual-help groups such as AA and NA. Similar to AA and other 12-step groups, TSF practitioners adhere to the disease model of addiction (Kingsre, 2013). Accordingly, the goal of therapy for those participating in TSF therapy is abstinence from alcohol and other drugs.

TSF Practitioner Characteristics

Nowinski et al. (2007) suggest that practitioners using the TSF approach should possess several important professional characteristics. First and foremost, the successful TSF practitioner should have formal training in addictions treatment and a comprehensive understanding of the 12 steps and related principles. This includes comfort in facilitating client reliance on 12-step fellowships and use of 12-step slogans (e.g., "one day at a time," "take it till you make it"). Additionally, TSF practitioners should be comfortable operating from an active, supportive, collaborative, and confrontational approach to treatment.

Nowinski et al. (2007) also stated that it is not essential for TSF practitioners to be in recovery. Provided they have extensive knowledge of the 12-step recovery process, nonrecovering practitioners can be just as successful with the approach as practitioners who are in recovery. When using TSF, nonrecovering practitioners should be prepared to answer questions about recovery status. Nonrecovering practitioners should also be ready to discuss how they can assist clients in being successful despite not having personal experience with addiction and recovery. In a qualitative study, Crabbe and Linton (2007) found that nonrecovering practitioners are more likely to operate strictly from a 12-step perspective when compared with their recovering counterparts. Whereas the authors did not link this finding to treatment outcomes, their results suggest that nonrecovering practitioners can indeed be comfortable in using the TSF model.

TSF Practitioner Roles and Responsibilities

To successfully implement the TSF approach, and to help clients achieve the overarching goals, Nowinski et al. (2007) outline several important roles for practitioners. The primary roles are that of educator and facilitator. As TSF educators, practitioners serve as a 12-step resource and guide. This includes (a) explaining the 12 steps and related concepts, (b) teaching clients to identify personal examples consistent with the 12-step orientation to addiction, (c) emphasizing the differences between recovery (desired outcome) versus cure, (d) encouraging reliance on the 12 steps and fellowship meetings as the path to recovery, (e) discussing sponsorship, and (f) answering questions about 12-step readings such as passages from the Big Book or other resources published by 12-step organizations.

In taking on the role of facilitator, TSF practitioners emphasize clients' between-session behavior and 12-step involvement participation (Nowinski et al., 2007). From the facilitator standpoint, practitioners (a) place the responsibility for change directly on clients, (b) encourage more personal involvement and participation in different types of 12-step fellowship groups (e.g., step meetings, discussion meetings), (c) explain and maintain the role of practitioner and avoid taking on roles such as sponsor or fellow group member, (d) highlight instances of denial particularly as it pertains to slips with alcohol or drug

use, (e) provide suggestions for recovery tasks, and (f) enhance clients' integration into the 12-step community, including active participation in 12-step fellowship meetings. As a facilitator, practitioners should strive to create change-inducing discussions aimed at meeting TSF treatment goals.

TSF Implementation

Nowinski (2013) offered several strategies for the implementation of TSF in group settings. Recommendations include the use of (a) small groups (6–8 clients), (b) an open format with newcomers welcome at all group meetings, (c) topic-focused sessions, (d) structured session formats, (e) handouts and other didactic materials, (f) discussions of urges, cravings, slips, and relapses, and (g) client commitment to recovery tasks at the end of each TSF meeting. Nowinski indicated that TSF practitioners should choose session topics ahead of time and cover only one topic per session. Assigned recovery tasks can include activities such as making a commitment to attend a certain number of 12-step mutual-help group meetings, conducting relevant readings on the topic of addiction and recovery, or engaging in other tasks that solidify recovery. Several TSF manuals and publications are available to assist practitioners in implementing this approach with clients (Nowinski, 2006; Nowinski & Baker, 2003; Nowinski et al., 2007; Ries et al., 2010).

Effectiveness of 12-Step Counseling

Numerous research studies have demonstrated the effectiveness of 12-step approaches to addictions treatment. One notable finding on the effectiveness of 12-step approaches to addictions treatment emerged during Project MATCH (Longbaugh & Wirtz, 2001). Participation in Project MATCH included 952 outpatient and 774 aftercare clients from multiple treatment sites. Among other variables examined in Project MATCH, treatment outcomes were compared for clients receiving either cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), or 12-step facilitation (TSF). Participants in each of these groups showed reductions in alcohol and drug usage at a 1-year posttreatment follow-up with no significant differences noted between the three groups. At a 3-year follow-up, however, participants in the TSF condition demonstrated significantly higher rates of abstinence (36%) when compared with the CBT (24%) and MET (27%) conditions (Butler Center for Research, 2010; Longbaugh & Wirtz, 2001; Slapmaker & Sheehan, 2008). Other studies have also demonstrated the effectiveness of 12-step-focused addictions treatment (Campbell, Goydich, Le, Wells, & McCarty, 2015; Galianer & Kasakura, 2008; Kingsre, 2013; Martino, 2013; Pearce et al., 2008). As such, TSF continues to be an effective option for the treatment of addiction.

ASSESSMENT AND PREVENTION IMPLICATIONS

Just as with any treatment approach, assessment is an important part of the 12-step model of addictions treatment (Nowinski, 2006). In general, assessment from a 12-step perspective includes many of the same information-gathering activities used in other approaches. This involves obtaining background on clients' substance use history, consequences of substance use, mental and physical health, education and employment history, legal history, and many other standard areas of inquiry. At the end of the assessment process, 12-step model

practitioners should have a thorough understanding of the client's relationship with alcohol and drugs and determine whether the client is an alcoholic or addict.

Contrary to popular belief, within the 12-step model not all persons who drink or use drugs in problematic ways are described as addicts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Whereas the behavior of some alcohol and drug users may mimic that of the alcoholic or addict (e.g., role failure, substance-related legal problems), not all persons who use alcohol and other drugs to excess have the disease of addiction. Rather, proponents of the 12-step model offer a typology, or continuum of sorts, to describe the progression of the disease of addiction.

In the *Big Book*, AA (2001) acknowledges that some people who drink heavily are able to return to moderate drinking and are therefore not alcoholics. The first of these is the moderate drinker. Moderate drinkers enjoy drinking alcohol and may even drink to excess at times. However, the moderate drinker can "take it or leave it" when it comes to alcohol and drug use. By AA standards, moderate drinkers can control their use even though they may, at times, seem to be out of control with their substance use or behaving in ways similar to the true alcoholic or addict.

Second, in comparison with the true alcoholic, AA (2001) acknowledges the hard drinker. The hard drinker is seen as a person who

may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason—all health, falling in love, change of environment, or the warning of a doctor—becomes operative, this man can also stop or moderate, although he may find it difficult or troublesome and may even need medical attention. (p. 20)

Whereas both moderate and hard drinkers do not fall into the category of alcoholic, they may, in the future, become alcoholics if their drinking increases and leads to bodily damage. In these situations, heavier drinking over time can lead to the onset of the disease of alcoholism to which the drinker was genetically predisposed.

Typologies of use also exist within the NA description of the disease of addiction. Narcotics Anonymous acknowledges that, whereas many persons may use drugs to intoxication and engage in risky behavior as a result of this use, not all persons who do so are addicts. Rather, addicts are those who experience an allergic reaction to drugs thereby limiting their ability to control their usage (Narcotics Anonymous, 2008). This allergic reaction, which results in symptoms of addiction, is understood to be the product of genetics and not some other psychological or environmental factor. Those who are not genetically predisposed to an allergic reaction to drug use could theoretically use drugs in a recreational manner, even after problematic use has occurred.

CASE STUDY RESPONSES

Having now summarized the 12-step approach to addictions treatment, the case of Gabriel is examined through the 12-step lens. This discussion includes a case conceptualization, suggestions for therapeutic approaches and techniques, and strengths and weaknesses of the approach as applied to Gabriel. Within this discussion, several unique aspects of Gabriel's

case are used to highlight the application of 12-step theory to his treatment and eventual recovery.

The first step in offering 12-step-based treatment to Gabriel would be assessment. During the assessment process the practitioner's primary responsibility would be to determine Gabriel's relationship with drugs and alcohol. Through discussion about Gabriel's patterns of use and related behaviors, the practitioner would try to determine if Gabriel has the disease of addiction.

Whereas Gabriel clearly does not fit into the category of the moderating user, it may be helpful to find out if he is a hard drinker versus an alcoholic or addict. Although the outcome of this assessment (i.e., hard drinker versus alcoholic) does not appear to impact the effectiveness of 12-step fellowship involvement (Longbaugh & Wirtz, 2001; Slaymaker & Sheehan, 2008), finding a common language for use in Gabriel's treatment will likely be advantageous to the therapeutic process. Because Gabriel has unsuccessfully tried on multiple occasions to reduce his alcohol and drug use, and because he has multiple substance-related legal offenses (i.e., DWI and possession), it may be more likely than not that he is suffering from the disease of addiction. Accordingly, abstinence would be his only feasible option for recovery.

In addition, during the assessment process the practitioner would take inventory of Gabriel's behaviors toward self and others while he is or was actively engaging in heavy alcohol and drug use. From the case study it is evident that Gabriel's patterns of drug and alcohol use have led to negative consequences for him and his family. For instance, Gabriel's alcohol and drug use has impacted his relationship with his niece, who we have been told looks up to Gabriel as a role model and mentor. Gabriel's niece knows of his struggles with addiction and has begged him on numerous occasions to stop using alcohol and drugs. Because Gabriel attempts to stay away from his niece while using, the time he is able to spend with her is greatly reduced because of his alcohol and drug use. In addition, Gabriel's mother has started attending Al-Anon meetings, a 12-step-based fellowship for family members of alcoholics, demonstrating that she has had difficulty coping with Gabriel's addiction issues. These factors, too, point to the presence of the disease of addiction.

One key issue to assess with Gabriel would be his views on spirituality. As delineated throughout the chapter, spirituality is the foundation for 12-step approaches to mutual-help groups and treatment. As a result, it would be imperative for the practitioner to discuss Gabriel's spiritual life and determine his beliefs concerning the presence of a higher power. Because a reliance on a higher power is necessary to complete Steps 1 through 3, having a discussion on spirituality would be key as the treatment process begins.

Finally, regarding assessment, the practitioner should pay close attention to Gabriel's strengths and determine how those strengths can be used to enhance the treatment process. From the case study we know that Gabriel has had some limited success (7 weeks of abstinence) while attending AA. In addition, Gabriel appears to have support within his family. His aforementioned niece could be a motivator for recovery, and his mother's attendance at Al-Anon may indicate a desire to help Gabriel with his recovery. Whereas being around some family members (e.g., Gabriel's father) might actually put Gabriel's recovery at risk, he appears to have some support as he attempts to change his relationship with alcohol and drugs.

Toward the end of the assessment process, treatment for Gabriel would begin. For the practitioner working from the 12-step theory, 12-step facilitation (TSF) could be considered the go-to model. At the start of treatment, the practitioner should determine whether Gabriel would benefit more from individual or group treatment or some combination of both. Small groups are recommended for use in TSF practice, but allowing for some client input into the selected treatment modality could be beneficial to the treatment process.

The first task in TSF would be to educate Gabriel on the 12-step model. This would include discussions of the Big Book and other AA/NA literature, the 12 steps, and 12 traditions, the disease model of addiction, and the necessity of attending 12-step fellowship meetings. With the help of the TSF practitioner, Gabriel would use both treatment and fellowship meetings to work through Steps 1 through 3 (the surrender steps). The time needed to successfully fulfill Steps 1 through 3 would depend on his spiritual beliefs. As such, patience on the part of the practitioner would be imperative as Gabriel begins his 12-step journey.

Following completion of the surrender steps, Gabriel would work Steps 4 through 12. His step work would be the primary topic of TSF, and treatment discussions would center on his attempts to navigate the 12 steps. In this sense, TSF as an intervention could be considered an adjunct to 12-step fellowship attendance. As such, one main goal for TSF could be to enhance Gabriel's participation in 12-step fellowships.

In comparing Gabriel's current situation to the 12 steps, several goals for Gabriel's treatment emerge. After surrendering to the higher power of his choosing, Gabriel would begin the process of self-examination. For example, in Step 4 Gabriel would take a personal inventory and admit to himself and his higher power the exact nature of his wrongs. The TSF practitioner would be actively involved in this process and could help Gabriel to realize the impact of his past behavior. Later, in Step 9, Gabriel would begin the process of making amends. From the case study we know that Gabriel's behavior has harmed his family members and has perhaps been related to his lack of success in romantic relationships. Again, the TSF practitioner could assist with this process and provide support to Gabriel as he takes on this challenging task. At some point during his treatment, the practitioner would work with Gabriel to identify a good sponsor and support him as he sought guidance from other 12-step fellowship members. Later in treatment, Gabriel would begin providing service and support to other addicts and alcoholics and may find solace in such altruistic activities. Again, the TSF practitioner could provide much support with this task.

There are several inherent strengths and weaknesses of the TSF approach as applied to Gabriel. Whereas Gabriel does have some supportive family members, it is unknown whether he has social support beyond that of his mother, sister, and niece. Twelve-step fellowship meetings would provide an opportunity for Gabriel to gain social support from persons with similar goals. In addition, we know from the case study that Gabriel has much shame related to previous romantic relationships, especially his first sexual encounter. In 12-step and TSF meetings, Gabriel would meet other persons experiencing similar shame about past actions. This experience of universality regarding his shame may propel him toward self-forgiveness and acceptance.

In addition to these strengths, two important weaknesses of the 12-step approach as applied to Gabriel should also be discussed. First, the TSF practitioner would need to obtain information about Gabriel's spiritual beliefs. Whereas we don't have any information about

this, the fact that spiritually is not mentioned in Gabriel's case study may indicate a lack of belief or commitment in this area. Were this true, helping Gabriel identify and surrender to a higher power may prove to be an arduous task. Practitioners' commitment to the TSF approach would be crucial here.

A second potential weakness of the TSF approach with Gabriel pertains to the diversity issues discussed earlier in the chapter. As a biracial 26-year-old male, Gabriel may feel less accepted or even out of place at 12-step fellowship meetings. The TSF practitioner could explore this reality with Gabriel and discuss ways in which Gabriel could find common ground with other fellowship members. Pursuant to this, it would also behoove the TSF practitioner to have information on multiple support groups present in Gabriel's geographic location, especially as it pertains to the diversity of membership at individual meetings. With this in mind, it is likely that the practitioner could assist Gabriel in identifying a group or groups where he feels welcomed, accepted, and comfortable, thereby increasing his fellowship participation.

Despite these potential weaknesses, Gabriel is likely to have success in TSF treatment. Should he commit to working the steps, TSF could help Gabriel establish new and healthy relationships. Twelve-step facilitation could also assist Gabriel in reconnecting with his family and working toward forgiveness of his past trespasses. Finally, Gabriel could use treatment and fellowship meeting attendance to address and eradicate feelings of shame over past behaviors. This would help Gabriel engage in more self-acceptance and could lead to a spiritual awakening that fellowship members aspire to obtain. With these factors in mind, Gabriel could find his way into successful recovery using 12-step principles and practices.