National Institute on Drug Abuse
Clinical Trial Network

STAGE-12

Stimulant Abuser Groups to Engage in 12-Step Programs

A Combined Group and Individual Treatment Program

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1.0 INTRODUCTION

1.1 About this Manual


1.2 About STAGE-12

STAGE-12 refers to Stimulant Abuser Groups to Engage in 12-Step Programs. This is a combined individual and group intervention targeted toward individuals who have primary or secondary diagnoses of abuse or dependence on methamphetamine, cocaine, or other stimulant drugs. It incorporates core treatment sessions from the *Twelve-Step Facilitation Therapy for Drug Abuse* and the procedures of the intensive referral process developed and evaluated by Timko and colleagues (Timko, DeBenedetti, & Billow, 2006; Timko & DeBenedetti, 2007) that uses members from community-based 123-Step groups to serve as “buddies” or temporary sponsors. The STAGE-12 intervention has been designed to be incorporated into intensive outpatient settings; however, it could equally well be incorporated into other treatment settings such as outpatient or residential. It could also be useful for clients with substance use disorders other than or in addition to stimulant abuse or dependence. The primary goals of STAGE-12 are to increase participants’ attendance at 12-Step meetings and to increase their active involvement in 12-Step activities. This increased attendance and engagement is thought to mediate subsequent reductions in substance use and to facilitate recovery.

1.3 About the Authors

Stuart M. Baker, MA, LADC is the Assistant Director of the Legion Clinic and a consultant to the Yale University School of Medicine Substance Abuse Psychotherapy Research Center. Mr. Baker’s research and clinical interests lie in the area of developing, specifying, evaluating and training behavioral treatments for substance users and evaluating combinations of psychotherapy and medications to enhance treatment outcome in the addictions. He has considerable experience as a clinician, supervisor, consultant, educator and administrator. Mr. Baker has authored or co-authored several treatment manuals including the Twelve-Step Facilitation Therapy (TSF) manual used in Project MATCH and Twelve-Step Facilitation Therapy for Drug Abuse used in a clinical trial for opiate dependent patients. He has provided numerous training programs on TSF throughout the U.S. and Canada.
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Dennis M. Donovan, Ph.D. is the Director of the Alcohol and Drug Abuse Institute, Professor in the Department of Psychiatry and Behavioral Sciences, and Adjunct Professor in the Department of Psychology at the University of Washington in Seattle. He was affiliated with the Addictions Treatment Center at the Seattle Department of Veterans Affairs Medical Center for over 20 years, involved in clinical, administrative, training and research activities, most recently serving as the Associate and Acting Director of the first Center of Excellence in Substance Abuse Treatment and Education (CESATE) within the Department of Veterans Affairs. He has over 150 publications in the area of substance abuse and addictive behaviors and has co-edited and co-authored a number of books. Dr. Donovan has served as an associate editor and/or as a member of the editorial boards for professional journals, and as an external peer reviewer for a number of journals in the area of addictions, psychology, and behavioral sciences. He has also been a member of the Clinical and Treatment Research Review Committee of NIAAA and the Behavioral AIDS Research Review Committee of NIDA. He is a member of a number of national professional organizations and served as President of the Society of Psychologists in Addictive Behaviors. He is a Fellow in the Division on Addictions of the American Psychological Association.

Anthony S. Floyd, Ph.D., is a Research Scientist at the Alcohol and Drug Abuse Institute, University of Washington. He completed pre-doctoral fellowships in Health Care and Health Policy in the Department of Health Research and Policy, Stanford University, and in Health Services Research and Development at the Department of Veterans Affairs, VA Palo Alto Health Care System, and Menlo Park, CA. He also completed a post-doctoral fellowship in substance abuse treatment research at the Center for Alcohol and Addiction Studies, Brown University, Providence, RI. He currently serves as the National Project Director for the STAGE-12 protocol in the NIDA Clinical Trials Network. He has written about enhancing alcohol treatment outcomes through aftercare and self-help groups and has also noted that AA and continuing care services deserve greater
attention in the treatment of substance abuse disorders, particularly as cost-effective additions to primary treatment. He is also a co-author with Dr. Donovan on a chapter, entitled "Facilitating involvement in 12-Step programs," in Volume 18 of Recent Developments in Alcoholism.

1.4 Forward

This manual reflects and extends prior work at the Yale University Psychotherapy Development Center to understand and improve drug abuse treatment by specifying and evaluating innovative psychotherapies. Twelve Step Facilitation (TSF) treatment manuals for alcoholism (NIAAA, 1995) and drug dependence (Baker, 1998), serve as the primary basis of the present manual. These TSF manuals reflect the work of numerous individuals who have contributed to the series of clinical trials conducted at the Yale Substance Abuse Treatment Unit that have evaluated TSF in comparison to other treatments. These include Stuart Baker, Art Woodard, Dr. Joseph Nowinski, and Dr. Kathleen Carroll, who, as counselors, supervisors, trainers, and authors, have fostered this exciting and promising treatment approach.

1.5 Research Support

Although approaches similar to the treatment described here are in wide use in the clinical community, there was, until recently, very little empirical evidence supporting their use (Holder et al., 1991; Miller et al., 1995). This occurred, primarily, because this type of approach had not been described in a form (i.e., a detailed treatment manual) necessary for evaluation in controlled clinical trials. This, and previous TSF manuals, is thus an important contribution to both the treatment and research communities. Now that this approach has been manualized and we can train counselors to use it consistently, a number of important studies have been completed that suggest this manualized TSF approach is very effective:

First, in the NIAAA-supported Project MATCH (Project MATCH Research Group, 1993, 1997), the largest alcohol treatment trial ever done, involving over 1700 alcohol dependent individuals in 9 clinical research units across the United States, TSF was associated with excellent retention and very good drinking outcomes. Moreover, TSF was found to be comparable in effectiveness to Cognitive-Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET) two forms of treatment with strong records of empirical support (Project MATCH Research Group, 1997). Furthermore, in the few instances where there were differences in outcome on some variables (such as in rates of complete abstinence and negative consequences of drinking), these tended to favor the Twelve Step Facilitation approach over CBT and MET (Project MATCH Research Group, 1997). Although Project MATCH was designed to detect patient-treatment interactions (matching effects), only two significant matching effect was seen, both of which also favored TSF. First, in the outpatient arm of the study, patients low in psychiatric severity (as measured by the Addiction Severity Index) had more abstinent days after TSF treatment than CBT; neither treatment was
clearly superior for patients higher in psychiatric severity. Second, at the 3 year follow-up TSF was more effective than MET for outpatient clients with social networks that were supportive of drinking (Longabaugh, Wirtz, Zweben, & Stout, 1998). This latter finding was mediated in part by AA involvement. Clients with networks supportive of drinking assigned to TSF were more likely to be involved in AA, and AA involvement was associated with better 3-year drinking outcomes for such clients.

Second, TSF has also been used in a trial of psychotherapy and medication for cocaine-dependent patients who also abuse alcohol (Carroll et al., 1998). This twelve-week randomized clinical trial of disulfiram and three forms of manual-guided psychotherapy (TSF, CBT, and Clinical Management) indicated the following: The two active psychotherapies, Cognitive-Behavioral Coping Skills Therapy and Twelve-Step Facilitation, were more effective than Clinical Management, a psychotherapy control condition, in fostering longer periods of consecutive abstinence from cocaine, abstinence from both cocaine and alcohol simultaneously, as well as a higher percentage of cocaine-free urine specimens. Moreover, the benefits of TSF and CBT compared with the minimal treatment were sustained through a one-year follow-up (Carroll, et al., 2000).

To date the Twelve Step Facilitation therapy that has been evaluated has been delivered as individual counseling. However, the modal method treatment delivery is group therapy. A group-based adaptation of TSF has been developed and evaluated (Brown, et al., 2002a, 2002b). It was found that clients who received the group-delivered TSF as aftercare had substance use outcomes comparable to those of clients who had received a group-delivered relapse prevention (RP) aftercare intervention. Further, a number of client-treatment matches were found. Females and individuals with a multiple substance abuse profile had better alcohol outcomes with TSF aftercare than with RP aftercare. Individuals with high psychological distress at treatment entry had longer periods of post-treatment abstinence with TSF aftercare than with RP aftercare.

The therapeutic approach underlying this manual is grounded in the principles and twelve steps of Narcotics Anonymous (NA), Cocaine Anonymous (CA), Crystal Meth Anonymous (CMA), and Alcoholics Anonymous (AA). It is important to note, however, that this manual has no official relationship with, or sanction from, any 12-Step program. The fellowships of NA, CA, CMA and AA are described in official 12-Step program literature and are realized through their worldwide meetings. NA, CA, CMA and AA do not sponsor or conduct research into drug dependence or its treatment or endorse any treatment program. While intended to be consistent with 12-Step principles, this treatment program is designed for delivery in research protocols and in clinical settings by trained and supervised counselors. Its goals are to educate patients regarding the NA, CA, CMA and AA view of drug dependence and to facilitate their active participation in NA, CA, CMA or AA.
1.6 Cautions

This manual, like any other, should not be used without appropriate training and ongoing supervision. It may not be applicable to all patient types, or compatible with all clinical programs or treatment approaches. This manual may supplement, but does not replace or substitute for the need for adequate assessment of each patient, careful case formulation, ongoing monitoring of patients' clinical status, or clinical judgment.

2.0 OVERVIEW OF STAGE-12 MODEL

2.1 Structure of Treatment Manual

This introductory chapter will provide a review of stimulant drugs and their effects on patients and families, causes of addiction, and summarize DSM IV symptoms of stimulant abuse and dependence. Other topics presented in this chapter include a brief introduction to the National Institute on Drug Abuse’s National Drug Abuse Treatment Clinical Trials Network (CTN), which is supporting the research of this model in nine treatment sites throughout the United States; a description of how we adapted this protocol from Twelve-Step Facilitation Therapy (TSF) and the Intensive Referral Program (IRP), and details on the process of developing this protocol as well as goals and objectives of STAGE-12. For clinicians interested in the research basis of 12-Step interventions, Chapter Two provides an extensive review of the literature, summarizing results from multi-site and single site studies. Issues regarding the effectiveness and efficacy and 12-step programs are discussed as well as the importance of sustainability once this research project is completed.

Subsequent chapters will describe the format and focus of the three STAGE-12 individual treatment sessions, the five STAGE-12 group treatment sessions, how clinicians are chosen and trained, and the adherence scale used to rate tapes of treatment sessions to insure that clinicians are delivering the treatment as it is intended.

An extensive bibliography and list of readings and other resources are included. These resources will provide clinicians with pertinent clinical and research literature as well as other resources related to 12-Step programs.

2.2 Stimulant Problems Significance to Public Health

Abuse and addiction to stimulants such as cocaine or methamphetamine represent a significant health problem in the United States. Problems with cocaine became more common in the 1990’s when many individuals became addicted to crack cocaine, an inexpensive form of cocaine with high addiction potential. In the past decade, methamphetamine use has increased, which has also led to more people becoming addicted to this drug. These stimulant drugs cause much harm for addicted individuals, their families, and society.

Many individuals with stimulant abuse or dependence disorders have other substance use disorders, medical problems, psychiatric disorders, and
psychosocial problems. Because of the public health significance of stimulant problems, this STAGE-12 treatment model has been developed for use in a multi-site clinical trial throughout the United States. Our belief is that this model will enable community treatment programs to systematically prepare addicted patients for “active” participation in 12-Step programs, which in turn will improve their outcomes regarding drug use and lifestyle change.

3.0 STIMULANT DRUGS

Stimulants are drugs that stimulate the central nervous system (CNS) to produce an increase in energy, psychomotor activity, a heightened sense of sensory arousal, pleasure, and euphoria, and a decrease in appetite and the need for sleep. Like all drugs, stimulant drugs affect judgment, emotions and behavior. Following is a brief review of cocaine and methamphetamine, two of the most common stimulants used.

3.1 Cocaine (C, coke, snow, flake, blow, crack)

Cocaine is a very addictive and strong central nervous system stimulant drug that directly affects the brain. This drug is derived from the coca bush, which grows primarily in South America. Cocaine is usually sold on the street as a fine, white, crystalline powder, which can be snorted, sniffed, dissolved in water and injected with a needle, or converted and smoked in the forms of “freebase” or “crack.” “Crack” is a cheap form of cocaine that made this drug available to more people. Crack is a smokable form of cocaine that has been processed with ammonia or baking soda and water, and heated to remove the hydrochloride from cocaine to make it smokable. It’s also smoked in combination with marijuana or tobacco. Street cocaine is often diluted with cornstarch, talcum powder, sugar, procaine (a local anesthetic) or other stimulants such as amphetamines. Some users mix cocaine powder with heroin to create a “speedball,” which can be a dangerous combination of drugs.

The initial high from smoking freebase or crack cocaine may last only 5-10 minutes while the high from snorting may last about 20-30 minutes. The high from cocaine is characterized by feelings of euphoria, an increase in energy, a decrease in fatigue, mental alertness or hyper stimulation. The user may also feel more talkative or sexual, or feel a decrease in appetite or the need for sleep.

Short-term effects of small or moderate amounts of cocaine can lead to constricted blood vessels, dilated pupils, as well as increased heart rate, blood pressure and temperature. Some users feel restless, irritable and anxious. Large amounts can lead to bizarre, unpredictable, erratic or violent behaviors. Those who use the drug repeatedly may experience tremors, vertigo, muscle twitches, paranoia or a toxic reaction. Occasionally, death can occur from cardiac arrest or seizures followed by respiratory arrest.

Long-term effects of use can lead to addiction, restlessness, irritability, mood disturbances, paranoia, auditory hallucinations, severe cardiovascular effects (disturbances in heart rhythm or heart attacks), respiratory effects (chest pain or
respiratory failure), neurological effects (seizures, strokes, or headaches), and abdominal pain or nausea.

People who abuse or are addicted to cocaine are also at increased risk to contract HIV/AIDS and hepatitis B or C, especially those who inject cocaine with needles.

3.2 Methamphetamine (meth, fire, speed, chalk, ice, crystal, crank, Tina, glass)

This is another powerful and addicting stimulant drug that affects the brain. It may be injected with a needle, swallowed in pill or capsule form, smoked in crystallized "chunks" that look like frozen ice water, or snorted in a powder form. The high, which is often described as an intense "rush," lasts from 8-24 hours, which is substantially longer than the high produced by cocaine. Unlike cocaine, which is derived from a plant, methamphetamine is made in laboratories, which sometimes leads to explosions and fires.

Short-term effects include the initial “rush” or high as well as an increase in wakefulness or alertness, an increase in heart rate, and a rise in body temperature. Other short-term effects include paranoia, hallucinations, convulsions, insomnia, dry, itchy skin, loss of appetite, acne or sores, and numbness.

Effects of methamphetamine on psychological functioning include an increase in excitability, anxiety, irritability, depression, delusions, aggressiveness, and panic. In addition, motivation and interest in work, friends, sex or food may actually decrease.

Long-term effects of methamphetamine use include damage to nerve endings in the brain, kidney or lung disorders, hallucinations, malnutrition, insomnia, weight loss, psychological problems, and difficulty functioning at work, in the family or in society. In some instances, the effects can make the user appear to have paranoid schizophrenia. Brain imaging studies suggest that chronic users may experience severe structural and functional changes in areas of the brain, which can lead to problems with learning, memory and controlling emotions.
3.3 Summary of Effects of Stimulants on Functioning

Following is a summary of physical, psychological and social problems that are common among those with stimulant use disorders:

Physical: withdrawal symptoms may be experienced such as severe craving, insomnia, restlessness, mental confusion, and depression. Other physical or medical problems include cardiovascular (e.g., hypertension, arrhythmia’s, cardiomyopathy, myocarditis, myocardial ischemia, myocardial infarction), head and neck (erosion of dental enamel, rhinitis, perforation of nasal septum), CNS (headache, seizures), lung damage, pneumonia, chronic cough, acute renal failure, sexual dysfunction, spontaneous abortion in the pregnant woman, and infections (HIV, hepatitis B or C, tetanus) from sharing needles.

Psychological: poor judgment, anxiety, depression, suicidal feelings and behaviors, insomnia, emotional liability, irritability, aggressive behavior, and psychotic symptoms. Symptoms of psychiatric disorders such as schizophrenia, panic disorder, depression, or mania can be triggered or exacerbated by stimulant use or withdrawal. The neurotoxic effects of methamphetamine include cognitive impairments and the early onset of movement disorders associated with aging.

Social/family: damaged or lost relationships, increased risk of child abuse or neglect, lost jobs, accidents, prostitution, spread of infections, criminal behaviors, violent behaviors, homicide, and high-risk sexual behaviors (unprotected sex, sex with strangers, or sex with multiple partners).

As a result of the significant health and social problems caused or exacerbated by stimulant abuse and dependence, the National Institute of Drug Abuse (NIDA) is sponsoring a multi-site study of STAGE-12 (STimulant Abuser Groups to Engage in 12-Step Programs), a psychosocial intervention that integrates group sessions from Twelve-Step Facilitation Therapy (TSF) with individual sessions adapted from the Intensive Referral Program (IRP). STAGE-12 is one of the evidence-based psychosocial treatments whose efficacy is supported by NIAAA and NIDA clinical trials. Studies also show that addictive individuals who received IRP reduce substance use more than patients receiving standard care. Patients receiving IRP also showed higher rates of engagement in 12-step recovery activities. Chapter 2 of this manual summarizes the research on TSF and IRP, as well as other 12-step counseling and facilitative interventions that serve as the basis for STAGE-12.

STAGE-12 is designed to be integrated into an existing ambulatory treatment program that offers a minimum of 5 hours of addiction treatment per week. Rather than offer this treatment as an “add-on” to current treatments offered in these programs, STAGE-12 “replaces” five group and three individuals sessions, which makes it easy to implement in community treatment programs that offer Intensive Outpatient, Day Treatment, Partial Hospital, or Evening programs that offer group treatments. This protocol was developed to help Community
Treatment Providers (CTPs) offer a systematic approach to facilitate patients’ involvement in 12-Step programs such as NA, CA, CMA or AA.

3.4 Causes of Addiction

Addiction to drugs including stimulants is caused by the interaction of many factors. No one factor in and of itself can explain why a given individual develops an addiction to these or other drugs. A biopsychosocial framework takes into account physical, psychological and social factors that contribute to both the development, and the maintenance of an addiction to drugs. Factors involved in the development of an addiction may vary from those that account for the continuation of an addiction over time.

Addictive drugs and alcohol work on the mesolimbic dopamine pathway or “reward pathway” of the brain, which is the part of the brain involved in making food, sex and social interactions pleasurable. This pathway runs from the base of the brain to the very front of the brain behind the eyes. This pathway developed to make eating food and engaging in sex rewarding so that these become important in our lives and we engage in them repeatedly. Regular food consumption is needed for our health. Sex is needed for reproduction to ensure continuation of our species.

Drugs such as alcohol, nicotine, cocaine, methamphetamine, morphine, heroin and marijuana stimulate this same brain system. It is the stimulation of this reward pathway that makes these drugs “habituating” and causes the addicted individual to repeat drug use despite negative consequences. The more frequently this brain system is stimulated by drugs, the more the use of drugs assumes a central importance in the person’s life, and the more a person “wants” or “needs” these drugs. With repeated drug use over time, a pattern of behavior develops in which the use of the drug becomes of central importance in the life of the addicted person. Friends, family, loved ones, sex, food, work, sports, hobbies, and other natural rewards then become less important. In a sense, the brain’s reward pathway gets “hijacked” by drugs, which results in dependence on drugs. This is why it is so difficult for those addicted to drugs to stop using them once they exhibit dependency. With abstinence over time in recovery, the brain has to “reset” itself, so that the natural rewards once again stimulate the reward pathway as strongly as drugs did in the past. Since this process takes time, many addicted individuals relapse before their brains have adjusted to living without drugs.

Another issue is what happens to the normal functioning of the brain when it is exposed repeatedly and continuously to addictive drugs. The brain engages in delicate biological processes, which are thrown out of balance by the effects of drugs used repeatedly. But the brain adjusts itself, so that it gradually returns to a normal level of functioning despite the impact of the drugs on its natural physiology. This process of adjustment or adaptation to exposure to drugs is called “tolerance.” Tolerance involves either a reduction in the effect of drugs over time, or the need for higher doses of drugs to achieve the same effect.
Drug withdrawal occurs after the brain (and body) has adapted to the drug being present by making changes in its own physiology, but the amount of the drug present is reduced or removed completely. The brain then has to undo all of the adaptive changes it had previously made. The symptoms produced by this “undoing” of changes are what patients experience as “withdrawal syndrome.” Tolerance and withdrawal comprise two elements of what DSM-IV-TR describes as physical dependence on drugs.
3.5 Narcotics Anonymous (NA) View of Drug Addiction

Mutual support programs such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) view addiction as a chronic, progressive illness, which if not arrested, may lead to insanity or death. Addiction is characterized by loss of the ability to control (limit) the use of drugs. Drug addiction is described in the “Basic Text” of Narcotics Anonymous (1988).

“At first, we were using in a manner that seemed to be social or at least controllable. We had little indication of the disaster that the future held for us. At some point, our using became uncontrollable and anti-social. This began when things were going well, and we were in situations that allowed us to use frequently. This was usually the end of the good times. We may have tried to moderate, substitute or even stop using, but we went from a state of drugged success and well-being to complete spiritual, mental and emotional bankruptcy. This rate of decline varies from addict to addict. Whether it occurs in years or days, it is all downhill. Those of us who don’t die from the disease will go to prison, mental institutions or complete demoralization as the disease progresses” (pp. 6–7).

Drug addiction, like all chronic illnesses, has predictable effects on an individual (symptoms) and a predictable course. As noted above, in addition to the physical aspects of addiction, the individual suffers psychologically, socially, and spiritually. Addiction to mood-altering substances is characterized by denial, or refusing to accept the limitations of the addiction.

“Many of us did not think that we had a problem with drugs until the drugs ran out. Even when others told us that we had a problem, we were convinced that we were right and the world was wrong. We used this belief to justify our self destructive behavior.” (Narcotics Anonymous, 1988, p. 5)

Twelve-Step Recovery programs such as NA, CA, CMA and AA are not a treatment method, but a fellowship of peers connected by their common addiction and guided by the principles of the 12-Steps of recovery. The only requirement to join one of these fellowships is a desire to stop using mood-altering drugs or alcohol.

These 12-Step programs make no commitment to a particular causal model of addiction. They limit the concepts to those of loss of control and denial from their roots in AA, 12-Step programs emphasize two themes:

1. Spirituality: a belief in a “power greater than ourselves,” which is defined individually, by each person, and which represents faith and hope for recovery.
2. Pragmatism: a belief in doing “what works” for the individual, meaning doing what ever it takes in order to avoid using the first drug.

4.0 APA CLASSIFICATION OF SUBSTANCE USE DISORDERS

In the DSM-IV-TR, the American Psychiatric Association delineates symptoms for the following classifications of substance use disorders: intoxication, withdrawal, abuse, dependence, and substance induced disorders. Each type of disorder has specific symptoms.

4.1 Intoxication

This refers to a reversible syndrome due to recent ingestion or exposure to cocaine or methamphetamine. Symptoms of stimulant intoxication include:

1. Clinically significant maladaptive behavioral or psychological changes that developed during or shortly after the use of stimulants.
2. Two or more the following symptoms develop during or shortly after the use of stimulants.
   a. Tachycardia (an excessively rapid heartbeat) or bradycardia (an abnormally slow heartbeat rate).
   b. Pupillary dilation.
   c. Elevated or lowered blood pressure.
   d. Perspiration or chills.
   e. Nausea or vomiting.
   f. Evidence of weight loss.
   g. Psychomotor agitation or retardation.
   h. Muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias (abnormal or irregular heartbeats).
   i. Confusion, seizures, dyskinesias (an impairment in the ability to control movements, characterized by spasmodic or repetitive motions or lack of coordination), dystonias (an abnormal muscle tone, characterized by prolonged, repetitive muscle contractions that may cause twitching or jerking movements of the body or a body parts), or coma.

These symptoms are not due to a general medical condition or better accounted for by another mental disorder.

4.2 Withdrawal

This is caused by stopping stimulant use after a heavy and prolonged period of use.

1. It involves a dysphoric mood (e.g., an emotional state characterized by anxiety, depression, unease, or distress) and two or more of the following physiological changes within a few hours to several days after stopping stimulant use:
a. Fatigue
b. Vivid, unpleasant dreams
c. Insomnia (an inability to sleep) or hypersomnia (sleeping for an excessively long time)
d. Increased appetite
e. Psychomotor retardation or agitation
f. These symptoms are not due to a general medical condition or better accounted for by another mental disorder.

4.3 Stimulant Induced Disorders

These disorders involve psychiatric symptoms that are thought to be caused by the effects of stimulants. DSM-IV-TR recognizes cocaine-induced psychotic, mood, anxiety, sleep and sexual dysfunction disorders (American Psychiatric Association, 2005).

4.4 Stimulant Abuse

These symptoms must have persisted for at least one month or have occurred repeatedly over a longer period of time. A diagnosis of psychoactive substance abuse is used if the individual does not meet the criteria for dependence but still shows a maladaptive pattern of substance use, as indicated by one or both of the following:

1. Recurrent use leading to the patient’s failure to fulfill major role obligations at work, school or home.
2. Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated).
3. Recurrent substance related legal problems. The patient continues to use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance.

4.5 Stimulant Dependence

According to DSM-IV-TR, the group of substance abuse and dependence disorders "deals with symptoms and maladaptive behavioral changes associated with more or less regular use of psychoactive substances that affect the central nervous system. These behavioral changes would be viewed as extremely undesirable in almost all cultures." Diagnostic criteria for psychoactive substance dependence include at least three of the following symptoms, some of which have persisted for at least one month, or have occurred repeatedly over a longer period of time:

1. A substance is often taken in larger amounts or over a longer period than the person intended.
2. There is a persistent desire or one or more unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to get the substance, taking the substance, or recovering from its effects.

4. The patient experiences frequent intoxication or withdrawal symptoms when he or she is expected to fulfill major role obligations at work, school, or home, or the patient persists in substance use when it is physically hazardous.

5. Important social, occupational, or recreational activities are given up or reduced because of substance use.

6. The patient continues substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance.

7. The patient develops a marked tolerance--that is, a need for markedly increased amounts of the substance (at least a 50 percent increase) in order to achieve intoxication or desired effect--or a markedly diminished effect with continued use of the same amount.

8. The patient manifests characteristic withdrawal symptoms related to types of substances used.

9. A substance is often taken to relieve or avoid withdrawal symptoms.

5.0 CONTEXT OF STAGE-12 RESEARCH PROTOCOL

5.1 NIDA’s Clinical Trials Network

The current STAGE-12 treatment protocol and clinician manual were developed for a multi-site clinical trial as part of NIDA’s National Drug Abuse Treatment Clinical Trials Network (CTN) to help patients with stimulant abuse or dependence. The CTN comprises 16 Nodes across the United States. Each Node consists of a Regional Research and Training Center (RRTCs), typically at an academic research center, which is affiliated with a number of Community Treatment Providers (CTPs) that serve as sites for the research trials. The CTN currently has approximately 240 CTP sites representing all types of programs and levels of care for addiction treatment.

The overall mission of the CTN is to improve the quality of care and outcomes of drug abuse treatment in community treatment programs throughout the country using science as the vehicle. Within this context, the CTN has two primary goals:

1. Conduct studies of treatment interventions in rigorous, multi-site clinical trials to determine effectiveness across a broad range of community-based treatment settings and diversified patient populations.

2. Transfer the research results to physicians, counselors, other providers and their patients to improve the quality of drug abuse treatment through the implementation of evidence-based practices.
5.2 Adaptation of Twelve-Step Facilitation Therapy (TSF)

STAGE-12 is a manual-guided brief treatment that adapts interventions from TSF initially developed for use in psychotherapy research protocols for the treatment of alcohol abuse and dependence. The initial TSF protocol involved 12-15 individual sessions with an additional 2-3 conjoint sessions if the patient was married. In the Project MATCH study of alcoholics, TSF was reduced to 8-12 individual sessions, including “Core” sessions that all patients received (e.g., Introduction to 12-Step Programs; Step 1, Steps 2 and 3; Getting Active; and Termination) as well as “Elective” sessions based on each patient’s individual needs (e.g., The Genogram; Enabling; People, Places and Things; HALT; Steps 4 and 5; and Sober Living). In addition, two “Conjoint” sessions were provided to patients married or involved in a significant relationship (e.g., Enabling; Detaching).

Since its initial development, the TSF model has been adapted for the treatment of drug abuse and dependence, including patients with cocaine and opiate problems. The content of the sessions was similar to that outlined above with the addition of two sessions. One session addresses “HIV Risk Reduction” since patients with drug abuse or dependence may engage in high-risk behaviors increasing the chances of transmitting or acquiring HIV infection (e.g., sharing needles or drug paraphernalia or engaging in unprotected sex or sex with multiple partners). Another session addresses the need to identify and manage feelings to reduce relapse risk as the inability to manage negative emotional states is one of the highest relapse risk factors. Emotions addressed include but are not limited to loneliness, anger, grief, anxiety, resentment and self-pity. The TSF model has also been adapted for use with families to facilitate their participation and use of mutual support programs such as Al-Anon or Nar-Anon. More recently, the TSF protocol has also been adapted for use in group as well as individual treatment.

TSF is designed for use in early recovery and has two primary goals:

1. **Acceptance**: help patients accept their addiction as a chronic disease and accept that this had led to unmanageability.
2. **Surrender**: help patients surrender and engage in a recovery process involving a willingness to go beyond oneself and follow a 12-step program.

5.3 Intensive Referral Program

The Intensive Referral Program (IRP) model was developed primarily to facilitate addicted patients’ active involvement in 12-Step programs such as AA, NA and others. While TSF attempts to provide patients with a better understanding of the principles of 12-step programs, with the expectation that this will increase the likelihood of attending meetings and getting involved in 12-step activities, the Intensive Referral Program goes about it in the opposite direction. That is, it attempts to get patients to attend meetings and get actively involved, with the expectation that over time they will gain a better understanding of and
appreciation for the principles of 12-step approaches. The IRP component of STAGE-12 is provided in three individual sessions, each of which focuses on helping the patient become involved in 12-Step programs through meeting attendance, finding a “home” group, getting a sponsor, and “working” the 12-Steps. These sessions also focus on the patients’ concerns about 12-Step programs as well as their experiences during participation in IRP sessions. In addition to reviewing aspects of the 12-step approach and providing the patient with a list of meetings and their locations and times, the primary method of facilitating getting patients to attend meetings is the counselor and patient calling a volunteer from a community-based 12-step program and arranging for the volunteer to take the patient to a meeting. This individual serves as a temporary sponsor for the patient, supports their efforts at recovery, explains the purpose and function of 12-step meetings, and helps them take the initial steps to attend a meeting. Subsequent sessions with the counselor either explore the patient’s experiences at the meetings or, if the patient did not attend, the barriers to attendance. If the patient did not attend, another call is made to a volunteer to again arrange for the volunteer to take the patient to a meeting. This approach has been shown to lead to increased attendance and a significantly greater level of engagement in 12-step activities than standard referral methods by counselors.

6.0 DEVELOPMENT OF STAGE-12 MODEL

6.1 Protocol Development Team

The current protocol for which this manual has been adapted was developed by the CTN 0031 (STAGE-12) Protocol Executive Committee (EC), which included broad representation of the CTN. Members of the CTN 0031 EC included those from:

1. Regional Research and Training Centers
2. Community Treatment Providers
3. NIDA Center for the Clinical Trials Network (CCTN)
4. The CTN Clinical Coordinating Center (EMMES Corporation)
5. The CTN Data and Statistics Center (Duke Clinical Research Institute)

Conference calls were held among the EC Committee and workgroups weekly or more often to review in great detail all aspects of the protocol including background and significance, prior research, various 12-Step interventions (both counseling and facilitative), assessment batteries, outcome measures, CTP acceptance of the STAGE-12 protocol, informed consent procedures, budgets, training, data analysis, and operating procedures.

6.2 STAGE-12 Protocol Development

We developed the STAGE-12 approach based upon an extensive review of the empirical literature on 12-Step interventions and a survey of Community Treatment Providers (CTPs) involved in the CTN that offer outpatient...
psychosocial treatment. Research indicates that while most addiction treatment programs incorporate 12-Step related interventions (education, counseling or both); this is typically not done in a consistent or systematic manner. The committee believed that the protocol could easily be adapted in community treatment settings, which would enable more patients to receive systematic preparation for active participation in 12-Step programs.

Most of the work done on TSF has used an individual counseling format; however, the bulk of treatment provided in CTPs is delivered in group settings. The majority of the 67 CTPs responding to the survey from the Protocol Executive Committee preferred a treatment protocol that could be provided in ambulatory treatment groups with several individual sessions added. A protocol combining individual and group approaches was seen as the most acceptable approach to use, particularly since most CTPs utilize group treatment as a major modality of treatment for addicted patients. Our decision was also informed from findings of the cocaine collaborative multi-site clinical trial, which found superior outcomes for patients receiving a combination of individual and group sessions that incorporated the 12-step philosophy of recovery.

The protocol team considered the importance of sustaining the implementation of this protocol upon completion of the trial. This led to the decision to integrate the 8-session protocol into an existing ambulatory program rather than attempt to “add” it on to current services. Five STAGE-12 group sessions replace five other existing group sessions, and three individual STAGE-12 sessions: (one for the initial session, one at about week three, and one at termination from the STAGE-12 protocol) will replace three individual counseling sessions from the standard treatment program. A unique feature of this program is teaming each patient up with a person in recovery who accompanies the patient to NA or other 12-Step meetings in the community.

This protocol is designed to be integrated into an existing intensive outpatient, partial hospital, day or evening primary treatment program for patients with any type of stimulant abuse or dependence. Therefore, it can easily be incorporated into an existing program as it is not an “add on” but a “replacement” for select current group and individuals sessions offered. The rationale of the STAGE-12 group sessions is to provide a systematic review of certain aspects of NA and AA in order to increase patient understanding, acceptance, and use of these mutual support programs in their ongoing recovery. The individual IRP sessions also aim to help the patient become active in NA or other 12-Step programs.

This treatment protocol is appropriate for patients who may have previously participated in Twelve Step programs such as NA or AA, patients who have never been exposed to 12-Step programs, and/or patients who may or may not have had previous treatment for a substance abuse or dependence problem. The program described in this manual is intended to be consistent with active involvement in 12-Step recovery programs such as Narcotics Anonymous (NA), Cocaine Anonymous (CA), Alcoholics Anonymous (AA), and Crystal Meth Anonymous (CMA). It assumes that addiction is a progressive disease of mind,
body, and spirit, for which the only effective remedy is abstinence from mood-altering substances, *one day at a time*. STAGE-12 adheres to the concepts set forth in the Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981) of NA, CA or AA.

The overall goal of this treatment is to promote abstinence from stimulants and other substances by facilitating patients' active involvement and participation in the fellowship of 12-Step recovery programs (NA, CA, AA, CMA). Active involvement in 12-Step programs is regarded as the single most important factor responsible in maintaining sustained recovery from drug abuse or dependence, and therefore, is the desired outcome of participation in this treatment.
7.0 GOALS AND OBJECTIVES OF STAGE-12 PROGRAM

The STAGE-12 program has two primary goals, which generally correspond to the first three Steps of NA, CA, CMA or AA: acceptance of addiction and surrender.

7.1 Acceptance of Addiction

The breakdown of the illusion that the individual through willpower alone can effectively and reliably control or limit his/her use of mood-altering substances.

1. Acceptance by patients that they suffer from the chronic and progressive illness of drug addiction.

2. Acceptance by patients that they have lost the ability to control their use of mood-altering substances.

3. Acceptance by patients that since there is no effective “cure” for addiction, the only viable alternative is complete abstinence from all mood-altering substances.

7.2 Surrender

1. This involves a willingness to reach out beyond oneself and to follow the twelve steps presented in 12-Step programs.

2. Acknowledgment on the part of the patient that there is HOPE for Recovery (sustained abstinence), but only through accepting the reality of the loss of control and by having faith that some HIGHER POWER can help the individual whose own willpower has been defeated by addiction to mood-altering substances.

3. Acknowledgement by the patient that the fellowship of NA, CA, CMA or AA has helped millions of addicts to sustain their recovery, therefore, the patient’s best chance for success is to follow the path of NA, CA, CMA or AA.

8.0 RECOVERY GOALS

Recovery is the process of managing the stimulant addiction over time, and making changes in oneself and one’s lifestyle to support abstinence from drugs. The two major goals of STAGE-12 are reflected in the following objectives which are congruent with the NA, CA, CMA and AA view of drug addiction or alcoholism. These objectives address all major domains of functioning and show that change is needed in addition to abstinence from substances.

8.1 Cognitive Aspects of Recovery

1. Patients should understand some of the ways in which their thinking has been affected by drug addiction.

2. Patients should understand how their thinking may reflect denial ("stinking thinking") and thereby contribute to continued drug use and resistance to acceptance (Step 1).
3. Patients should see the connection between their drug use and negative consequences that result from it. These consequences may be physical, social, legal, psychological, financial, or spiritual.

8.2 Emotional Aspects of Recovery
1. Patients should understand the NA, CA, CMA, and AA view of emotions and how certain emotional states (anger, loneliness) can lead to drug use.
2. Patients should be informed regarding some of the practical ways 12-Step programs suggest for dealing with emotions so as to minimize the risks of using drugs.
3. STAGE-12 attempts to introduce and guide the individual in the use of 12-Step program tools for dealing with such emotions as anger, loneliness, and grief. These tools include making use of the program slogan “Don’t let yourself get too hungry, angry, lonely, or tired” (H.A.L.T.).

8.3 Interpersonal Aspects of Recovery
1. Addiction has been described as a “disease of isolation.”
2. STAGE-12 provides support for patients to become connected to 12-Step programs by going to meetings, participating in meetings and establishing a relationship with a sponsor.

8.4 Behavioral Aspects of Recovery
1. Patients should understand how the powerful and cunning illness of drug addiction has affected their whole lives and how many of their existing or old habits (people, places and things) have supported their continued drug use.
2. Patients should replace people, places and things that threaten their abstinence with people, places and things that support their recovery.
3. Patients should turn to the fellowship of NA, CA, CMA or AA and to make use of its resources and practical wisdom in order to change their addictive behavior.
4. Patients should “get active” in NA, CA, CMA or AA as a means of sustaining their abstinence.

8.5 Social Aspects of Recovery
1. Patients should attend and participate regularly in 12-Step meetings of various kinds, including NA, CA, CMA or AA sponsored social activities.
2. Patients should access NA, CA, CMA or AA whenever they experience the urge to use or when they slip or relapse.
3. Patients should re-evaluate their relationships with “enablers” and fellow drug users.
8.6 Spiritual Aspects of Recovery

1. Patients should experience hope that they can recover from their drug addiction.
2. Patients should develop a belief and trust in a power greater than their own willpower.
3. Patients should explore and re-evaluate their purpose in life.
4. Patients should make a commitment to ethical and moral behavior, and acknowledge specific immoral or unethical acts, and harm done to others as a result of their drug addiction.

9.0 RESEARCH ON 12-STEP INTERVENTIONS

9.1 Types of 12-Step Interventions

There are two types of interventions related to 12-Step programs provided in addiction programs. These include: (1) 12-Step oriented counseling or therapy, and (2) facilitation of active involvement in 12-Step programs such as NA, CA, CMA or AA. The main difference between the two is that the latter facilitative intervention focuses primarily on helping patients engage and actively use 12-Step programs in the community while the 12-Step counseling or therapy approaches also deal with many of the common issues facing addicted individuals in recovery. These issues include, but are not limited to the impact of addiction on the family, managing social pressures to engage in substance use, identifying early warning signs of relapse as well as high-risk relapse factors, addressing other addictions (gambling, sex, internet), or changing lifestyle. Counseling approaches may also entail helping patients develop specific recovery “skills” to manage these challenges of recovery. Following is a brief review of several twelve-step counseling approaches that are described in treatment manuals.

9.2 Twelve-Step Facilitation Therapy for Alcohol Problems (TSF)

This original version of TSF was developed as a brief, structured treatment by Nowinski and Baker for use with alcohol problems. This model involved 12-15 individual sessions with single patients, with 2-3 additional sessions with the patient’s partner for those patients who were married or involved with a significant other. This TSF model was based on the 12-Step program of Alcoholics Anonymous (AA). It was subsequently adapted and a manual was developed by Nowinski, Baker and Carroll for use in Project MATCH, a large, multi-site clinical trial in the treatment of alcoholism in which TSF was compared with Cognitive-Behavior Therapy and Motivational Enhancement Therapy. In this revised version, TSF was delivered in 12 individual sessions, or 10 individual and 2 conjoint sessions for patients with a partner. The goals, structure and content of TSF were similar in these two variations of TSF.
9.3 Twelve-Step Facilitation Therapy for Drug Abuse

This model was adapted by Baker and colleagues at the Yale University Psychotherapy Development Center for use with drug abuse and dependence. Minor changes were made to reflect recovery needs and issues of patients with drug use disorders. This TSF approach involved 12 individual sessions and 2 conjoint sessions for patients with partners. Variations of this approach have been used with cocaine and opioid addiction.

9.4 Twelve-Step Facilitation Therapy for Families (TSF-F)

Nowinski also adapted this model for use with families to address their needs in recovery since they are often adversely affected by a loved one’s alcoholism or drug addiction. TSF-F for families was also a brief, structured treatment based on the 12-Step program of Al-Anon.

9.5 Individual Drug Counseling (IDC)

This model was developed by Mercer and Woody, and used in a large, multi-site clinical trial of treatment of cocaine use disorders. Three individual treatments (IDC, Supportive-Expressive Psychotherapy and Cognitive-Behavioral Therapy) combined with Group Drug Counseling (GDC) were compared to GDC combined with brief case-management sessions (GDC plus case management was the control condition for this study).

IDC involved individual sessions twice per week for 3 months, weekly for 3 months, and monthly for 3 months for a total of 42 sessions over a 9-month period of time. Although IDC was rooted in the philosophy of NA and the 12-Step recovery model, it addressed many early and middle recovery issues and focused on learning recovery skills in addition to engaging in 12-Step programs of recovery. IDC sessions covered a range of topics and issues based on the individual patient’s problems and concerns. These topics include post-acute withdrawal symptoms, the use of other drugs and alcohol, managing cravings, social pressures to use drugs and other high-risk situations, compulsive sexual behaviors, relationships, relapse prevention, drug-free lifestyle, spirituality, shame and guilt, personal inventory, character defects, anger management, relaxation and use of leisure time, employment issues, money management and the transfer of addiction to “other” behaviors. In this clinical trial, IDC was combined with weekly Group Drug Counseling (GDC) sessions to provide a comprehensive outpatient program to patients with cocaine problems.

9.6 Group Drug Counseling (GDC)

This model, developed by Daley, Mercer, and Carpenter for the multi-site cocaine treatment trial, was also grounded in NA and the 12-Step program of recovery. GDC involved 24 weekly group sessions. Phase I involved 12 weekly, structured psycho educational sessions, each focusing on a specific issue or topic related to addiction or recovery. Issues addressed during these weekly group sessions included: causes and symptoms of addiction; the process of recovery; managing cravings, people, places and things; relationships in recovery; self-help groups;
establishing a support system; managing feelings; coping with guilt and shame; warning signs of relapse; coping with high-risk relapse factors; and maintaining recovery over the long-term. Phase 2 involved 12 weekly problem solving groups during which time the patients comprising the group discussed their personal problems and concerns related to addiction and recovery. Many of the issues reviewed in Phase 1 were revisited as well as other problems or issues.

10.0 ROLE OF 12-STEP PROGRAMS IN TREATMENT AND RECOVERY

Twelve-step oriented mutual support programs such as NA, CA, CMA and AA represent an important, readily available, and pervasive resource in recovery from substance use disorders, whether associated with formal treatment or not (Room and Greenfield 1993; Humphreys 1999; Kelly 2003). Individuals with substance use disorders can become involved with 12-Step programs before entering professional treatment, as part of their professional treatment, as aftercare following professional treatment, or instead of professional treatment (Fuller and Hiller-Sturmhofel 1999). These mutual support programs, which include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), Crystal Meth Anonymous (CMA) and a number of others, are highly accessible and are available at no cost in communities throughout the world. For some individuals with substance use disorders 12-Step programs are the only resource ever used to recover from an alcohol or drug problem (Room and Greenfield 1993; Hasin and Grant 1995; Kaskutas, Weisner et al. 1997). Although initiated with alcohol as its primary focus, this philosophy has also been integrated into the treatment of drug dependence, and there is increasing evidence to support the potential utility of 12-Step groups with stimulant abusers (Donovan & Wells, 2006), as in the Group Drug Counseling (GDC) and Individual Drug Counseling (IDC) approaches developed for treatment of cocaine addicts (Crits-Christoph, Siqueland et al. 1997; Crits-Christoph, Siqueland et al. 1999; Daley, Mercer et al. 1999; Mercer and Woody 1999). Participation in 12-Step programs is also a recommended component in the Matrix Model used in the treatment of both cocaine and methamphetamine dependence (Shoptaw, Rawson et al. 1994; Rawson, Shoptaw et al. 1995; Obert, McCann et al. 2000). Many residential and outpatient treatment programs include 12-Step meetings on-site and encourage patients to become involved in community-based 12-Step meetings and activities as part of their ongoing recovery (Fuller and Hiller-Sturmhofel 1999).

The 12-step philosophy refers to a particular view of the recovery process. It emphasizes the importance of accepting addiction as a disease that can be arrested but never eliminated, enhancing individual maturity and spiritual growth, minimizing self-centeredness, and providing help to other addicted individuals (e.g., sharing recovery stories in group meetings, sponsoring new members) (Humphreys, Wing et al. 2004). Self-help programs based on this philosophy outline 12 Steps those individuals with substance use disorders can use to guide their recovery process. These Steps specify that addicted individuals must admit their powerlessness over alcohol and drugs, rely on a Higher Power for help in
recovery, take a moral inventory of themselves, admit the nature of their wrongs, make a list of individuals whom they have harmed, and make amends to those people. Individuals who establish significant periods of recovery may then “take the message” to others, which is the focus of Step 12.

Involvement in such mutual support programs is meant to provide participants with support for remaining substance free, a social network (“fellowship”) with which to affiliate, and a set of 12 guiding principles to facilitate change in various areas of life (the 12 “Steps”) to be followed in the recovery process (Kaskutas, Bond et al. 2002). Caldwell and Cutter (1998) described the general guidelines for recovery based on this philosophy as the “12-step’six pack”: don’t drink or use drugs, go to meetings, ask for help, get a sponsor, join a group, and get active

11.0 EFFECTIVENESS AND EFFICACY OF 12-STEP MUTUAL SUPPORT PROGRAMS

There has been an increased focus on 12-step self-help groups by clinicians, policy makers, and researchers over the recent past. Given cutbacks in funding for professional treatment, 12-Step programs are seen as an inexpensive and readily available complement to formal treatment and as a source of support following treatment (Etheridge, Craddock et al. 1999; Florentine 1999; Humphreys 1999; Humphreys 2003). Recent efficacy and effectiveness studies provide support for the effectiveness of 12-Step oriented approaches (Donovan 1999). Generally, these studies have found a positive relationship between 12-Step involvement and improvement on substance use outcomes for both alcoholics and drug abusers, even over extended periods of time ranging up to 16 years (Emrick, Tonigan et al. 1993; Montgomery, Miller et al. 1995; Timko, Finney et al. 1995; Morgenstern, Labouvie et al. 1997; Project Match Research Group 1997; Watson 1997; Ouimette, Moos et al. 1998; Fiorentine and Hillhouse 2000; Fiorentine and Hillhouse 2000; Weiss, Griffin et al. 2000; McKay, Merikle et al. 2001; Tonigan 2001; Kaskutas, Bond et al. 2002; Morgenstern, Bux et al. 2003; Moos and Moos 2004; Kaskutas, Ammon et al. 2005; Moos and Moos 2005; Moos and Moos 2006).

Weiss and colleagues found that active involvement in self-help activities (as opposed to meeting attendance) in a given month predicted fewer days of cocaine use in the next month (2001; 2005). Patients who increased their involvement in self-help activities during the first three months of treatment had significantly fewer days of subsequent cocaine use. The best outcomes were found among those individuals who received both the 12-step oriented Individual Drug Counseling (IDC) and Group Drug Counseling (GDC). The combined effects of being involved in a treatment approach that emphasizes 12-step involvement plus actual engagement in self-help activities were associated with the best outcomes.

McKellar and colleagues (2003) reported that research provides increasingly supportive evidence that 12-step involvement “works;” that is; increased 12-step meeting attendance and/or involvement lead to a decrease in subsequent alcohol
and drug use. Attendance at 12-step meetings, whether independent of formal treatment or as an adjunct to treatment, has also been found to be associated with reductions in health care costs, particularly those related to subsequent substance abuse treatment (Humphreys and Moos 1996, 2001, 2007). Treatment approaches or interventions that are meant to increase engagement in 12-step activities appear to be effective in doing so and, thus, contribute to positive substance use outcomes through their impact on increasing 12-step activities and attendance (Carroll, Nich et al. 1998; Humphreys 1999; Morgenstern, Bux et al. 2003; Weiss, Griffin et al. 2005).

11.1 Meeting Attendance and Engagement in 12-Step Activities

Involvement, rather than attendance, appears to be the better predictor of substance use outcomes. The greater the level of involvement in 12-Step activities, the better the outcome for alcoholics and cocaine abusers (Gilbert 1991; Montgomery, Miller et al. 1995; Caldwell and Cutter 1998; Weiss, Griffin et al. 2000; Weiss, Griffin et al. 2001; Weiss, Griffin et al. 2005). While more people are attending than are getting involved in the 12-Step programs, regular attendance may be a precursor for involvement for many of these individuals. Caldwell and Cutter (1998) found that individuals who attend AA daily in early recovery are more likely to embrace both the program and fellowship dimensions of AA, and that those who have dropped out or who attend meetings infrequently or erratically tend to be less accepting of all aspects of AA. This latter group also appears to do less well than those who have frequent and consistent attendance (Morgenstern, Kahler et al. 1996; Weiss, Griffin et al. 2000; Moos and Moos 2004; Kaskutas, Ammon et al. 2005; Moos and Moos 2005). Fiorentine (1999) found that weekly or more frequent meeting attendance was associated with drug and alcohol abstinence among patients at outpatient drug treatment programs. Similarly, Moos (2004) found that more frequent participation in AA (e.g., attending two or more meetings per week) during the first year after seeking help was associated with a higher likelihood of subsequent abstinence at 1- and 8-year follow-ups. Furthermore, the timing of this attendance was crucial. Early involvement was important; individuals who delayed participation for a year or more and then eventually entered AA had outcomes that were no better than those of individuals who never entered AA. Continued attendance and the duration of involvement in 12-step activities over time were also important and were predictive of a broader range of substance use and psychosocial outcomes than was attendance. Participation in AA had a positive influence on alcohol-related outcomes over and above the effects attributable to professional treatment.

These findings suggest that it is important not only to get patients to attend 12-step meetings, but to do so early after they have sought treatment and to encourage consistent attendance over time. It is also important to have patients become actively involved in the 12-step process beyond meeting attendance. However, interventions that are effective in increasing attendance may be insufficient to ensure active involvement. Caldwell and Cutter (Caldwell and
Cutter 1998) suggest that individuals who are attending AA but are having difficulty embracing key aspects of the program may need professional assistance that focuses more on 12-step practices and tenets and less on meeting attendance.

### 11.2 Low Rates of 12-Step Attendance and Involvement Following Treatment As Usual

Despite the potential benefits associated with 12-step involvement and attendance, 60-70% of substance abusers have never attended a 12-step meeting. Kelly and Moos (2003) found that approximately 40% of a cohort of nearly 3,000 individuals who had attended 12-step meetings in the 90 days prior to or during treatment had dropped out over the following year.

Among drug abusers, Fiorentine found that higher levels of post treatment attendance at 12-Step meetings were associated with higher rates of abstinence from both drugs and alcohol. Fiorentine also found that those who participated concurrently in both treatment and 12-Step programs had higher rates of abstinence than those who participated only in treatment or in 12-step programs (Fiorentine and Hillhouse 2000).

Moos and Moos (2004) found that individuals with alcohol use disorders who participated in AA for 4 months or longer in the first year after seeking help had better 1-year and 8-year alcohol-related outcomes than individuals who did not participate in AA. Individuals who sustained their participation in AA in Years 2–8 had better 8-year outcomes than did individuals who did not continue to participate or who participated for a shorter interval. Individuals who delayed participation in AA had no better outcomes than those who never participated. Early engagement during and/or shortly after treatment and sustained involvement in 12-Step programs contribute positively to substance use outcomes. However, such low rates of attendance during or after treatment are found despite the fact that most treatment programs incorporate a 12-step philosophy and that professional staff report a high rate of referral to 12-step programs (Humphreys 1997). However, referral by professionals is not always introduced to patients in a manner that fosters acceptance of 12-Step programs (Caldwell 1999). This is of concern since substance abusers appear less likely to become involved in 12-step activities if left to do so on their own than if more active encouragement and referral are provided in treatment (Sisson and Mallams 1981; Humphreys 1999; Weiss, Griffin et al. 2000; Timko, DeBenedetti, et al. 2006). Even if patients initially attend meetings, there typically are high rates of attrition, which prevents them from receiving the maximum benefit from 12-step involvement (Godlaski, Leukefeld et al. 1997). Caldwell and Cutter (Caldwell and Cutter 1998) suggest that early attrition from attending meetings may, in part, be due to individuals’ inability to embrace or utilize other aspects of the 12-step program.

In a study of inpatient substance abuse treatment within the Department of Veterans Affairs (DVA), researchers found that individuals treated in 12-step
oriented programs had significantly higher rates of substance abstinence at the follow-up than did those in cognitive-behaviorally oriented programs (Ouimette, Finney et al. 1997), a finding consistent with Project MATCH (Project Match Research Group 1997; Donovan 1999). The greater a program’s emphasis on 12-step approaches, the stronger the positive relationship between 12-step participation and better substance use outcomes. Also, 12-step oriented programs and those having a higher percentage of staff in recovery were more likely to make referrals to 12-Step programs than were cognitive-behavioral or eclectic programs (Humphreys 1997). Thus, it appears possible to enhance the attendance at and effectiveness of 12-step self-help groups, particularly when involved in a formal treatment program that has a strong 12-step orientation (Humphreys, Huebsch et al. 1999; Fiorentine and Hillhouse 2000; Fiorentine and Hillhouse 2000). This finding is consistent with that of Weiss, et al. (Weiss 2005) who reported that the combined effects of being involved in a treatment that emphasized 12-step involvement plus actual engagement in self-help activities was associated with the best clinical outcomes for cocaine addiction.

12.0 EFFICACY OF INTERVENTIONS TARGETING INCREASED 12-STEP INVOLVEMENT

12.1 Single Site Studies

Results of single-site trials have been equivocal related to the relative efficacy of interventions targeting 12-step engagement compared to other types of treatment such as cognitive-behavioral therapy with respect to substance use outcomes. Wells et al. (1994) found that an outpatient "recovery support group" for cocaine addicts that was based on the 12-steps of AA and focused on the first three of the 12 steps (acceptance, higher power, and surrender) had substance use outcomes both during the treatment period or at a 6-month follow-up that were comparable to those in a group-based relapse prevention intervention. Given similar findings that the outcomes of TSF were equal to or better than those seen with relapse prevention in an aftercare setting, Brown et al. (2002) concluded that the adoption of well-supervised and structured TSF inspired programs seems a reasonable strategy for most patients.

Carroll and colleagues (1998) found that self-help involvement during treatment was significantly higher for patients assigned to TSF compared to those assigned to CBT or clinical management. Furthermore, 58% of all participants reported attending at least one AA or self-help meeting over the follow-up period. Both TSF and CBT were associated with substantial and significant reductions in alcohol and cocaine use over the course of the 12-week treatment period compared to the clinical management condition. Carroll and colleagues (1998; 2000) also found that participants who attended any self-help groups, regardless of treatment condition, had significantly better cocaine outcomes during follow-up than those who did not attend these programs.
With the exception of one study by Maude-Griffin, et al. (1998), the results from these clinical studies indicate that interventions designed to facilitate involvement in 12-Step programs, whether delivered as individual or group therapies, result in significant and substantial reductions of substance use comparable to and not different from the outcomes of more established, evidence-based treatments such as cognitive behavioral therapy and relapse prevention.

12.2 Multi-Site Studies

Two large-scale multi-site clinical trials support the conclusions that it is possible to enhance the attendance at and involvement in 12-step self-help groups particularly when involved in a formal treatment program that has a strong 12-step orientation, and, in doing so, improve outcomes. Project MATCH (1993 & 1997) evaluated three manually guided, individually delivered treatments for alcohol dependence: Cognitive-Behavioral Therapy (CBT), brief Motivational Enhancement Therapy (MET), and Twelve Step Facilitation Therapy (TSF) (Donovan, Kadden et al. 1994; Donovan, Carroll et al. 2003). The content of TSF therapy was designed to be consistent with AA and other 12-step programs, and with treatment programs based on the Minnesota Model (Nowinski and Baker 1992; Nowinski, Baker et al. 1992). The primary goal of TSF is to promote abstinence by facilitating the patient’s acceptance of the addiction, surrender to a Higher Power, and active involvement in 12-Step meetings and related activities. While participants in all three Project MATCH therapies demonstrated significant and comparable reductions in the number of drinks per drinking day and increases in the percent days abstinent, those participants who received TSF had significantly higher rates of continuous abstinence when compared to the other two treatments at a 1-year follow-up. This differential benefit for the TSF group appears to have been related to differences in the treatments’ ability to engage patients in 12-step activities. Participants in the outpatient TSF also reported significantly more involvement in 12-step activities than those in either CBT or MET. AA participation, in turn, positively predicted the frequency of abstinent days in the post treatment period (Connors, Tonigan et al. 2001). Compared to CBT or MET, TSF resulted in a greater awareness of a higher power, endorsement of total abstinence, and engagement in AA practices. Two of these active ingredients, emphasis on abstinence and commitment to AA practices, were predictive of greater abstinence, and commitment to AA practices mediated or explained why TSF patients reported significantly higher abstinence rates 6 months after treatment relative to CBT and MET.

In a multi-site study of cocaine addiction, Crits-Christoph and colleagues (1997 & 1999) found that patients who received Individual Group Counseling (IDC) and Group Drug Counseling (GDC) combined did better than those who received GDC combined with Supportive Expressive (SE) or Cognitive Behavioral Therapy (CBT). IDC (Mercer & Woody, 1999) and GDC (Daley, Mercer & Carpenter, 1999; 2002) emphasized the 12-step philosophy, focused on the disease concept of addiction, advocated healthy behavioral and lifestyle changes, and strongly encouraged and reiterated the importance of self-help group attendance as well
as getting and using a sponsor. Overall, patients in all treatment conditions reduced their cocaine use significantly; however, those in the combined GDC+IDC conditions reduced their cocaine use significantly more and did so more rapidly than those in the other conditions (Crits-Christoph, Siqueland et al. 1999). The combined GDC+IDC condition had the highest rates of 12-step attendance and involvement. The incremental benefit of adding Individual Drug Counseling to Group Drug Counseling was notable. Patients in the GDC-only condition reported attending fewer 12-Step meetings compared to the combined GDC+IDC condition.

12.3 Treatment as Usual and Twelve Step Facilitation Are Not the Same

The fact that a program or a counselor indicates that treatment is guided by 12-step philosophy does not necessarily mean that 12-step practices, let alone 12-step facilitation practices, are actually being employed. STAGE-12 therapy is quite different from 12-step referral methods typically found in substance abuse programs.

Humphreys and colleagues (2004) report that there are few “pure” 12-step treatment programs or practitioners. Rather, most are likely to incorporate an eclectic perspective, blending 12-step, cognitive-behavioral, and other philosophies and techniques. Even practitioners who describe themselves as “12-step oriented” typically consider only a subset of 12-step processes important for patients. Thus, even having treatment with a 12-step program philosophy and counselors that encourage 12-step involvement may not be sufficient to increase 12-step involvement and activities; a systematic, manually guided 12-step facilitative intervention and treatment-as-usual are not equivalent.

Morgenstern and colleagues (2001) studied community-based intensive outpatient treatment programs (IOP). The programs were described as having a 12-step orientation, a focus on overcoming denial, an emphasis on facilitating involvement with self-help groups, the provision of education about the disease of addiction, and an emphasis on the need for abstinence. All of these are viewed as 12-step-oriented treatment components. However, based on monitoring of program content, only one of these treatment elements, encouraging involvement with self-help groups, was observed to be occurring. Other 12-step activities, including discussing the disease concept of addiction, encouraging 12-step recovery, invoking the concepts of spirituality and higher power, and exploring the patient’s denial, were even less frequently employed. Galloway and colleagues (2000) found a high degree of variability in the extent to which attendance at 12-step meetings was required as part of treatment by community-based programs involved in the CSAT-funded multi-site trial of treatment for methamphetamine abuse.

One of the recommendations of an expert consensus panel (Humphreys, Wing et al. 2004) is that community-based treatment programs, even those that label and represent themselves as “12-step oriented,” should evaluate whether their
current program practices actively support involvement in 12-step self-help groups. Further, they also should examine the methods employed by their counselors in this regard. Typically, they noted, when counselors do attempt to support 12-step self-help group involvement in TAU, they rarely use empirically supported methods. When clinicians use empirically validated techniques to support mutual help group involvement, it is far more likely to occur (Humphreys 1999).
12.4 Briefer 12-Step Interventions to Fit Current Practice Issues of Sustainability

Humphreys believes that in order to make 12-step facilitative interventions more useful in clinical practice, researchers and clinicians should develop and evaluate briefer forms of such interventions. The current STAGE-12 protocol was developed as a briefer intervention that can easily be sustained in community treatment programs that offer levels of care such as intensive outpatient or partial hospital programs. This protocol can easily be integrated into an existing program’s structure without requiring significant changes that would create a burden for clinical staff.

13.0 INTENSIVE REFERRAL (THE “BUDDY” SYSTEM)

An approach that is both consistent with the recommendation for developing briefer 12-step facilitative interventions and related to the 12-step recovery model involves the use of 12-step members serving as a “bridge” between formal treatment and individuals’ entrance into a 12-step program. It has been a common practice in many treatment programs to use AA or NA members who serve as volunteers in a “buddy system” or as temporary sponsors (Blondell, Looney et al. 2001; Collins and Barth 1979; Chappel and DuPont 1999). This is consistent with the pamphlet, available on-line from Alcoholics Anonymous (http://www.alcoholics-anonymous.org/en_pdfs/p-49_BridgingTheGap.pdf), entitled “Bridging the Gap between Treatment & AA through Temporary Contact Programs.” It provides guidelines for 12-step community members to serve as the temporary “buddy” or sponsor to help facilitate the transition of clients from treatment into the community. Patients who have engaged in 12-step activities through the efforts of such volunteers have credited the peer intervention as being the most important factor that motivated them to seek help for their substance use disorder. When recovering alcoholics and drug addicts provide help to a substance-abusing patient, they are also furthering their own 12th-step work. Furthermore, such interventions are relatively simple, practical, involve little or no costs, and pose little patient risk (Blondell, Looney et al. 2001).

One form of such a voluntary “buddy system” intervention is “Systematic Encouragement and Community Access” (SECA), an intensive referral procedure developed by Sisson and Mallams (Sisson and Mallams 1981). In addition to suggesting that the patient attend 12-step meetings and providing a printed list of meeting times and locations, the counselor arranges an in-session telephone call to a current member of a 12-step group, who talks to the patient briefly and arranges to attend a meeting with him or her. The 12-step group member contacts the patient with a reminder telephone call the night before the meeting, and drives the patient to the meeting. Timko and colleagues (Timko, DeBenedetti et al. 2006; Timko and DeBenedetti, 2007) have recently completed a large randomized trial evaluating a manualized 3- session version of this intensive 12-step referral procedure with individuals entering outpatient substance abuse treatment. In comparison to the two participating clinics’
standard referral procedure (e.g., encouraging meeting attendance and providing list of meetings and times), the intensive referral to 12-step meetings resulted in significantly greater engagement in 12-step activities (doing service work, having experienced a spiritual awakening, and overall involvement), greater reductions on the alcohol and drug use composite scores of the Addiction Severity Index, and higher rates of abstinence from drugs over a 6-month follow-up period.

13.1 12-Step Interventions Delivered in Group Format

One approach that may be more sustainable with respect to both clinical service delivery and reimbursement models than individually administered STAGE-12 is the provision of 12-step facilitative interventions in a group setting. Group formats represent the modal form of delivery of addiction treatment services (Stinchfield, Owen et al. 1994; Brook and Spitz 2002; Weiss, Jaffee et al. 2004; Flores and Georgi 2005). Treatment programs provide group treatment because of its cost-efficiency and perceived effectiveness at engaging patients and bringing about abstinence or reduced drug use. Further, groups may involve a number of “curative factors” that facilitate behavior change and the acquisition and maintenance of abstinence. Such factors include knowing that one is not alone, giving and receiving support, instilling hope, learning from others’ experiences and from interacting with others; learning to communicate feelings and needs more effectively, making sense of one’s own experience through interaction with similar others, and confronting problematic behaviors, such as denial, manipulativeness and grandiosity (Stinchfield, Owen et al. 1994; Flores and Georgi 2005).

These mechanisms of change associated with group therapy may well be operative in 12-Step programs (Kassel and Wagner 1993). However, for a number of logistical, methodological, and statistical reasons, addiction researchers have not focused on evaluating group treatment to the extent that it has been studied in other areas of behavioral health (National Institute on Drug Abuse 2003). This constitutes a major gap between addiction research and clinical practice (Lamb, Greenlick et al. 1998).

The results of controlled trials of group therapy with substance abusers, in general, have been equivocal (Weiss, Jaffee et al. 2004). However, as noted above, the results of Wells and colleagues (1994) and Brown and colleagues (Brown, Seraganian et al. 2002a, 2002b) indicated that 12-step oriented interventions delivered in a group format were comparable to more well-established, empirically supported relapse prevention groups with respect to substance use outcomes. These findings suggest the viability of group-based approaches to 12-step facilitative interventions. Further, the results of the NIDA Collaborative Cocaine Treatment Study suggest that group based 12-step approaches may be enhanced further by the addition of individual sessions that reinforce and augment the 12-step emphasis provided in groups.
13.2 Summary and Rationale

William Miller, serving as a discussant for a symposium on AA involvement and change mechanisms (Owen, Slaymaker et al. 2003), provided the following conclusions about the current status and future direction of research and clinical practice in this area (p.531):

- AA cannot be ignored in understanding treatment outcomes. At the very least, studies should carefully inquire about AA involvement, to examine its relationship to treatments and outcomes.

- It is possible to facilitate AA attendance. Without question, there are counseling procedures that significantly increase AA attendance, at least during and often after treatment. TSF therapy clearly did this in Project MATCH. Systematic encouragement can significantly increase attendance.

- Treatment is the time to initiate AA attendance. If AA attendance is not initiated during the period of treatment, it is quite unlikely to happen. Treatment, then, is a good time to encourage sampling of the program and meetings of AA.

- Attendance is not involvement. When frequency of AA meeting attendance is measured separately from behavioral indicators of involvement in the program and fellowship of AA, the two measures are moderately correlated. In fact, among more frequent AA attendees during Project MATCH treatment, AA attendance declined over the course of follow-up while AA involvement remained steady or increased. This suggests a gradual process of internalization of the AA program and surely indicates that conclusions cannot be drawn from attendance alone.

- AA involvement predicts better outcomes. Longitudinal studies usually, although not always, find that AA involvement after treatment is associated with higher rates of abstinence regardless of the kind of treatment received. When AA attendance and AA involvement are both measured, the latter tends to be the stronger predictor of outcome.

Miller’s conclusions about AA, as well as the empirical findings on which they are based, have helped shape the present protocol that will focus on a broader range of 12-Step programs. It will evaluate the impact on substance use of a combined group and individual treatment approach for stimulant abusers. Specifically, the present approach is based on the TSF therapy from Project MATCH as modified for use with drug abusers (Baker 1998) and delivered in a group format (Brown, Seraganian et al. 2002; Brown, Seraganian et al. 2002). These group sessions will be augmented by three individual sessions, two of which are drawn from the STAGE-12 manual, into which are integrated action-oriented interventions derived from the intensive referral procedure of Timko, et al. (2006) as a means of increasing involvement in 12-step activities and meeting attendance. This combined group plus individual approach is named STAGE-12 (STimulant Abuser Grou[12]-Engage in 12-Step programs).
Twelve-step programs serve as cost-effective resources that complement, support, and extend the cognitive and behavior changes made in treatment (McCrad 1994). However, given the low rates of involvement in and high rates of attrition from 12-step programs, it is necessary to evaluate methods to help substance abusers and treatment programs take full advantage of self-help groups (Humphreys 1999). Implementation of systematic, structured, and manual-guided 12-step programs, integrated within treatment, represents one such method to increase engagement and retention in professional treatment.

14.0 STAGE-12 AND OTHER TREATMENTS FOR ADDICTION

14.1 Treatment for Addiction

Many efficacy and effectiveness studies sponsored by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAAA) have been conducted on psychosocial, pharmacotherapy and combined treatment approaches for drug abuse or dependence and alcohol abuse or dependence. This research has led to the establishment of a significant evidence-base for effective treatment of drug or alcohol abuse and dependence. Many of the psychosocial treatments for drug addiction are described in NIDA’s Therapy Manuals for Drug Addiction series, and effective treatments for alcohol problems are described in the NIAAA’s Clinical Research Guides for Counselors. Several treatment approaches such as Twelve-Step Facilitation Therapy and Motivational Interviewing have been used with both drug and alcohol use disorders.

These evidence-based psychosocial treatment approaches include:

1. Cognitive and behavioral therapies
2. Coping and social skills training
3. Community reinforcement approach
4. Integrated treatment for substance use and co-occurring psychiatric disorders
5. Family and marital therapies
6. Individual drug counseling
7. Group drug counseling
8. MATRIX model of recovery from cocaine and methamphetamine disorders
9. Motivational enhancement therapy
10. Motivational interviewing
11. Twelve-step facilitation therapy

In addition, there are many effective pharmacotherapies for alcohol, nicotine and opioid addiction. These include medications used to manage withdrawal syndromes, as “replacement” medications for addiction to drugs like heroin or other opioid, and to reduce cravings and relapse risk. Medications are usually
used in conjunction with psychosocial therapies in the treatment of drug or alcohol addiction. Following are the most common medicines used to help individuals in recovery manage their addiction:

1. Alcohol: Disulfiram (Antabuse), Acamprosate (Campral), Naltrexone oral (ReVia) and injections (Vivitrol).
2. Opioids: Methadone, Naltrexone, Buprenorphine (Buprenex, Suboxone and Subutex).
4. Cocaine: Disulfiram (Antabuse), Topiramate, Modafinil (Provigil), Propranolol (Inderal), Naltrexone, Baclofen (Lioresal), TA CD (Cocaine Vaccine).

15.0 STAGE-12 MODEL

15.1 Active Ingredients: Counselor Behaviors Prescribed and Proscribed

All behavioral or psychosocial treatments include common factors as well as unique factors or active ingredients (Strupp & Hadley, 1979). Common factors refer to dimensions of treatment that are shared across most psychotherapies. These common factors include the provision of education, a convincing rationale for the treatment, enhancing expectations of improvement, provision of support and encouragement, and in particular, the quality of the therapeutic relationship (Rozenzweig, 1936; Castonquay, 1993). A positive therapeutic relationship, or alliance, has repeatedly been associated with better outcome in a range of psychotherapies (Horvath & Luborsky, 1993), including substance use (Luborsky et al., 1985; Carroll, Nich & Rounsaville, 1997; Connors, et al., 1997; Barber, et al., 2001). A positive working relationship is an essential component of virtually all therapies, yet, by itself, is not necessarily sufficient to produce change. Unique factors refer to a treatment’s active ingredients, or those techniques and interventions that distinguish or characterize particular psychotherapies. While common factors are shared, unique factors might include transference interpretations in psychodynamic psychotherapies or invoking the “Twelve Steps,” as in STAGE-12

STAGE-12, like most therapies, consists of a complex combination of common and unique factors. For example, in STAGE-12 mere delivery of factual information about 12-Step program tools without grounding in a positive therapeutic relationship may lead to a dry, overly didactic psycho-educational approach that alienates or bores patients and ultimately has the opposite effect of what was originally intended. It is important to recognize that STAGE-12 is thought to exert its effects through this intricate interplay of common and unique factors and a major task of the counselor is to achieve appropriate levels of balance between delivering the information about 12-Step recovery tools and attending to the relationship. For example, without a solid therapeutic alliance, it
is unlikely that a patient will either stay in treatment, be sufficiently involved to learn the use of 12-Step recovery tools, or to share successes and failures in trying to apply these tools to living. Rather, empathic delivery of knowledge about recovery tools to help the patient manage his/her life more effectively, with the counselor giving the message of, “I see you really struggling with craving. These are some suggestions of effective ways that others have used to deal with it,” may form the basis of a strong working alliance. To specify STAGE-12 in terms of its active ingredients and to clarify the range of counselor interventions that are consistent and inconsistent with this approach, STAGE-12 interventions will be described in terms of the system recommended by Waltz and colleagues (1993): First, STAGE-12’s essential and unique interventions, that is, the active ingredients that are specific and unique to STAGE-12; second, STAGE-12’s recommended interventions, those that are thought to be active and important, but which are not necessarily unique to STAGE-12; third, interventions, behaviors, or processes that are acceptable within the therapy but are not essential or unique; and finally, interventions, behaviors, or processes that are proscribed, or not consistent with this approach.

15.2 Essential and Unique Interventions

In STAGE-12, the active ingredients which distinguish it from other substance abuse treatments and that must be delivered in order to adequately expose the patient to STAGE-12 include:

1. Taking a drug history (or reviewing the history collected as part of the standard clinic intake process), identifying positive and negative consequences of drug use, and giving feedback as ground work to Step 1.

2. Providing education about: Steps 1, 2, and 3 of the 12-Step programs; the Process of Denial as it relates to the Grief Process; the 12-Step program view of addiction as a disease; the principles of recovery in 12-Step programs.

3. Examination of the patient’s “stinking thinking” about substance use and suggesting the use of slogans and the Serenity Prayer as tools to change this.

4. Exploring discrepancies between the patients’s stated goals and actions in terms of denial.

5. Identification of “People, Places, and Things” that could trigger drug use and identification of “People, Places, and Things” that support recovery.

6. Encouraging patients to actively work the “Twelve Steps” as the primary goal of treatment.

7. Supporting the point of view that the best chance of staying clean over the long run is if you accept the loss of control over drugs, and reach out to fellow recovering drug abusers through the 12-Step programs.
15.3 Recommended but Not Unique Interventions

Interventions or strategies that should be delivered during the course of each patient’s treatment, but are not necessarily unique to STAGE-12 include:

1. Discussing, reviewing, reformulating the patient’s goals for group or individual treatment
2. Monitoring drug use and craving
3. Monitoring general functioning
4. Exploring positive and negative consequences of drug use
5. Exploring the relationship of affect and drug abuse
6. Providing feedback on urinalysis results
7. Setting an agenda for the individual session
8. Covering content of group sessions based on session topic
9. Identifying alternative activities to replace drug use
10. Making group process comments as indicated
11. Discussing the advantages of abstinence as the goal of treatment
12. Exploration of patients’ commitment to abstinence
13. Supporting patient efforts to recover
14. Explaining the difference between a lapse and a relapse

15.4 Acceptable Interventions

Interventions that are not required or strongly recommended in the delivery of STAGE-12 but are compatible with this approach include:

1. Eliciting concerns about substance use and consequences
2. Self-disclosure by the counselor regarding their recovery status

15.5 Proscribed Interventions

Interventions that are not consistent with STAGE-12:

1. Functional analysis of substance use
2. Coping skills training
3. Practice of skills during sessions
4. Exploration of interpersonal aspects of substance use
5. Exploration of patient’s underlying conflicts or motives
6. Provision of reinforcement for abstinence (e.g., vouchers, tokens)

15.6 Compatibility with Adjunctive Treatments

This manual describes STAGE-12 for stimulant abuse or dependence as a short-term, combined individual plus group, stand alone intervention that can be integrated into ambulatory treatment programs. However, STAGE-12 is compatible with various other approaches and treatments that address a wide range of co-morbid problems and severity of the disorder. These include pharmacotherapy for drug use and/or concurrent psychiatric disorders, family
and couple therapy, vocational counseling, parenting skills, and so on. When STAGE-12 is provided as part of a larger treatment package, it is essential for the STAGE-12 counselor to maintain close and regular contact with other treatment providers.

16.0 STAGE-12 IN CONTRAST TO OTHER TREATMENTS

It is often easier to understand what a treatment is in terms of what it is not. This section discusses STAGE-12 for drug abuse and dependence in terms of its similarities and differences with other psychosocial treatments for substance abuse.

16.1 Approaches Most Similar to STAGE-12

STAGE-12 for drug abuse and dependence is similar to TSF for Alcohol Abuse and Dependence that was developed for Project MATCH (Nowinski, Baker & Carroll, 1992) and TSF for Drug Abuse and Dependence developed for the Yale University Psychotherapy Development Center (Baker, 1998). These treatments share the same goal: the active use of 12-Step programs as a means for the patient to remain drug free and using the 12-Step program to facilitate long-term recovery. While the techniques employed by both approaches are very similar, changes in TSF for Drug Abuse and Dependence reflect differences in the resources that are drawn upon for help (e.g., a greater focus on Narcotics Anonymous readings and material rather than Alcoholics Anonymous ratings and material). Also, while these previous versions of TSF have been developed and delivered as individual counseling, STAGE-12 is primarily a group-based intervention that is augmented by brief individual sessions.

Sometimes counselors and patients mistakenly confuse 12-step facilitative interventions such as TSF and STAGE-12 with 12-step support groups. They are not the same. TSF and STAGE-12 are formal, systematic, manualized counseling approaches, the goal of which is to facilitate patients’ involvement in community-based 12-step meetings and activities.

17.0 APPROACHES MOST DISSIMILAR TO STAGE-12

While it is important to recognize that all psychosocial treatments for drug abuse share a number of features and may overlap and closely resemble one another in several ways, there are some approaches that are more dissimilar to STAGE-12.

17.1 STAGE-12 vs. Cognitive-Behavioral Therapy (CBT)

STAGE-12 and other disease model approaches are dissimilar from CBT, or learning model approaches, in a number of ways. STAGE-12 is grounded in the concept of drug addiction as a spiritual and medical disease. The content of this treatment is consistent with the Twelve Steps of NA, CA, CMA or AA, with the primary emphasis given to Steps 1 through 3. In addition to abstinence from all psychoactive substances, patients are actively encouraged to attend self-help
meetings and to maintain journals of their 12-Step group attendance and participation. While STAGE-12 and CBT share some concepts, for example the similarity between STAGE-12’s *people, places, and things*, and CBT’s *high risk situations*, there are a number of important differences. STAGE-12 is grounded in a conception of addiction as a disease that can be controlled but never cured. CBT views addiction as a learned behavior that can be modified.

While learning model approaches emphasize self-control strategies, STAGE-12 emphasizes the patient’s acceptance of loss of control over substance use and other aspects of life due to the disease of addiction, and a willingness to follow suggestions from 12-Step programs to recover from addiction. With CBT-like models, the focus is on what the patient can do to recognize the processes and habits that underlie and maintain substance use, and what can be done to change them. The major change agent in STAGE-12 is involvement in the fellowship of 12-Step programs such as NA, CA, CMA or AA and working the 12 Steps. STAGE-12 assists the patient in overcoming his/her resistance to accepting help and suggestions. Behavioral learning approaches teach coping skills to replace old, unsuccessful coping strategies the patient may have used in the past (i.e., using drugs to deal with negative affect.) Contrasts between STAGE-12 and CBT are also found in the table below.

17.2 STAGE-12 vs. Interpersonal Therapy (IPT) and Supportive-Expressive Therapy (SET)

STAGE-12 is also different from Interpersonal Psychotherapy (IPT) (Rounsaville & Carroll, 1993) and Supportive-Expressive (SET) Therapy (Luborsky, 1984), a brief, dynamic form of therapy. IPT is based on the concept that substance abuse and dependence are intimately related to disorders in interpersonal functioning that may be associated with the onset or perpetuation of the disorder. IPT for substance dependence has four definitive characteristics: (1) adherence to a medical model of treatment, (2) focus on the patient’s difficulties in current interpersonal functioning, (3) brevity and consistency of focus, and (4) use of an exploratory stance by the counselor that is similar to that of supportive and expressive therapies.

IPT and SE differ from STAGE-12 in several ways: STAGE-12 is a structured approach, whereas IPT and SET are more exploratory. Extensive efforts are made in STAGE-12 to teach and encourage the patient to use the tools of 12-Step programs to address substance use as the primary problem, while the more exploratory approaches view substance use as a symptom of other difficulties and conflicts. As a result, substance abuse may not receive direct attention. Contrasts between IPT and STAGE-12 are also found in the table below.
### Contrasts Between STAGE-12 and Other Psychosocial Treatment

<table>
<thead>
<tr>
<th></th>
<th>TSF and STAGE-12</th>
<th>Cognitive-Behavioral (CBT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals of Treatment</strong></td>
<td>Encourage patient to accept the diagnosis of addiction and understand addiction as a progressive, fatal disease. Facilitate patient's integration into NA, CA, CMA or AA.</td>
<td>Help patient master coping behavior as effective alternative to drug use. Increase patient's self-efficacy.</td>
</tr>
<tr>
<td><strong>Approach Agent of Change</strong></td>
<td>Medical/disease oriented treatment. Fellowship/Higher Power</td>
<td>Behavioral treatment. Mastery of skills</td>
</tr>
<tr>
<td><strong>Labeling</strong></td>
<td>Labeling patient as addict is encouraged, as this label provides the framework for the treatment. Acceptance of the diagnosis is necessary; it determines a set of symptoms (e.g., loss of control, denial) and the steps required for recovery.</td>
<td>Labeling discouraged; drug abuse/dependence is conceived as over learned behavior that can be broken down into a finite set of discrete problem situations and behaviors.</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>Emphasis on loss of control. Patient cannot control drug use; as s/he has the disease, addiction, which s/he is powerless to control. Patient can control whether s/he has the next run, whether or not s/he uses NA/AA, whether or not patient harbors the idea that s/he can control drug use.</td>
<td>Emphasis on self-control. Patient makes decisions regarding drug use over which s/he has control. Patient can learn to understand and better control the decision-making process. Patient can exert self-control by choosing to engage in alternative behaviors.</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Patient responsible for own sobriety, by <em>working</em> the 12-Step program.</td>
<td>Patient responsible for own behavior. Emphasis on enhancing self-efficacy through skills training.</td>
</tr>
<tr>
<td><strong>Conception of Craving</strong></td>
<td>Because of disease processes, patient's body will crave drugs periodically. First use will trigger craving.</td>
<td>Craving as conditioned response. Craving can be coped with and reduced through stimulus control, urge control, etc.</td>
</tr>
<tr>
<td>Goals of Treatment</td>
<td>Motivational Enhancement (MET)</td>
<td>Interpersonal Therapy (IPT)</td>
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<tr>
<td></td>
<td>Maximize patient’s motivation and interpersonal problems associated with drug use.</td>
<td>Help patient develop more productive commitment to change his/her strategies for dealing with social and drug use.</td>
</tr>
<tr>
<td>Approach Agent of Change</td>
<td>Motivational Patient Readiness for change</td>
<td>Brief dynamic Treatment Acquisition of alternate strategies for meeting interpersonal needs</td>
</tr>
<tr>
<td>Labeling</td>
<td>Labeling is strongly discouraged; alternative conceptions of drug use are accepted/encouraged.</td>
<td>Labeling strongly discouraged; drug use seen as highly individualized and related to interpersonal context.</td>
</tr>
<tr>
<td>Control</td>
<td>Emphasis on choice. Patient has full control over decision to alter drug use.</td>
<td>Emphasis on self-control and the function that drug use serves for the patient. Symptom of drug use seen as a method of controlling environment and others to get needs met.</td>
</tr>
<tr>
<td>Conception of Craving</td>
<td>Patient free to develop and capable of developing strategies for dealing with craving on his/her own.</td>
<td>Signal of unresolved interpersonal problem. Patient should begin to translate what triggered craving into underlying interpersonal problem.</td>
</tr>
<tr>
<td>Strategies Addressing Ambivalence and Motivation</td>
<td>TSF and STAGE-12</td>
<td>Cognitive-Behavioral (CBT)</td>
</tr>
<tr>
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<tr>
<td>Remember last run. Addiction is a disease that motivates denial, educate patient re sinister aspects of disease. Current problems attributed to disease.</td>
<td></td>
<td>Positive/negative consequences of decisions to use or stay abstinent. Instill belief that effective coping will provide alternatives to drug use.</td>
</tr>
</tbody>
</table>

| Patient's Response to Substance Use | External, uniform approach. Use NA/AA social network (call sponsor, go to a meeting). Remember slogans (eschews alternative strategies, because of denial). “Do not think you can control the consequences of use.” | Individual approach. Develop and use individualized set of coping strategies (challenge cognitions, problem-solve, etc.). Examine antecedents, behaviors, and consequences. “You can learn skills to avoid lapses and prevent lapses from becoming relapse.” |

| Coping Behaviors | NA/AA fellowship/network constitutes a ready-made set of strategies and the one preferred solution. | Individualized set of strategies, generalizable problem-solving approach. Specific training in drug refusal skills, urge control, altering cognitions, emergency planning, etc. |

| Cognitions | Generally interpreted as evidence of denial, e.g., "stinking thinking". | Identified, examined, and challenged; encourage alternative perceptions/cognitions. |

| Handling Resistance | Confrontation of denial, exhortation of acceptance of addiction. | Application of problem-solving. Reinforcement of even minimal positive steps. |

| Role of Spouse/S.O. in Treatment | Reduce enabling, facilitate detaching, and seek support through Nar-Anon mutual support program. | Reinforce positive behavior change. |

| Phone Calls/Crises | Refer patient to NA sponsor. "Use the fellowship". | Encourage patient to implement coping and problem-solving strategies. |

<p>| Level of Structure | Highly directive and structured | Moderately directive and structured |</p>
<table>
<thead>
<tr>
<th></th>
<th><strong>Motivational Enhancement (MET)</strong></th>
<th><strong>Interpersonal Therapy (IPT)</strong></th>
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<tbody>
<tr>
<td>Strategies Addressing Ambivalence and Motivation</td>
<td>Acknowledge validity of patient feelings, elicit self-motivational statements. Empathic listening, primacy of patient's choice. FRAME.</td>
<td>Challenge positive view of drug effects and emphasize deleterious effects by enumerating cost repeatedly. Emphasize authentic gratification patient will experience from improved interpersonal functioning.</td>
</tr>
<tr>
<td>Patient's Response to Substance Use</td>
<td>Internal, individualized approach. Reviews progress, reviews/evaluates initial plan, and renews motivation and commitment. &quot;It's up to you whether you use or not.&quot;</td>
<td>Explore interpersonal consequences of drug use and what needs were being met by using. Call attention to discrepancy between patient's goals and drug use. &quot;You feel more sociable when you're high, yet your cocaine use has alienated your family. What about that?&quot;</td>
</tr>
<tr>
<td>Coping Behaviors</td>
<td>Patient free to develop own coping strategies. Development of strategies encouraged, but not provided by counselor.</td>
<td>Patient free to develop own coping strategies. Development of strategies is encouraged, but not provided by counselor. Encouragements to use social supports instead of drugs.</td>
</tr>
<tr>
<td>Cognitions</td>
<td>Accepted as valid, met with distorted exploration and reflection.</td>
<td>Exploration of effects of thinking on interpersonal relationships is critical.</td>
</tr>
<tr>
<td>Role of Spouse/S.O. in Treatment</td>
<td>Facilitate patient's motivation to change drug use behavior.</td>
<td>Explore ways of providing support to patient. Exploration of relationship vis-à-vis drug use.</td>
</tr>
<tr>
<td>Phone Calls/Crises</td>
<td>Meets patient's concerns with reflection.</td>
<td>Reinforce use of interpersonal contact instead of drugs in times of crisis. Encourage use of social supports.</td>
</tr>
<tr>
<td>Level of Structure</td>
<td>Patient structured</td>
<td>Moderately directive and loosely structured</td>
</tr>
</tbody>
</table>

18.0 STAGE-12 INDIVIDUAL SESSIONS

18.1 Introduction

Patients who participate in the STAGE-12 protocol will be those who are attending a Partial Hospital, Intensive Outpatient, Day or Evening ambulatory treatment program consisting of group and individual sessions for a minimum of five treatment hours per week. Therefore, they will already have been assessed and will meet specific criteria for this protocol.

The original Twelve-Step Facilitation Therapy (TSF) protocol from which STAGE-12 was developed included an introductory session involving an in depth assessment of the substance use disorder. However, the assessment of patients participating in this protocol will have been completed prior to participation in STAGE-12 by a member of the community treatment agency’s clinical staff. A thorough assessment usually involves gathering information on the following areas to determine the level of care needed for treatment of the substance use disorder.

1. *Current and past substance use history*: types, amounts and patterns of current and past substance use, frequency of use, age at first use for each substance, consequences of substance use (positive and negative), significant events associated with substance use disorders onset or relapse following periods of recovery.

2. *DSM-IV symptoms*: for diagnoses of intoxication, withdrawal, abuse and/or dependence. This includes information about withdrawal symptoms, physical or psychological dependence, tolerance changes, loss of control, and impact of substance use on psychosocial functioning.

3. *Motivation to change*: current level of acceptance of addiction and the need for treatment, and level of internal and external motivation to change.

4. *Past treatment experiences*: in addiction, mental health, or co-occurring treatment programs. In addition, it is helpful to gather information on treatment completion, AMA experiences, adherence to ambulatory treatment, medications for addiction, and outcomes of treatment.

5. *Experiences in mutual support groups*: experiences attending NA, CA, CMA, AA, other 12-Step or other mutual support groups for addiction or co-occurring disorders, use of a sponsor, “working” the 12-Steps, or service work within the program.

6. *Medical history*: current symptoms, disorders diagnosed or treated in the past, current medications, and any history of adverse reactions to medications. The medical history also includes a review of infectious diseases since these are common among individuals with substance use disorders.
7. **Psychiatric history:** current symptoms, disorders diagnosed in the past, current and past treatments of psychiatric illness, suicidality and homicidity.

8. **Family history:** impact of disorder(s) on family and children, family involvement in past treatment, current family relationships, and significant family history of medical, substance use or psychiatric disorders.

9. **Support system:** current family and social supports, access to a confidante, and involvement in community or recovery organizations.

10. **Other history:** work, school, legal, financial and spiritual issues.

In addition to a history obtained from clinical interviews and completion of questionnaires by the patient, laboratory tests and urinalysis are also used in the assessment process. Details of the results of these procedures and the history are used to determine current and past substance use disorder diagnoses, current severity of substance problems, other problems (medical, psychiatry, family, legal, occupational), current level of social support, relapse potential, and type of treatment needed (e.g., detoxification, residential, ambulatory, specialty program, etc). This information is also used to develop the initial treatment plan for a given patient with specific problems, goals and steps that will be used to reach these goals. This approach is compatible with the American Society on Addiction Medicine’s patient placement criteria, which evaluate all major dimensions of functioning to determine the type of treatment setting most appropriate for a specific patient.

Because the standard clinic intake assessment has already been completed, it is not necessary to do another history as part of the initial STAGE-12 individual session. However, it is important to review the intake assessment in order to get an overview of the individual’s substance abuse and treatment history, which will be reviewed with the individual during the initial session.

### 18.2 Individual Treatment Sessions

Three individual sessions are held to augment the group sessions, one each during week one, week three and at termination from the protocol (week 5-8). In order to facilitate the rolling admission to groups, two of the core sessions from the *TSF for Drug Abuse and Dependence* manual will be delivered as individual sessions. These include the introductory session and the termination session. These individual sessions will complement the STAGE-12 group sessions and will incorporate clinical strategies from the Intensive Referral Program (formerly called SECA), a model developed by Timko and colleagues (2006, 2007). All three sessions focus on the patient’s use of 12-step recovery programs in the community, emphasizing active participation in 12-step activities as a primary means to recovery from addiction. The program participant is encouraged to attend 12-step meetings, to secure a “sponsor” as a mentor in recovery, to turn to the fellowship of the 12-step program to gain support from other recovering addicted individuals to change thinking and behaviors that maintain substance use, to “work” the 12 steps, and to increase social involvement with other 12-step
members. A particularly salient aspect of the intervention noted by participants in Timko’s study was the positive experience of personal contact with a 12-step program volunteer who served as both a role model and an additional source of support.

The first individual session, incorporating the STAGE-12 introductory component and the phone call to a 12-step program member to arrange contact with the participant, is likely to require more time than the other two sessions, which have considerably less content to cover. A description of each individual session follows:

18.3 First Individual Session

In the first individual session, the counselor introduces and provides an overview of the STAGE-12 intervention, what is involved in the 5 group and 3 individual sessions, and where the person will be starting in the sequence of group sessions. The counselor discusses how these sessions will be integrated into the patient’s Partial Hospital, Intensive Outpatient, and Day or Evening ambulatory treatment program.

The objectives of the initial sessions are to:

1. Establish rapport with the patient.
2. Review the NA philosophy of addiction and recovery.
3. Briefly review the patient’s history of addiction and give feedback regarding the addiction. Ask the patient what they see regarding the addiction and then build a case that abstaining from drugs "one day at a time" is the best action to take with the help of NA, CA or CMA 12-Step programs.
4. Explain the STAGE-12 program and orient the patient to individual and group sessions.
5. Initiate the process of engaging the participant in active participation in 12-Step programs.
6. Facilitate the patient’s acceptance to meet with an NA, CA, CMA or AA “buddy” to serve as a bridge to participation in 12-Step programs.

This first session includes discussion of the patient’s history and future goals for sobriety and 12-Step program participation. The counselor provides information about specific 12-Step meetings and orients the patient to participation to NA, CA, CMA and AA. This includes the counselor giving the patient a schedule of AA, NA, CA, CMA and other self-help group meetings in the local area and encourages him/her to attend 12-Step self-help group meetings. The counselor also gives the patient a list of local meetings favored by other patients in the CTPs outpatient program, with the times and locations of, and directions to (by foot, car and public transportation) these meetings. In addition, the counselor gives the participant a handout on 12-Step self-help groups for alcohol and drug misuse (Using 12-Step Programs in Recovery: For Individuals with Alcohol or Drug Addiction) that provides an introduction to 12-Step philosophy and the
structure and terminology of 12-Step groups, addresses common concerns about participation and encourages participants to set goals for attending self-help, working the first Steps, joining a home group and obtaining a sponsor. The counselor reviews the handout with the patient.

This session also incorporates contact with an outside 12-Step member who agrees to serve as a “buddy” or a temporary sponsor to accompany the participant to an NA, CA, CMA or AA meeting following the procedures of the Intensive Referral Program. The counselor and patient may call a self-help group volunteer and make arrangements for this person to meet with participant so they can attend a 12-Step meeting together. If the patient is already active in NA, CA, CMA or AA and has a sponsor, this intervention may not be needed. The patient and counselor agree on the 12-Step meetings to be attended before the next session, and this agreement is written into the patient’s journal. Patients in the STAGE-12 condition are asked to keep this journal to record the meetings attended (dates, times, places) and, briefly, their personal reactions to and thoughts about the meetings (or their reasons for not attending). At the end of the session, the recovery task assignments to be reviewed at the next session are discussed.

Here is an outline of the basic elements involved in Session 1, with some additional information about the types of issues that might be covered in each element:

**STAGE-12 Session 1: Basic Elements**

1. **Build Rapport**
   - Why is the client coming for help at this time?
   - Were there any outside pressures from job, family, or the law?
   - How does then patient feel about coming for treatment?
   - If the patient was mandated to come, what possible benefits could the patient derive from treatment?
   - Give the patient an opportunity to tell his/her story briefly.

2. **Briefly Review the Client’s History of Addiction**
   - Drugs of use
   - Use of alcohol
   - Nature of use
   - Length of use
   - Positive and negative consequences of use
   - Ask client what he/she sees regarding the addiction

3. **Give Feedback Regarding the Addiction**
   - What you see regarding the addiction

4. **Briefly Review Treatment History and Experiences**
   1. **Prior Involvement in Treatment**
When?    What type?  
How often?  Completed?  
Outcome?  Longest period substance-free?

2. Prior Involvement in 12-Step Groups
   What groups?  How frequently attended?  
   Duration of attendance?  Other activities?  
   Had a sponsor?  Outcome?  
   General experience?  See it as resource?  
   Potential barriers, concerns, objections, negative expectancies?

5. Review the 12-Step Philosophy of Addiction and Recovery
   • Addiction is a **progressive** disease
   • One is **powerless** and unable to control the use of alcohol or drugs - they control your life
   • This results in **unmanageability**, which means that problems result
   • Abstaining from drugs “one day at a time” is the best action to take
   • One effective way to do this is with the help of AA, NA, CA or CMA 12-Step programs
   • Attending meetings and getting actively involved in 12-Step programs has been shown to help people stop using alcohol and drugs
   • The 12-Steps provide a guide for recovery and the fellowship provides the support

6. Provide Information on Addiction and 12-Step Approach
   • Counselor gives the participant a copy of *Using 12-Step Programs in Recovery: For Individuals with Alcohol or Drug Addiction*, which:
     - provides an introduction to 12-Step philosophy and the structure and terminology of 12-Step groups
     - addresses common concerns about participation
     - encourages participants to set goals for attending self-help, working the first Steps, joining a home group and obtaining a sponsor
   • Counselor reviews this handout with the patient

7. Explain the STAGE-12 Program
   • Orient the participant to individual and group sessions, including where he/she will begin in the sequence of groups
     - Combines two approaches, TSF and Intensive Referral, that have been shown to contribute to increased 12-Step engagement and improved outcomes
     - Combined individual and group counseling based on CTP input
- Individual sessions focus primarily on **GETTING ACTIVE** in 12-Step
- Group sessions focus primarily on **UNDERSTANDING** 12-Step principles (e.g., acceptance, surrender)
- Understanding + Action leads to better outcomes than either Understanding or Action alone

8. **Provide Client with Information about Local Meetings**
   - Give client a schedule of AA, NA, CA and other self-help group meetings in the local area and meetings favored by other participants who have been in the out-patient program
   - Include the times and locations of, and directions to (by foot, car and public transportation) these meetings
   - Encourage the participant to attend 12-Step meetings

9. **Arrange for 12-Step Counselor arranges a meeting between the client and a participating member of an AA, NA, CA or other self-help group**
   - Counselor arranges a meeting between the client and a participating member of an AA, NA, CA or other self-help group
   - The counselor and client call a 12-Step volunteer during the session
   - The volunteer arranges to meet the participant before a self-help meeting so that they can attend the meeting together

10. **Introduce the Participant Recovery Journal**
    - The client and counselor agree on the 12-Step meetings to be attended before the next session
    - Clients are asked to keep this journal to record the 12-Step meetings attended (dates, times, places) and, briefly, their personal reactions to and thoughts about the meetings (or their reasons for not attending).

18.4 **Second Individual Session**

The primary objective of the second individual session is to determine whether the individual has hooked up with a 12-Step “buddy” based on the arrangements made in Session 1 and whether he/she has attended a 12-Step meeting. The focus and content of the remaining portion of this session will vary, depending on whether the patient attended 12-Step meetings since the initial individual session. If the individual has attended a 12-Step meeting since the last session, explore the client’s reactions to the meeting and review his/her recovery tasks. Provide a list of currently available sponsors who are active in that group and recommend that the individual obtain a temporary sponsor from this list (by calling or by approaching the individual at a meeting), explaining that this sponsor could be replaced by a more permanent one when the participant is more familiar with other 12-Step members. Also, address any concerns the
client may have about asking for and working with a sponsor. If no meetings were attended, or if the client seems reluctant to attend meetings, the counselor explores this with the client in an attempt to understand this resistance, identify perceived and/or actual barriers, and problem solve ways of dealing with or overcoming these barriers. The counselor repeats the procedure of contacting a 12-Step volunteer to arrange to take the participant to a 12-Step meeting.

In addition, the following topics/issues should be reviewed. Review of Drug Urges and “Slips” or Episodes of Use

During individual session 2 (and also during session 3), the counselor reviews the patient’s attempts at maintaining abstinence, any strong drug cravings or thoughts about using substances since the last session, and any actual lapses or relapses to drug or alcohol use. Lapses and relapses are handled by examining the antecedents to the drug use, then suggesting appropriate 12-Step tools that might have been employed to avoid using drugs (meetings, contacting sponsor/peers, reading of recovery materials, writing in a journal, etc) Episodes of use are treated non-judgmentally and interpreted to be times when the power of the illness of drug dependence overcomes the patient’s coping abilities.

18.5 NA, CA, CMA or AA Meetings  
All headings need to be 18.4.2, 18.4.3 etc until “Third Individual Session/Termination from STAGE-12 Program”

The counselor congratulates the patient for any periods of drug abstinence/sobriety, and for efforts to remain abstinent one day at a time. The counselor explores the patient’s reactions to any 12-Step meetings attended. If no meetings were attended, or the patient seems reluctant to attend meetings, the counselor explores this with the patient in an attempt to understand this resistance.

18.6 Readings and Journal

A review of the patient’s reaction to assigned readings or journal give the counselor an opening to assist the patient in working through barriers that he or she may be experiencing in becoming actively involved in 12-Step programs.

18.7 Recovery Tasks

The counselor follows up on any other suggested recovery tasks such as contacting a sponsor or taking on service work at a meeting. This review of the week provides the patient a chance to talk about day-to-day life and provides the counselor with an opportunity to teach and encourage the use of the tools of 12-Step programs for dealing with life situations.

18.8 Wrap-Up

The counselor discusses strategies for staying sober during the coming week (or period between sessions). The counselor and patient discuss suggested recovery tasks, which may include readings from recovery literature, listening to recovery tapes, or performing recovery related activities such as contacting
recovering peers or going to 12-Step related social activities. Specific recovery tasks include:

- A mutually agreed upon list of 12-Step meetings to be attended.
- Suggested readings from NA, CA, CMA or AA texts:
  - Narcotics Anonymous ("Basic Text of NA").
  - Living Sober
  - It Works: How and Why

Other suggested readings or materials the counselor is familiar with and thinks the patient would benefit from reading may also be used. Mutual support programs such as NA and AA have an extensive recovery literature. In addition, major publishers of recovery literature also provide informational booklets, pamphlets, books and interactive workbooks that are used in the treatment of addiction.

18.9 Third Individual Session/Termination from STAGE-12 Program

The third and final individual session should take place during weeks 5-8 after the fifth group session. This session focuses on helping the participant evaluate the treatment experience in the STAGE-12 protocol, and establish goals for the future regarding the use of 12-Step programs for use in ongoing recovery. This session will also review recovery assignments and experiences in NA, CA, CMA or AA. It will focus on discussing the participant’s views of 12-Step programs now compared to prior to treatment. It will focus on finding an NA, CA, CMA or AA sponsor if the participant has been attending meetings. Or, if will focus on setting up a meeting with a 12-Step program volunteer if NA, CA, CMA or AA meetings have not been attended. Barriers to participation will also be discussed. Goals and plans for future 12-Step meeting attendance and involvement in the program will be discussed. Finally, the participant’s willingness to continue keeping a written journal will be reviewed.

In this final session, the counselor reviews the following issues:

1. **Meetings:** NA, CA, CMA, AA, and other 12-Step meeting attendance during the time in the protocol, plans for future meetings, resistance to ongoing meeting attendance and patient’s level of participation at meetings.

2. **Drug free days:** how is the patient doing living “one day at a time” as espoused by NA? How is the patient doing in regards to Step 1? What can the patient do differently next time? What people, places and/or things does he or she agree to change?

3. **Drug cravings:** how often did the patient crave drugs and to what degree? What did the patient do to manage drug cravings (give in and use; use other positive coping strategies)? How can the patient use NA, CA, CMA or AA to help with drug cravings in the future?

4. **Lapses or relapses:** if the patient used drugs or alcohol, where did this occur, when and with whom? What can the patient do differently next
time regarding changing people, places and things in order to reduce the risk of a lapse or relapse?

5. **Readings:** what recovery material is being read by the patient? What are the patient’s reactions to these readings? What questions does the patient have about addiction, recovery, or the use of mutual support programs from his or her readings?

6. **Getting a sponsor:** what progress is being made with a sponsor? If the patient has a sponsor, how has this aided recovery? How is the patient using a sponsor? If the patient has not obtained a sponsor yet, what is the basis of any resistance to getting one? What suggestions can the counselor make, and what commitments will the patient make regarding getting a sponsor?

7. **Telephone therapy:** how is the patient doing in regards to getting phone numbers of other members of NA, CA, CMA or AA, and calling them on the phone to get support for recovery?

8. **Evaluation of STAGE-12 experience:** how has the patient’s views on the following changed since starting treatment in STAGE 12:
   a. Addiction to stimulant drugs.
   b. Addiction as an illness vs. a character defect.
   c. The “addict” part of personality, and how this controls drug use.
   d. NA, CA, CMA or AA as a support to ongoing recovery from addiction (meetings, sponsor, getting active, calling 12-Step friends).
   e. Being dependent on drugs.
   f. Negative consequences of continued use.
   g. Most helpful parts of STAGE-12.
   h. Least helpful parts of STAGE-12.
   i. Treatment for addiction.
   j. The need for ongoing participation in 12-Step programs.
   k. Keeping a journal as part of ongoing recovery.

In helping patients evaluate their experiences with STAGE-12, the counselor needs to encourage honesty. Most likely different patients will have found different parts of the program more or less helpful in their recovery.

Regardless of the patient’s view of success in STAGE-12 treatment in regards to drug free days vs. lapses or relapses, treatment should end on a respectful note. The patient should be reminded how to contact and use 12-Step programs, which are available every day.
19.0 STAGE-12 GROUP TREATMENT SESSIONS

19.1 Structure of Group Sessions

Weekly group sessions of 90-minutes each are held for five weeks. The first 15-20 minutes of each group session is the “check-in” period during which time group participants share briefly their experiences or concerns regarding participating in 12-step programs since the previous sessions. During this check-in period, each participant shares his or her addiction, date of last drug use, and whether or not strong cravings for drugs or any episodes of drug use occurred since the previous session. However, if the group is particularly large, it is important and necessary to stick to the time frame even if this means that not all group members are able to share.

The next 45-60 minutes focus on a recovery oriented discussion of the group topic for the day. New material is discussed and the patients relate to this in a personalized manner to express their questions and concerns and to share their experiences. For example, in the session on “Acceptance,” patients may vary in what they share about accepting their addiction and the need for involvement in professional treatment and mutual support programs like NA, CA or AA. Or, the session on “Emotions” may review strategies to manage boredom or depression without relapsing to drug use.

The final 15-20 minutes of each group session reviews participants’ reactions to the material presented and discussed during the session, as well as their plans for the upcoming week regarding 12-step program participation (meetings, sponsor, calling NA members on the telephone, service at meetings, and reading NA or recovery literature).

19.2 Topics of Group Sessions

The five topics covered in the STAGE-12 group component include those listed below. Topics one through four were adapted from the TSF manual’s “core” topics and topic five was adapted from its “elective” topics.

1. Acceptance
2. People, Places and Things (Habits and Routines)
3. Surrender
4. Getting Active in 12-Step Programs
5. Managing Emotions

Each group session is structured and has a specific agenda with a topic, objectives and specific points for discussion. The group leader conducts the session in an interactive manner that engages patients in the discussion of the topic areas covered by sharing personal experiences, opinions and questions. Given that a rolling admission procedure will be used, participants can enter the groups at any point in the sequence of topics/sessions. They will be informed about where they will be joining the group in the first STAGE-12 individual counseling session to help orient them to sequence. Group counselors will need
to help integrate the new members into the group membership and process as they join.

To supplement learning from the group sessions, patients are asked to keep a personal journal, and recovery tasks are suggested each week to complete between sessions. Central to this approach is strong encouragement to attend several different kinds of 12-Step meetings per week and to read the 12-Step program literature throughout the course of treatment.

19.3 Written Journal

Each program participant will be asked to maintain a "personal journal," which is summarized in group at the beginning of each session. In this journal, the patient records the following:

1. All meetings attending since the last group sessions (dates, times, places)
2. Personal reactions to the meetings (thoughts, feelings, experiences)
3. Reactions to suggested readings
4. Any actual episodes of drug or alcohol use (lapses or relapses)
5. Reactions to recovery tasks
6. Strong cravings or urges to use drugs and how the patient managed these

When offering patients advice or giving them recovery tasks from the point of view of a 12-Step oriented program like STAGE-12, it is important to remember that 12-Step programs prefer the word suggestion to the word rule. Specific strategies for staying clean are as varied as the number of people who are in the 12-Step fellowship. It is important for each individual drug abuser to do what works for them to maintain abstinence.

19.4 Technical Problems

In keeping with the spirit of 12-Step programs, counselors using this manual are advised to avoid making assignments, in the sense of telling patients what they should do. The 12-Step tradition tells us that it is better to share "some things that other addicts have found helpful in your situation" without pressing for the kind of commitment that other therapies might.

Suggestions made by the 12-Step counselor should be consistent with what is found in 12-Step publications. Examples of strategies for dealing with urges and slips that are consistent with 12-Step programs include:

1. Calling a friend
2. Going to an NA, CA, CMA or AA meeting
3. Going to a 12-Step social event
4. Calling your sponsor
5. Calling the NA, CA, CMA or AA Hotline
6. Changing a habit pattern
7. Distracting yourself
Aside from being consistent with 12-Step traditions, recovery tasks should be specific, and the counselor should make a point of following up on them at the beginning of each session.

Finally, the counselor should be familiar with 12-Step literature, as well as with the locations, times, and types of meetings that may be available in the area. When dealing with technical problems like those described below, the goal is to determine if the patient is still interested in and capable of participating in therapy.

19.5 Troubleshooting-Lateness/Cancellations
Patient is consistently late, cancels or fails to show for group or individual sessions. In individual sessions, the counselor can explore the reason why the patient was late, missed, or rescheduled a therapy session. Listen for evidence of denial. “I can do this on my own,” “I don’t think my problem is as bad as you seen to think it is,” “I don’t believe I’ve lost control of my drug use,” “I was busy and forgot about our session,” and so on.

Group sessions can also discuss the issue of missed sessions or lateness, which provides a learning opportunity for other patients present. Often, they will offer their ideas on why other members miss or come late to group sessions.

When denial is the issue, the counselor should identify and interpret it as part of the illness of addiction. Remember that denial is not necessarily verbalized, but may be acted out through behavior or through various excuses for not going to meetings, not completing suggested readings, missing group or individual sessions and not following through with agreements made in group sessions (e.g., seeking a sponsor or going to specific NA meetings). One form that denial often takes is chronic lateness and cancellations. If this pattern emerges, but patients refuse to “own up to it” as resistance, try to engage them in a frank and non-judgmental discussion of their reservations about treatment. If the pattern continues, a more open discussion about motivation for treatment may be helpful. Eliciting feedback from other groups members can help as well (e.g., “What do other group members think about what Lisa said was the reason she missed the past two group sessions”).

Keep in mind that this form of resistance does not invariably reflect denial of the addiction. In some cases, it may be due to a fear of failure or social anxiety or shyness. Help resistant patients clarify their reasons for resisting active involvement in 12-Step programs and work from there.

19.6 Patient Comes to Group Session High on Drugs or Alcohol.
Do not proceed with a session if a patient shows up under the influence of drugs or alcohol. Ask the patient to call the NA, CA, CMA or AA Hotline, a 12-Step program friend, or a sponsor. If the person is not willing to do this, encourage him to call a significant other to arrange for transportation home. Other treatment
program staff may have to help should this occur so that group sessions are conducted on time.

19.7 Patient Resists Going to NA, CA, AA or CMA Meetings
This common resistance can take many forms, from making excuses to criticizing the 12-Step meetings or their members. Interpret this respectfully as denial, as evidence of the patient's refusal to accept loss of control and the fact that drugs are making life progressively more unmanageable (Step 1). It is appropriate to coach patients regarding how to go to a meeting and what to expect. The counselor should not offer to take patients to a meeting but may do anything reasonable short of that, such as role-playing or arranging for an escort through various 12-Step program contacts the counselor has developed, following the procedures of the intensive referral process used in the STAGE-12 individual counseling sessions.

If a patient continues to resist going to meetings, patiently persist in trying to get this person to make definite commitments to meetings, using the NA, CA, CMA or AA meeting schedules to identify specific meetings to attend. However, a STAGE-12 counselor should never terminate a patient for refusing to go to meetings, as this would be inconsistent with 12-Step program philosophy of recovery.

19.8 Patient Uses Other Types of Drugs or Alcohol
Substance substitution is one symptom of addiction and should be interpreted as such if the patient appears to be using a substitute for their primary drug of choice. Addicted individuals cannot be allowed to believe that they can safely use other substances, for two reasons. First, use of another substance will reduce resistance to use of the patient's substance of choice. Second, there is a risk of cross-addiction (multiple addiction) if the patient turns to a substitute mood-altering substance.

19.9 Response to Emergencies
When working with patients who may be actively using drugs or alcohol, or whose abstinence is compromised by lapses or relapses, it is not uncommon for counselors to be confronted by various emergencies. Typical examples of such emergencies include:

1. Getting arrested for drug related charges.
2. Having a serious family dispute as a result of drug use.
3. Feeling depressed about being dependent on drugs.
4. Getting into trouble on the job as a consequence of drug use.
5. Needing medical detoxification as a consequence of a binge.
6. Re-awakening of intense urges to use drugs and fear of full blown relapse.

Usually, in times of crisis, the STAGE-12 counselor should consistently encourage patients to turn to the resources of 12-Step programs as the basis for
their recovery. The counselor may offer specific advice and help in this regard, such as assisting the patient in contacting the NA Hotline or the patient's sponsor.

Serious psychiatric (suicidality, psychosis, violence, self-injury) or medical emergencies (need for detoxification from addictive substances) require either an emergency session with the counselor, a referral to an emergency mental health service, or to a hospital emergency room for evaluation and possible intervention. In such instances, patients' continued participation in the STAGE-12 program may require review.

19.10 Group Process Issues

In addition to problems experienced in recovery or participation in 12-Step programs, problems are also commonly encountered in the group “process.” These problems may require the Group Counselor to intervene to help the group address them. Following is a discussion of some of the more common group process problems and some suggested strategies for the Group Counselor.

19.11 A group member dominates the discussion or always brings the discussion back to himself

The Group Counselor can thank the member for the contributions and then elicit opinions and experiences from other group members. If the group member persistently tries to dominate group discussions or always turns the discussion back to his own problems or issues, this behavior pattern can be pointed out by the Group Counselor to make this member and other group members aware of the behavior. The other members can be asked how they feel about the member's dominating the discussion, and how they want to deal with this in a way that is satisfying to everyone in the group. Even though this creates a problem on one level, on another level some group members find that it creates a safety net for them because they may believe they don’t have to self-disclose personal problems or feelings as long as another member is taking up the group time. For example, if Levon is dominating the discussion of people, places, and things, the Group Counselor could say to the group “Levon has shared his experiences with people, places and things. Now, let’s hear from some others. Megan, what are your experiences with people, places, and things in relation to your cocaine addiction?”
19.12 A member does not disclose any personal information or open up much in the group session

The Group Counselor can share his/her observations about the member’s behavior, generalizing the issues that group members have talking about any difficulties that contribute to problems in self-disclosing (e.g., shame, shyness, social anxiety). Discussion can then focus on ways this member (or other group members who have trouble self-disclosing) can gradually learn to trust the group and self-disclose personal thoughts, feelings, problems or concerns. The Group Counselor can also mention that learning to share in the STAGE-12 group may help members feel more comfortable sharing at NA, CA, CMA or AA meetings. For example, if Robert shies away from sharing personal information when the group is discussing spirituality, the Group Leader might say “Robert, you appear to be a bit uncomfortable with our discussion about a Higher Power. We would be interested in hearing your opinions and any concerns you have about using a Higher Power in Recovery.”

19.13 A member rejects the input, advice or feedback of other group members regarding 12-Step involvement or recovery from addiction

The Group Counselor can point out this pattern and engage the group in a discussion of why this pattern is occurring. Members’ who offer help and support only to have their attempts rejected can be asked to talk about what this feels like so that the member rejecting their help is aware of the impact of this behavioral pattern on others. For example, if Lisa rejects ideas shared by the group on asking a member of NA to be her sponsor, the Group Counselor could say “Lisa, other group members strongly recommended that you not get a male NA sponsor, but you seem to disagree with this. Why do you think they are suggesting you stick with a female when you get a sponsor?”

19.14 A member can only pay attention when the discussion focuses on his problems or who interrupts others when they talk

The Group Counselor can point out his/her observations of the group member and discuss the reasons for this behavior. The group can then engage in a discussion of the effects of this behavior (e.g., upsets other members, turns them off, makes them feel like their problems aren’t important) and the importance of “giving and receiving” mutual support by listening to each other’s concerns and problems. For example, if John keeps jumping into the group discussion about the Steps and cutting other members off, the Group Leader may say “John, I’m glad you are freely expressing your opinions, but you’re cutting other people off. I’d like you to sit back and listen for awhile.”
19.15 A member wants easy answers to problems or is quick to provide easy solutions to others when they discuss personal problems

The Group Counselor can share his/her observations of these behavioral patterns and ask the group to discuss the importance of taking responsibility to find solutions to their problems, and to identify more than one strategy to address a particular problem. The leader can emphasize that while there are many different alternative ways to resolve specific problems, seldom are there easy or simple solutions, and that time, patience and persistence are needed for group members to adequately resolve problems. When a group member provides an easy solution, the Group Counselor can acknowledge that this is one strategy that may help some people, but it is also helpful to have other strategies. The Counselor can then engage the group in a discussion of other strategies to resolve the problem under discussion. Finally, the Group Counselor can emphasize to the group that learning how to think about problem solving is just as important as dealing with specific problems since everyone in the group will continue to face multiple problems in their ongoing recovery. For example, if Trina repeatedly asks group members what she should do when she has strong cravings for meth, the Group Counselor could ask her “Trina, what do you think is one or two things you can do to not give in to your cravings for meth? There have been times when you did manage your cravings. What helped you?”
20.0 STAGE-12 GROUP TOPIC #1: ACCEPTANCE (STEP 1)

20.1 Objectives of Group Session #1

1. Review format of STAGE-12 group sessions and recovery journal assignments.
2. Provide a brief overview of the 12-Step program of NA, CA, CMA and AA.
3. Review and the key concepts of Step 1: Powerlessness, unmanageability, and denial.

20.2 Methods and Points for Group Discussion

1. Use a brief presentation and an interactive discussion format to review the content of this group session. Elicit experiences and examples from group members related to the content as it is reviewed in group.
2. Review format of group sessions.
   a. Each session will start with a check-in of 15-20 minutes.
   b. During this time, group members will briefly report on any substance use, strong urges or desires to use drugs, involvement in 12-step meetings and use of the “tools” of recovery, and completed journal assignments.
   c. This will be followed by a 45-60 minute discussion of group topic.
   d. Each session will end with a check-out of 15-20 minutes.
3. Review the use of recovery journals while in STAGE-12.
   a. Journals will be kept by group participants to summarize their experiences in 12-Step programs.
   b. Information in journals will include meetings attended as well as patients’ responses and experiences to meetings: what they liked or disliked, what they learned, how they felt attending meetings.
   c. Some entries of group participants may be briefly shared during the check-in phase of the group.
4. Discuss how 12-Step programs are a major source of support in recovery from addiction. These include NA, CA, CMA, AA and many other 12-Step programs. These programs involve many components such as:
   a. Meetings
   b. Sponsorship
   c. 12-Steps
   d. Recovery events
   e. Readings on addiction and recovery
   f. Service
   g. Slogans
5. State that the five group sessions will focus to a large extent on helping members understand and get actively involved in the 12-Step program. Today’s discussion will focus on Step 1.

6. **Step 1**: Ask a group member to write this Step on a board or flip chart and then read it aloud. “**We** admitted that we were **powerless** over our addiction and that our lives had become **unmanageable**.”

7. Ask the group what this Step means to them. Some patients may respond that they think it means that they are **helpless** over their addiction and insist that they are still in control, or that they cannot change. Others may not see any connection between their use and the unmanageability in their lives. Break the Step down into three key words: we, powerless, unmanageability.
   a. **We**: the 12-Step program works on inter-dependence among members. People get better by helping each other. One slogan that reflects this is: “**You alone can do it, but you can’t do it alone.**” Each recovering person is responsible to make the efforts to stay sober, but they have the support of other recovering persons. Remind the group that recovery works best when it is seen as a “we” process rather than an “I” process.
   b. **Powerless**: rephrase this concept to accepting a “limitation.” Everyone is faced with accepting limitations of one kind or another in their lives. Ask the group members what kind of limitations they have had to face in their lives. Most will come up with several examples. In this case, the limitation is that the patients can no longer use drugs **safely**. Most patients are experts on how to use drugs; however, they can no longer use safely. Do the patients believe that they can still control their drug use? This concept seems easily grasped by most patients. While they are powerless over the fact that they can no longer use safely, they have the power to do something about it. This is the paradox of accepting “powerlessness.” How does it feel to be powerless? Anger and sadness are common responses. Ask the patients if they have ever accepted a limitation in another part of their life. What was that like? What were their thoughts and feelings about that experience?
   c. **Unmanageability**: ask the group what this term means to them, and to give personal examples of “unmanageability” in their life related to drug use. For those patients who resist the idea of their lives becoming unmanageable, suggest that they think about the history of their drug use and the effects on them and their family. Unmanageability is all of the negative consequences that have occurred throughout the patient’s substance use.

8. **Grief Process**: explain to the group that the natural human response to facing a limitation (**powerlessness** and **unmanageability**) is grief. The first
stage of the grief process is denial. As one moves through the process of acceptance of being “powerless” the stages that one experiences are similar to those of accepting loss. Some patients may experience a “loss” related to addiction as well as their lifestyle. This explanation helps to humanize the experience of denial with the patients. Outline the stages of grieving and assure the patients that this is a process with movement back and forth among the stages, and that 12-Step programs help with this process.

a. **Stages of Grief:** these include 1) denial; 2) anger; 3) sadness, sorrow or depression; 4) bargaining; and 5) acceptance.

b. **Denial:** explore with the patients how they have used denial in relation to their disease of addiction. Review some examples of denial:

- Simple Denial: refusing to discuss drug use; resisting doing a serious drug use history; refusing to acknowledge the real consequences of using; rejecting clear evidence of tolerance; and refusing to attend 12-Step meetings.
- Minimizing one’s own use and maximizing others’ use.
- Avoidance through sleep, isolation, other compulsive behavior, work.
- Rationalizing or finding excuses to use
- Distracting or changing the topic away from one’s drug use.
- Contrasting self with others, believing, “I’m different.”
- Pseudo choice or “I really wanted to experience those negative consequences!”
- Bargaining to placate self or others.

9. Ask the group members for **personal examples of denial.** This is a good point to talk about the dual nature of addiction. Drawing a rough outline of a person, indicate one “healthy” part, a small part, that wants recovery today, then indicate another “addicted” part, much larger, that pulls the person to want to use drugs. This much larger part is composed of many voices that talk to the patient or the Anti-recovery Committee. Ask the patients what messages that they give themselves about using. Note these next to the figure on the using side. This is a catalog of the patients’ denial. The Anti-recovery Committee never completely goes away. An NA slogan is that “While I am in the room getting recovery, my disease is in the parking lot doing push-ups!” The job of recovery is to strengthen the recovering part, the human part. Ask the patients how they can do this. Suggest that 12-Step programs offer support and positive messages about recovery and living.

10. **Review the stages of acceptance** and ask the patient to pick where they fit relative to these stages and to identify where they are in the process of denial versus acceptance.
a. **Stage 1:** I have a problem with drugs.
b. **Stage 2:** Using is gradually making my life more difficult and is causing problems for me.
c. **Stage 3:** Since I have lost my ability to limit my use of drugs, the only alternative that makes sense is to stop using.

11. **Summarize** this portion of the session with a brief recap of how 12-Step programs view the disease of addiction:
   a. There is no cure, only recovery.
   b. Abstinence—*one day at a time*—is the only option that works.
   c. Self-reliance and willpower are not enough. The support of peers is vital.
   d. Remind the patient that the goal of 12-Step programs is to maintain abstinence by avoiding the first use, *one day at a time*.

20.3 **Recovery Tasks**

1. The last 15-20 minutes of the group session focuses on what recovery tasks the patients will do during the week related to 12-Step programs. Ask patients about which specific 12-Step meetings they will attend during the week.

Remind them to keep their journal and instruct them to complete the written questions on the “First Step Worksheet.”

2. Suggested readings include:
   b. It works How and Why (Narcotics Anonymous) pp. 5-16
   c. Living Sober (Alcoholics Anonymous, 1975, pp. 7–10)

20.4 **Wrap-Up**

Before ending the session, ask the group members what they understood to be the gist of the session. Then ask them if they understand the recovery task assignments and ask for their commitment to follow through on them.

20.5 **Troubleshooting**

Once the concept of denial is presented, slips and resistance to getting involved in 12-Step programs can be interpreted in this light. These interpretations should be made frankly and repeatedly, though non-judgmentally. One approach to denial regards it as a normal part of the grief process. People seem to be naturally predisposed to deny losses and limitations, and drug dependence represents both. Here are some examples of interpretations that reflect this point of view:

1. “I think that part of your unwillingness to go to meetings is denial. I think there’s a part of you that does not want to accept this limitation — that you are drug dependent and you have to give up using drugs. That part of you wants you to avoid going to an NA, CA, CMA or AA meeting.”
2. “You slipped because you fooled yourself into thinking you were safe. So you met with your old friends, thinking you could do that and not use.”

3. “The part of you that wants to deny your addiction tells you that you can control your use that it was okay for you to use at a party. You fooled yourself into believing that you could limit your use, because you wanted to believe that.”

4. “I know you don’t like to hear this, but I see your denial at work again. The part of you that still wants to use — that doesn’t want to let go of drugs was telling you that you could use just a little, and that you would be able to stop there, even though experience proves you can’t.”

A second way of conceptualizing denial is to think of it as “insanity” as that word is used in 12-Step programs. Addiction as a form of insanity is implied in Step 2 (“Came to believe that a Power greater than ourselves could restore us to sanity”). The form of insanity involved in addiction is the addict’s belief (delusional because it flies in the face of experience) that they can use safely.

Addiction has been described as an illness of the mind as much as an illness of the body. The addict rationalizes using and creates an illusion of choice when, in fact, using is an obsession that leaves no room for free will or conscious (rational) choice. From this perspective, resistance to accepting a diagnosis of addiction or of continuing to think and act in ways that promote using are aspects of addiction itself, just as much as physical tolerance is. The counselor can interpret resistance in these terms as follows:

“Addiction is in fact an illness — an illness of the mind and of the body. It affects you physically — for example, you’ve had heart palpitations from cocaine. It also affects you mentally — in the way you think, even when you’re clean. When you went to that party last weekend, you convinced yourself that it would be okay to use as long as you used only at the party. Then you went home and continued using until you passed out. That’s the illness at work. It’s called ‘stinking thinking’ in 12-Step programs.”

“From the 12-Step point of view, that fact that you don’t want to go to meetings is just another symptom of the illness. You know from experience that once you start using you can’t stop until you run out of money or pass out, but you continue to convince yourself that you really don’t have this obsession or that you can control it in some way when the facts speak to the contrary.”

Finally, some counselors may find it helpful to approach denial by viewing it as an internal conflict. The addicted individual can be thought of as someone who has a “dual personality”: the part of the self that wants to stay clean and enjoys clean and sober consciousness and clean and sober living (the recovering personality) versus the part that resists the idea of limitation, craves drugs, and will do anything to get them (the addict personality). Recovery represents an ongoing struggle between these two forces within the drug dependent patient. The counselor needs to ally with the recovering personality and assist the patient
in strengthening it, while confronting the addict personality consistently but with respect and compassion. Keep this phrase in mind throughout treatment: Denial never sleeps. Recovery demands eternal vigilance, which is what active involvement in a 12-Step recovery program can provide.

In order to align effectively with the recovering personality within the patient, the counselor must understand that:

1. Addiction is more powerful than the patient’s individual willpower alone, so the addictive personality and denial will inevitably win out if the patient chooses to fight them without help in the form of a 12-Step program.

2. It is normal human tendency to resist accepting limitation and to test limitation. This is deadly to the addict in the long run.

The addicted person’s personality is cunning and clever and will make every effort to lower the defenses of the recovering personality by trying to convince the addict that s/he is safe (no longer needs NA, CA, CMA OR AA or can use safely). Some have compared being in recovery to walking up a down escalator: As soon as addicts stop working a recovery program, the illness will begin bringing them down. Alternatively, it could be said that recovery requires eternal vigilance.
21.0 STAGE-12 GROUP SESSION #1: FIRST STEP WORKSHEET

The first step of NA, CA, CMA or AA states “We admitted we were powerless over our addiction, that our lives had become unmanageable.” Experience has shown that people who have been able to remain clean and sober have come to terms with this statement as it applies to their lives. In order to assist you in taking this step, try honestly answering the following questions in your written journal. After that, discuss these with your sponsor (if you have one) or your counselor.

The first thing is to admit powerlessness, or, in other words, to say “I can't control my use of drugs, or the consequences of my use of drugs.”

1. How have drugs placed your life, or the lives of others, in jeopardy?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. How have you lost self-respect due to your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

3. How have you tried to control your use of drugs?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4. What types of physical abuse have happened to you, or others, as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
5. How do you feel about yourself for having a drug abuse or dependence problem?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Take an honest look at how the consequences of your drug use has affected you and others. This is “connecting the dots.” Looking back over your drug use answer the following questions.

1. What health problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. What family/personal problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

3. What sexual problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4. What legal problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

5. What financial problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
6. What work problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Remember that “loss of control” (powerlessness) and problems (unmanageability) are symptoms of the disease of drug dependence. In order to recover, people have admitted their limitations and accepted that the solution is to be open to support from others (NA, CA, CMA or AA) and to stay away from the first use, one day at a time!
22.0 STAGE-12 GROUP TOPIC #2: PEOPLE, PLACES, & THINGS

Objectives of Group Session #2

1. Review experiences in 12-step meetings, readings, urges or episodes of use (lapse or relapse).
2. Discuss the concept of “People, Places, and Things” in recovery from addiction.
3. Identify when to avoid certain people, places, events and things that pose a relapse risk.
4. Review strategies to manage people, places and things without using drugs.

22.1 Review and Check-in

1. Written Journal and Meetings: Ask if patients kept their written journal and attended any NA, CA, CMA or AA meetings. Invite some members to share parts of their journals.
   a. Did the patients attend any 12-Step meetings? If they did attend, discuss their reactions. This therapy is based on the belief that the best way for the patient to remain clean and sober is through active involvement in 12-Step recovery programs. Help the patients make sense of their experiences at 12-Step group meetings.
   b. If any patients failed to attend 12-Step meetings, explore their resistances. What interfered with their ability to access this resource for recovery?
   c. Some patients may act out their denial by failing to attend agreed upon meetings. When confronting denial remember to separate the person from their disease. Constructively point out how their failure to follow through with commitments is symptomatic of the disease of addiction.

2. Readings: Next, review the patients’ reactions or thoughts about any assigned readings or recovery activities.
   a. How did they relate to the readings or other members of 12-Step meetings? Some patients see themselves as different from others in 12-Step programs because they have not experienced the losses they hear or read about.
   b. The slogan “Y.E.T.” is fitting in this instance.
   c. This stands for “You’re Eligible Too!” meaning that anyone with an addictive disease, who continues to use drugs, will continue to experience progressively more severe symptoms and problems. Encourage patients to keep an open mind about what they hear or read.
3. **Drug Cravings**: Ask the patients if they experienced any thoughts about using or cravings to use. In early recovery from drug addiction strong cravings are common.
   a. How do patients experience drug cravings (e.g., physical signs, thoughts, and feelings)? How did the patients manage their cravings? Did they use any 12-Step tools?
   b. Offer support for all positive efforts made to avoid that first use of drugs.
   c. If needed, suggest other 12-Step tools such as calling other recovering peers, keeping to a routine schedule of meetings, putting off using and getting busy with safe activities, etc.

4. **Slips (lapses or relapses)**: If any patients used drugs and had a lapse or relapsed, review the events that occurred prior to re-starting their drug use.
   a. What set off this behavior to use drugs?
   b. Review the role that the patient’s denial may have played in continued use or their lapse or relapse.
   c. If necessary, encourage them to return to review Step 1 and focus on “acceptance.” At any time in the treatment process, it is reasonable to review the first Step with the patient.

5. **Getting Active**: Ask about what efforts group members made in becoming actively involved with 12-Step programs.
   a. What efforts have they made at obtaining a sponsor?
   b. Have they committed to any service work, participated in any social activities, obtained any new phone numbers or called any recovering peers? Be sure to congratulate the patient for each clean day since the last session.

22.2 **Methods and Points for Group Discussion of New Material**

1. Use a brief presentation and an interactive discussion format to review the content of this group session. Elicit experiences and example from group members related to the content as it is reviewed in group.

2. State that material for this group session deals with the pragmatic details of changing one’s lifestyle.
   a. Adages in 12-Step programs are that “if nothing changes, nothing changes” and “avoid slippery people, slippery places, and slippery things, unless you want to slip.”
   b. There are often powerful people, places, and things (habits and routines) connected with drug use. By identifying those people, places and things (habits or routines) that are dangerous to recovery and exploring new people, places and things that can be put in place that support
3. Lifestyle Agreement: The heart of this session is getting group members to complete and discuss the “Lifestyle Contract,” a table with four columns and three rows. Start with asking one or two patients to volunteer to complete this in front of other group members, which can help other group members understand how to personalize this recovery assignment.

   a. In the left column, the patients list the people, places and things (rituals or routines) that they believe are “dangerous to recovery” and what needs to be given up for recovery to progress.

   b. In the next column, patients list their “feelings” about these dangers to recovery. This helps patients become aware of how people, places and things can impact on their feelings, which in turn can impact on their behaviors.

   c. In the next column, patients list people, places and things that “support recovery” or that can be substituted to counteract the “dangers” to recovery.

   d. In the last column, patients list their feelings about these supports.

4. For those who are currently struggling with being clean and sober, ask who, where, and what the current dangers are to recovery.

   a. Be specific as possible. For example, list people by first name. Name as many as necessary, prompting the patient to think of any one else.

   b. Be specific about places and habits, routines and rituals as well.

5. Once the group members have exhausted all possibilities on the dangerous side, list those people, places, and things (habits, routines, and rituals) that are supportive of recovery.

   a. In early recovery from drug abuse or dependence, this list is typically short. By posting these on a board or flip chart the weight of the negative lifestyle can be dramatically seen by the patient.

   b. What can group members do to shift this balance and fill the void left by abandoning dangerous people, places, and things?

6. As part of this topic’s recovery tasks, contract with the group members to identify one new positive person, place and activity to shift the balance away from danger.

22.3 Recovery Tasks

The last part of the session focuses on the recovery tasks the patient will do during the upcoming week. Remind the patient of the three things they agreed to do to actively change their lifestyle during the exercise and get a commitment from them about specific 12-Step meetings they will attend during the week. Remind them to keep their journal. Suggested readings include:

Living Sober (Alcoholics Anonymous, 1975; chapters “Changing Old Routines,” (pages 19 – 22), and “Being Wary of Drinking Occasions” (pages 65 – 71)).

Wrap up the session by asking the patient what they understood to be the gist of the session. Then ask them if they understood the recovery task assignments and get their commitment to following through with them.

### 22.4 Troubleshooting

An issue that may arise doing this exercise is the patient’s resistance to letting go of some of those things listed on the dangerous side of the chart. Be sensitive to the process of letting go and grieving the past. Even though, for example, some people may be dangerous to a person’s recovery, they have also been a source of companionship. Some individuals, like spouses and lovers, may straddle the chart. Take time to explore what about the patient’s relationship with these people makes recovery difficult or what about it supports recovery? If the patient’s own home is dangerous to recovery, what can the patient do to change this? Does the patient need to leave this situation? Often, drug dependent patients live in toxic situations with cohorts who are also addicted or abusive. This exercise heightens the awareness of this conflict for some patients. What achievable goal can the patient work on to shift the balance towards recovery?
STAGE-12 GROUP SESSION #2: LIFESTYLE AGREEMENT

<table>
<thead>
<tr>
<th>DANGEROUS TO RECOVERY (what needs to be given up)</th>
<th>PATIENT’S FEELINGS ABOUT DANGERS</th>
<th>SUPPORTS RECOVERY (what needs to be substituted)</th>
<th>PATIENT’S FEELINGS ABOUT SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Things (rituals/routines)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STAGE-12 GROUP SESSION #2: LIFESTYLE AGREEMENT

#### Example of Levon

<table>
<thead>
<tr>
<th>DANGEROUS TO RECOVERY (what needs to be given up)</th>
<th>PATIENT’S FEELINGS ABOUT DANGERS</th>
<th>SUPPORTS RECOVERY (what needs to be substituted)</th>
<th>PATIENT’S FEELINGS ABOUT SUPPORT</th>
</tr>
</thead>
</table>
| **People**
Dealer John
Girlfriend
JJ (get high partner) | I feel he’s a threat to my recovery; he wants to make money, that’s all. She likes to get high more than me.
JJ and me are tight, but he don’t care about recovery. Be hard to cut him loose, but I got to. | NA sponsor and friends
Hang with brother and a couple friends who don’t get high.
Attend NA meetings at least every day for awhile.
Have to stick with others who don’t get high. | I feel they will support me, help me focus on my program and staying off drugs. These people care about my well-being and will help me. Makes me feel good. |
| **Places**
Bars
JJ’s house
Parties | I feel these places could be a negative influence on me and my recovery. I’d be tempted if I went to JJ’s. He always gets high.
I might miss parties for awhile, but I see the danger, even if I drink I’m more likely to use cocaine. | NA meetings.
Local recovery club; they sponsor dances and social events in addition to meetings.
My brother has an open invitation to go to his home every weekend. | I feel safer at these places.
I feel part of family when I hang with my brother.
I know I can get used to being bored without the action of bars and parties. |
| **Things (rituals and routines)**
Crack pipe
Friday and Saturday nights at bars and parties | I got rid of my pipe and feel it was the right thing to do.
I’m going to meetings and NA sponsored dances on weekends. | NA meetings
Brother’s house
Dances at recovery club | I feel good about staying connected to positive people.
Hanging with others in recovery is the only way for me to feel I can recover. |
23.0 STAGE-12 GROUP TOPIC #3: SURRENDER (STEPS 2 AND 3)

Objectives of Group Session #3

1. Review experiences in 12-step meetings, readings, urges or episodes of use (lapse or relapse).
2. Discuss the concept of “Surrender”
3. Review Steps 2 and 3 of NA, CA, CMA or AA.

23.1 Review and Check-In

1. **Written Journal and Meetings:** Begin the session with a review of the patients’ recovery efforts. Ask the patients if there is any part of their written journal that they wish to share in group. If they have not kept a journal, explore what obstacles prevented them from doing so.
   a. Did the patients attend 12-Step meetings? What were their reactions to meetings?
   b. Explore any resistance to or avoidance of meetings. How might this be a reflection of denial? Some patients present the situation of putting others’ needs and wants ahead of their own needs and wants. In this situation, the counselor may want to remind the patient that recovery must come first.
   c. The 12-Step adage to put “first things first” is appropriate here. Another slogan is “whatever you put in front of your recovery is the first thing you lose”.

2. **Recovery Tasks:** Review any reactions that the patient has from the previous session recovery task assignments and to determine if the patients follow through?
   a. If not, what got in their way of trying to add new people, places and things for recovery? What 12-Step tools might have helped the patient?
   b. Have group members made efforts to collect and use phone numbers of recovering peers they have met at meetings?
   c. Have they established a routine for attending 12-Step meetings on a regular basis?

3. **Readings:** Next, review the patients’ reactions or thoughts about any assigned readings or recovery activities.
   a. How did they relate to the readings or other members of 12-Step meetings? Some patients see themselves as different from others in 12-Step programs because they have not experienced the losses they hear or read about.
4. **Drug Cravings**: Ask the group members if they experienced any thoughts about using or cravings to use. In early recovery from drug addiction strong cravings are common.
   a. For group members who report strong urges, what strategies to delay the first use of drugs did they apply when they had these urges? What have they learned from this? How many clean and sober days did the patients accomplish? Congratulate all efforts made by the patient towards recovery.
   b. Offer support for all positive efforts made to avoid that first use of drugs.
   c. If needed, suggest other 12-Step tools such as calling other recovering peers, keeping to a routine schedule of meetings, putting off using and getting busy with safe activities, etc.

5. **Slips (Lapses)**: If any patients lapsed or relapsed, review the factors, events or situations that may have contributed to their drug use.
   a. Explore their “stinking thinking” and the possible role of denial.
   b. Identify dangerous people, places, and things.
   c. What internal feelings may have contributed to lapse or relapse?
   d. How did they (or could they) stop a lapse from becoming a full blown relapse?

6. **Getting Active**: Ask about what efforts group members made in becoming actively involved with 12-Step programs.
   a. What efforts have they made at obtaining a sponsor?
   b. Have they committed to any service work, participated in any social activities, obtained any new phone numbers or called any recovering peers? Be sure to congratulate the patients for their sober days and efforts at recovery.

23.2 **Methods and Points for Group Discussion of New Material**

1. Use a brief presentation and an interactive discussion format to review the content of this group session. Elicit experiences and example from group members related to the content as it is reviewed in group.

2. State that the new material is about the process of surrender, Steps 2 and 3 of the 12 Steps.
   a. Step 1, which deals with “powerlessness” and “unmanageability” can be phrased as “I can’t handle it.”
   b. Step 2 deals with belief that someone or something more powerful than the individual can help.
   c. Step 3 states that one is going to allow an outside force to help.

1. Acknowledge that some people are wary of the spiritual part of 12-Step programs. By this point in treatment, they may have already mentioned some of their concerns. This topic allows a structure for
discussion of these concerns. Begin with Step 2: “Came to believe that a power greater than ourselves could restore us to sanity.”

2. Ask the group members what the words of Step 2 mean to them. Reassure them that 12-Step fellowships are open to people of all beliefs and backgrounds, including atheists and agnostics.

3. As with the first Step, break Step 2 down into its key concepts. The action of the Step is “Came to believe.” Explore with the patient their beliefs. What are the nature and qualities of their “higher power”? How did they come to this belief? In what religious background was the patient raised? Has this been a positive or negative experience in their life? The group leader can write the responses of group members on a chalkboard or flip chart.

   a. If group members do not believe in a Higher Power, what would they be open to exploring or trying? How do group members define spirituality? At this point the counselor may want to differentiate between spirituality and religious belief.

   b. One definition of spirituality is: What gives a person a sense of purpose in their life. The process of becoming more spiritual is discussed in the “Big Book of AA (Alcoholics Anonymous, 1976, pp. 569–570).

   c. Some patients may feel ashamed and guilty about past behaviors that they do not believe that anyone or anything would care about their welfare. Others may be angry because of the traumatic events in their life. The counselor needs to be prepared and open to whatever issues patients present.

   d. Remind group members that recovery is a process that takes place over time. They may not believe today, but remain open to the possibility that they may come to believe in the future. Have a group member share a brief story of personal spiritual group or provide an example to the group.

1. **Power greater than ourselves**: explore ideas about what a “power greater than ourselves” means to group members.

   a. What forces outside of themselves have been more powerful than they? Did they ever have people that they looked up to or admired?

   b. What did they admire or respect about those people?

   c. What “Higher Powers” have been benign and loving?

   d. Share with the patients that recovery from addiction works best when it is with and through other people. The appropriate slogan is, “We alone can do it, but we can’t do it alone.”

   e. Explore with the patients what their relationship with their “higher power” is like? When was the last time the patient used prayer or meditation to help themselves? Does the patient want help? Does the patient believe s/he can be helped? Does the patient believe
that he is worth helping? What is the patient’s experience with asking for help? The issue is “trust” in other people.

2. **Restore us to sanity**: what were some of the “insane” behaviors that the group members engaged in while actively using drugs. These are all examples of “unmanageability” from Step 1.
   a. Some examples of the insanity of drug addiction are the poor decisions people make regarding managing their lives, the stubborn belief that they can stay in recovery without help (arrogance), and the sense of false pride that they don’t need others advice or help (defiance).
   b. One definition for “insanity” that comes from 12-Step programs is “continuing old behaviors and expecting new results.”
   c. Tying this all together, who then is responsible for restoring the addict to sanity? Clearly, the Step states that it is the job of one’s higher power. What is required in Step 2 is the belief that this can happen.
   d. Step 3: This Step has to do with allowing someone or something to help: “Made a decision to turn our will and our lives over to the care of God--as we understood him.”

3. **Write Step 3 on the board or flip chart**.
   a. The third Step is an action step. Like a key opening a locked door, moving away from the destruction, hopelessness and despair of addiction towards the hope and opportunity of recovery. The patients’ willingness to work this Step is demonstrated by their ability to accept and follow the suggestions of others about recovery. This may mean going to meetings and changing old habits and routines.
   b. Turning one’s will over to the care of a higher power does not mean that God will take care of everything in one’s life. It does mean that one will be presented with opportunities to take care of oneself. The individual is responsible for taking advantage of those opportunities to help him/herself.

4. **Made a decision**: discuss the key phrases in the Step and discuss the meaning of each. The action of the Step is that we “Made a decision.”
   a. While in Step 2 it was a process of coming to believe, here it is an action of decision. The decision is to trust one’s life to someone or something outside themselves.
   b. This decision is made repeatedly throughout recovery.
   c. This is a conscious and deliberate decision on the part of the patient.
5. **Turn our will and our lives over**: discuss what is meant in 12-Step programs by “turning it over.”
   a. What have been the patients’ experiences trusting others? Have they ever followed another’s advice? How did that turn out? How do patients decide who is trustworthy and who is not?
   b. What does the idea of “turning over” your will mean to the patients? Ask them if they believe that the experience of other addicts and alcoholics can have any relevance for them.
   c. Part of recovery may involve following a “common wisdom” such as that found in the 12 Steps. Working this Step means setting aside one’s will as it applies to using, and being open to following the suggestions of others about staying clean and sober.
   d. Some patients have major therapeutic issues around trust due to past traumas and may require more time and care with this Step (Baker and Triffleman, 1998).

6. **Care of God, as we understood Him**: The final key phrase is that one’s will is turned over to the, “care of God, as we understood Him”. Depending on personal experience, some people have a more caring concept of God than others. One suggestion for newcomers is to consider the possibility that the 12-Step recovery groups act as their “higher power” at first.

23.3 **Readings and Recovery Tasks**
1. Recovery tasks for this topic include readings from:
2. Ask group members what 12-Step group meetings they will attend between sessions, remind them to keep their journal and assign appropriate readings.
3. Instruct group members to complete the written handout “Thinking about a Spiritual vs. a Non-spiritual Way of Living” and bring to the session next week

Ask the group members to summarize the session and contract to follow through on their commitment to complete the agreed upon recovery tasks.

23.4 **Troubleshooting**
Again, when presenting material in Steps 1, 2 and 3, the best therapeutic stance is frank but non-judgmental. The counselor must believe in the illness model of addiction: that drug addiction is an illness affecting the body, mind, and spirit. The counselor must be prepared, however, for the patient to resist these ideas. Patients may criticize or demean NA, CA, CMA or AA and the 12 Steps or may attempt to draw the counselor into a discussion (or argument or debate) about whether addiction is really an illness or whether or not controlled use is possible.
They may attempt to change the agenda of this program, for example, to make it into marital therapy or psychodynamic psychotherapy. The counselor is advised not to enter into such debates, not to react defensively to criticism, and not to get off the track of the program. Keep the following in mind:

1. The objective of this STAGE-12 treatment is facilitation of the patient’s active involvement with 12-Step programs.

2. The counselor does not need to defend NA, CA, CMA or AA--it does very well on its own and will continue to whether or not this particular patient believes in it.

3. Believing that the 12 Steps can help, or in a Higher Power may be less important than simply going to meetings, which should be the first goal.

4. Addiction is a powerful and cunning illness, and patients may just insist on doing it their way for now.

5. Every clean and sober day (and sometimes every clean and sober hour) is important and should be recognized. Whenever you are confronted with a slip, think about now many clean and sober days (hours) the patient has had since seeing you last.

Addiction is an illness that defeats the will and causes addicts to regress, becoming more and more infantile (impulsive, self-centered) and difficult to deal with over time. It is important to separate the illness from the person it affects.
24.0 STAGE-12 RECOVERY ACTIVITY: SPIRITUALITY WORKSHEET

Thinking about a Spiritual vs. Non-Spiritual Way of Living

- Spirituality has to do with *meaning and purpose in life*; what it means to be human, who we are, and why we are here.
- Spirituality does **NOT** mean mysticism or spiritualism, or an Eastern religious practice.
- It is **NOT** a set of rules about what is good and bad, right and wrong.
- It is **NOT** a church doctrine or religious belief.
- Spirituality is a way of life, a way of thinking that helps sobriety.
- The following is a comparison of non-spiritual vs. a spiritual way of living and thinking:

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<thead>
<tr>
<th></th>
<th>NON-SPIRITUAL</th>
<th>SPIRITUAL</th>
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<tbody>
<tr>
<td>VALUE</td>
<td>Things</td>
<td>People</td>
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<tr>
<td>THE GOAL IS...</td>
<td>Acquire Things</td>
<td>Good Relationships</td>
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<td>THE GOOD LIFE IS...</td>
<td>Money</td>
<td>Friends</td>
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<td>GET THE GOOD LIFE BY...</td>
<td>Competing and Getting</td>
<td>Caring and Giving</td>
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<td>GET SELF-WORTH THROUGH...</td>
<td>Doing Being Perfect Success</td>
<td>Being</td>
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<td></td>
<td></td>
<td>(Who I am as a person)</td>
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<td>Being Human</td>
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<td></td>
<td>(Accepting my limits and dependences)</td>
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<td></td>
<td></td>
<td>Faithfulness</td>
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Adapted from: Woodard, A. & Wuelfing, J. (1991)
25.0 STAGE-12 GROUP TOPIC #4: GETTING ACTIVE

Objectives
1. Review patients’ experiences in recovery and participation in 12-Step programs in the past week, which should be documented in their journals.
2. Review differences between “abstinence” from substances and “recovery.”
3. Review specific strategies to be “active” in using 12-Step Programs: meetings, phone contact with other members, and getting and using an NA, CA or CMA sponsor.

25.1 Review and Check-in
1. Written Journal and Meetings: Ask if patients kept their written journal and attended any NA, CA, CMA or AA meetings. Invite some members to share parts of their journals.
   a. Did the patients attend any 12-Step meetings? If they did attend, discuss their reactions. This therapy is based on the belief that the best way for the patient to remain clean and sober is through active involvement in 12-Step recovery programs. Help the patients make sense of their experiences at 12-Step group meetings.
   b. If any patients failed to attend 12-Step meetings, explore their resistances. What interfered with their ability to access this resource for recovery?
   c. Some patients may act out their denial by failing to attend agreed upon meetings. When confronting denial remember to separate the person from their disease. Constructively point out how their failure to follow through with commitments is symptomatic of the disease of addiction.
2. Readings: Next, review the patients’ reactions or thoughts about any assigned readings or recovery activities.
3. Drug Cravings: Ask the patients if they experienced any thoughts about using or cravings to use. In early recovery from drug addiction strong cravings are common
4. Slips (lapses or relapses): If any patients used drugs and had a lapse or relapsed, review the events that occurred prior to re-starting their drug use.
   a. What set off this behavior? Be sure to congratulate the patients for stopping, returning to treatment and being honest with the group.
   b. Review what role the patient’s denial may have played in continued use or their lapse or relapse.
c. If necessary, encourage them to return to review Step 1 and focus on “acceptance.” At any time in the treatment process, it is reasonable to review the first Step with the patient.

5. **Getting Active:** Ask about what efforts group members made in becoming actively involved with 12-Step programs.
   a. What efforts have they made at obtaining a sponsor?
   b. Have they committed to any service work, participated in any social activities, obtained any new phone numbers or called any recovering peers? Be sure to congratulate the patient for each clean day since the last session.

25.2 **Methods and Points for Group Discussion of New Material**

1. Ask the group what they think is the difference between “abstinence from drugs” and “sobriety” (or recovery from addiction).
2. Discuss how just stopping drug use is not enough for recovery to progress as addiction affects all parts of a person’s life and often leaves a void in a person’s life that needs to be filled.
   a. Have a group member read the following passage, which is adapted from the recovery guide entitled *Living Sober*:
      “Just stopping drinking (using drugs) is not enough. Just not drinking (using drugs) is a negative sterile thing. That is clearly demonstrated by our experience. To stay stopped, we’ve found we need to put in place of our drinking (drug using) a positive program of action.” (*Living Sober*, Alcoholics Anonymous, 1975, p. 13).

25.3 **Getting Involved in 12-Step Programs**:

1. Ask the group members how they define “a program of action.” Use their ideas to discuss the following points and to give examples:
   a. Recovery, then, needs to address each of these areas of life
   b. This program of action involves “getting involved” in 12-Step programs since addiction is a disease that erodes a person’s life such as: mental abilities, emotional well-being, physical well-being, social relationships, spiritual well-being, and willpower.
2. Simply stopping drug use without changing one’s lifestyle, beliefs or attitudes leaves an addicted person vulnerable to relapse.
   a. Discuss the difference between “white knuckle” abstinence and sobriety with a program.
   b. White knuckle abstinence refers to someone who has stopped use, but is still unhappy because they are carrying around resentments and self-pity from the past.
c. Often addicted people can go for long stretches without using drugs, but because they do not use the tools of 12-Step recovery, they are more vulnerable to relapse when life presents a stressful situation.

25.4 12-Step Program Participation:

1. Getting involved in 12-Step programs and following the suggestions of what has been helpful to other addicts seems to be what has worked the best for most.

2. Sobriety with a program of recovery offers an opportunity to learn about living life on life’s terms without unnecessary feelings of resentment and self-pity.
   a. Ask the group members if they have noticed people in different stages of recovery at 12-Step meetings.
   b. What is the difference between those who have surrendered and are willing to follow suggestions and those who are still struggling with acceptance?
   c. Encourage the patients to stick with the winners in 12-Step programs. Their job is to learn from those who have recovered.

3. Another danger is growing complacent about recovery, a phenomenon that is common in early recovery.
   a. Some 12-Steppers refer to it as being on a “pink cloud.”
   b. The danger is that after a period of abstinence the person relaxes their participation in 12-Step recovery efforts (i.e., cutting back on the number of meetings they attend or allowing other activities, like work, to take precedence over recovery). This leaves a person vulnerable to relapse.

4. As mentioned in the material on Step 3, simply believing that a “higher power” can help is not enough. Each person is responsible for their own recovery.
   a. Put another way, “faith without work is dead.”
   b. Explain that getting active in 12-Step programs, in part, involves going to meetings, making use of telephone therapy, and making use of a sponsor.

5. Ask the group members what types of NA, CA, CMA or other 12-Step meetings they are attending, and their experiences in these recovery programs. If they only attend "speaker" meetings, encourage them to give the reasons for them and to be open to attend discussion meetings.
   a. Open vs. closed meetings.
   b. Speaker vs. discussion meetings (listening to a lead vs. sharing during discussions). If a patient is shy about
speaking at a meeting, ask group members to share strategies to increase verbal participation.

c. Home group where member attends the same meeting regularly.

d. Meetings on the 12-Steps of NA, CA, CMA.

e. Meetings to discuss “topics” of relevance to recovery from addiction.

f. Meetings to discuss specific readings from the NA “Basic Text.”

g. Meetings for specialty groups (women, gay men, health care professionals, etc.).

h. Where do patients “sit” during meetings? If they sit at the back alone, encourage them to move up to the front of the room. Some successful recovering addicts report that they choose to sit as close to the front as possible so they won’t be distracted during the meeting.

6. Encourage patients to attend different types and formats of meetings and to get involved in “service.”

   a. This may include helping to set up or clean up the meeting, make coffee, set out literature, etc.

   b. These jobs may be assigned during the business meeting held monthly following the regular NA, CA or CMA group meeting.

7. Encourage patients to meeting and interact with other people in recovery, before and after the meetings.

8. Discuss events sponsored by NA, CA or CMA such as dances, sporting events, holiday celebrations, dinners, and 24-hour meeting marathons.

9. Discuss frequency of meeting attendance.

   a. Depends on availability of meetings, motivation of each patient, severity of addiction, and level of commitment to recovery.

   b. Discuss commonly accepted guideline of attending “90 meetings in 90 days” in early recovery. However, provide support and encouragement for patients who attend meetings regardless of the frequency of attendance.

25.5 Telephone Therapy as a Recovery Tool

1. This is a long tradition in 12-Step programs dating back to the day when Bill Wilson, one of the co-founders of AA, used the telephone to contact another alcoholic for help.
a. This involves calling other 12-Step group members to gain support from them.

b. Ask the patients if they have observed other group members exchanging phone numbers. Advise them that someone may ask for their number. Explore what the patient’s experience has been with this and any resistance there may be to using the phone. Does the patient have a phone?

c. Examples of when to use the phone to reach out to recovering peers are:
   - Daily, to stay in touch and keep reaching out
   - Whenever there is an urge to use
   - As soon as possible after a slip
   - Whenever they feel hungry, angry, lonely, or tired
   - Whenever they feel overwhelmed
   - Whenever they feel good

d. Suggest to group members that they commit to obtaining phone numbers from at least three 12-Step program members during the coming week. For some patients, using the telephone has been a turning point in their recovery.
   - Advise them to get at least 2 numbers from same sex friends.
   - Suggest that each commit to calling at least one of these people and have a five-minute conversation with them.
   - If necessary, role play with the patients around asking for a phone number or talking to a recovering peer on the phone.

25.6 Sponsorship in AA and NA

1. Another important part of “getting active” involves finding a 12-Step sponsor.

   a. The tradition of sponsorship started in the early days of AA.
   b. Originally sponsors were people who were willing to take responsibility for visiting alcoholics in the hospital and for taking them to an AA meeting when they were discharged.
   c. Also, sponsors were used as resources for questions about material in the Alcoholics Anonymous literature.
   d. Today, in 12-Step programs, sponsorship has evolved into a way for newcomers to get practical advice and support from more experienced peers.
   e. Being a sponsor is both a privilege and a responsibility.
f. The job of a sponsor is to:

- Provide basic information about 12 Step programs and their traditions.
- Answer questions about working the Steps.
- Suggest 12-Step meetings that may be helpful.
- Introduce the newcomer to other recovering addicts.
- In short, the sponsor facilitates the newcomer’s participation in 12-Step recovery. A sponsor is not a counselor, a judge, or a parent. A good sponsor can only share by example and make suggestions to the newcomer.

25.7 Difference Between Sponsor and Counselor

1. Both a counselor and sponsor offer support and advice, however, there are important differences.

   a. A counselor knows the patient for a prescribed period of time, with specific appointment times for counseling sessions that focus on agreed upon goals.

   b. Once treatment is over, the counselor is no longer part of the patient’s life. A sponsor however, is available throughout the patient’s life, for as long as that relationship exists.

   c. A sponsor does not use therapeutic techniques to treat the patient, rather shares experience through self-disclosure and offers support. Whereas the roles of the counselor and the sponsor differ, it is not uncommon for each to give the patient similar advice.

25.8 Guidelines for Choosing a Sponsor:

   a. Sponsors should be of the same sex as the patient. (With Gay or Lesbian patients, care should be taken to avoid situations with the potential for sexual attraction, as involvement in an intimate relationship too early in recovery may trigger a relapse).

   b. Sponsors should be of the same age or a little older than the patient. Having shared experiences makes it easier to bond.

   c. Sponsors should have at least one full year of recovery from drugs and be actively working a 12-Step program, including going to meetings, using the telephone, and having their own sponsor.

25.9 How to Find a Sponsor

   a. The simplest way to find a sponsor is to ask for a “temporary sponsor” at an NA, CA, AA or CMA meeting.
b. As most patients are just getting involved in 12-Step recovery, they do not know many people well. A “temporary sponsor” can be available to a patient until they find someone else who can be their regular sponsor.

c. Let the patients know that there is nothing binding about sponsorship. If the relationship is not working out, it can be ended and another sponsor can be found.

d. Another way to find a sponsor is to observe and listen at meetings and look for someone they can relate to and whom they respect. Advise them to seek out someone who is happy in recovery and working a solid 12-Step program. Encourage the patient to then seek this person out, before and after meetings. Some patients are more shy than others. It may be necessary to role play asking someone to be a sponsor. Ask the patient to commit to looking for a sponsor over the next week, before the next session.

25.10 Recovery Tasks

Recovery tasks for this topic include the following readings:
- *Narcotics Anonymous* (Narcotics Anonymous, 1988) chapters 5, 8, 9; and
- “I Kept Coming Back”, pp. 238–242

Contract with the patient about which 12-Step meetings they will attend during the upcoming week. Ask the patient to continue to work towards the goal of “90 meetings in 90 days”. Ask what specific commitments they are willing to make to becoming more active in their recovery program (e.g., obtaining three phone numbers, calling at least one recovering peer, finding a sponsor).

25.11 Wrap-Up

In closing, ask the patient the gist of today’s session. Do they understand the recovery tasks and are they willing to follow through with them?

25.12 Troubleshooting

The counselor should be thoroughly familiar with the material in all readings: Narcotics Anonymous “Basic Text” (Narcotics Anonymous, 1988), *It Works: How and Why* (Narcotics Anonymous, 1993), and *Living Sober* (Alcoholics Anonymous, 1975), and should make efforts to integrate readings from all into each session. These books are filled with practical advice and wisdom and should be resources to counselor and patient alike. Do not hesitate to read a relevant passage together and discuss its relevance to any issue at hand.

A guide for the counselor with “Getting Active” is to meet the patients where they are in regards to accepting the need for involvement with 12-Step programs in an aware and sensitive manner. Getting Active is a process that takes place on a continuum of activity level. At one end of the continuum is the patient who flatly refuses to go to meetings, yet who appears for scheduled therapy sessions.
With this situation the counselor may want to suggest that the patient give 12-Step programs a fair chance. We are not asking that people join NA, CA, AA or CMA, but that they go to meetings, sit, listen, and process their experience with their groups to share their experiences.

Some addicted patients with co-occurring psychiatric disorders who have strong anxiety and fears about group meetings may need encouragement to gradually approach and experience meetings. For example, a patient was encouraged to first drive by the meeting site, then enter the parking lot, peek in the window of the meeting room, and finally enter the meeting. This process took several weeks.

Other patients may have fears of disclosing too much about themselves to strangers. In these cases encourage the patient to not share at first, but to sit and listen at meetings. If possible, encourage them to return to the same 12-Step group meetings on a regular basis. What the patient will discover is that what was once a room full of strangers has become a room full of friends.

As you process their experience at meetings in group sessions, explore in depth their feelings and thoughts about what was said and if any of the people in the meeting room seemed trustworthy. How might they begin to relate to these people? What might they have in common with some others in the meeting, etc? More typically, patients may attend one to two meetings per week at first. With the “Getting Active” topic, the goal is to increase the patient’s level of participation. This may include increasing the number of meetings attended during the week. The target goal is to attend daily 12-Step meetings for ninety days (90 in 90). If a person is attending only one meeting per week, a reasonable goal might be to push for three meetings per week.

Looking for a sponsor can be a daunting task for some patients. Some of our patients have been hurt by past personal relationships and are very slow to trust others. One helpful strategy is to ask the patient what qualifications s/he would look for or want in a sponsor. The purpose of this topic is to introduce the concept of sponsorship and encourage the patient to begin looking for a temporary sponsor. Temporary sponsors may or may not turn into permanent sponsors. The idea is that the relationship is on a trial basis for both parties. This may help alleviate some fears for patients.
26.0 STAGE-12 GROUP TOPIC 5: MANAGING EMOTIONS

OBJECTIVES

1. Review experiences in recovery and 12-Step programs during the past week, which should be documented in patients’ journals.

2. Help patients identify emotions which are most often associated with lapses and relapses to drug use after a period of recovery.

3. Review strategies that patients can use to manage their emotions to reduce their risk of relapse.

26.1 Review and Check-in

1. Written Journal, Meetings and Drug-Free Days: Ask if patients kept their written journal and invite some members to share parts of their journals.
   - Discuss groups that members attended and their reactions.
     a. Review their plans for future meetings.
     b. Discuss any resistance at this point to going to meetings.
     c. Review their level of participation in meetings.
     d. If they did attend, discuss their reactions.
     e. How many drug free days do group members have?
     f. How have patient done with living “one day at a time?”

2. Readings: Review the patients’ reactions or thoughts about any assigned readings or recovery activities.
   - What is being read?
   - What are group members' reactions to readings?
   - What questions do they have from these readings?

3. Drug Cravings and Urges to Use: Ask group members if they experienced any thoughts about using or cravings to use.
   - Where and when did drug cravings occur?
   - What did they do to manage cravings?
   - How could group members use AA, NA, CA and other 12-Step programs to help with cravings in the future?

2. Slips (Lapses): If any patients relapsed, or continued their active use, review the events that occurred prior to use.
   - Review where, when and with whom drugs or alcohol were used.
   - How are group members who lapsed or relapsed coming to terms with Step 1?
   - What can group members do differently in the future regarding people, places and things to change to reduce relapse risk?

3. Getting a Sponsor: Ask what efforts group members made in obtaining and using a sponsor in NA, CA, CMA or AA.
a. What progress has been made in getting and using a sponsor?
b. If they have not made any attempt, what is the basis of their resistance?
c. What suggestions can the group counselor make, and what commitments will the patients make to get a sponsor immediately?

4. **Using the Telephone**: Ask group members about their use of the telephone to stay connected to other members of support groups.

   a. How are they doing with this (who have they called? what have they discussed? how helpful has this been? if they have not called anyone, what are the reasons?).
   b. What suggestions can the group counselor make, and what commitments will the patients’ make to use the telephone to talk with others about recovery?

26.2 **Methods and Points for Group Discussion of New Material**

   1. Use a brief presentation and an interactive discussion format to review the content of this group session. Elicit experiences and example from group members related to the content as it is reviewed in group.
   2. The purpose of this group session is to help group members use of 12-Step tools for dealing with the stresses of everyday life, and manage their feelings without abusing drugs or alcohol.

   a. Inability to manage negative emotional states is one of the most common relapse risk factors in drug abuse and addiction.
   b. Awareness of feelings and skills in managing them reduce the risk of relapse, and enhance the quality of recovery.
   c. HALT: the advice given in 12-Step programs is “don’t let yourself get too hungry, too angry, too lonely, or too tired or you may have a slip (lapse).”
   d. Ask group members to identify feelings or emotions that they believe can increase their risk of relapse following a period of recovery.
   e. Review the following common feelings or emotional states that can precede relapse if the recovery individual does not recognize or use coping skills include:
      - Anger and resentment
      - Anxiety
      - Boredom or emptiness
      - Depression and grief
      - Loneliness
• Shame and guilty

1. The belief in 12-Step programs is that drug dependent persons are most vulnerable to the above emotions and most likely to use when they are either hungry or tired. Therefore, the program puts a strong emphasis on getting rest and eating well.

2. Many 12-Step slogans and sayings — *Easy Does It*, *Let Go and Let God*, *One Day at a Time*, *First Things First*, *Turn it Over* — relate to one or more of the above feelings.
   a. They reflect common wisdom for handling difficult emotions. Their value lies in their simplicity. Through these sayings and slogans, the fellowship teaches drug dependent persons how they can live without drugs. The counselor should therefore be familiar with these slogans and use them in treatment.
   b. In addition, teaching patients to connect particular slogans to situations in their lives that trigger risky emotions can be extremely helpful.

3. Fatigue: group members need to develop a lifestyle that allows them to get adequate rest and nutrition. A state of exhaustion is an invitation to use drugs for some.

4. Related to this topic is physical conditioning — a body in poor physical condition will get tired more quickly than one that is being taken care of.
   c. How much sleep does the patient get on average? Is this adequate? What changes, if any, could be made so the person could get more rest?
   d. Have you experienced using, or had a strong desire to use when you were especially tired?
   e. What is the overall state of the person’s health? Are they capable of doing some routine exercise to gain stamina?

5. Hunger: along with the need to avoid exhaustion, 12-Step programs emphasize the need for the recovering person to avoid excessive hunger. Regular meals are encouraged and, beyond that, the addicted individual is encouraged to snack so as to avoid getting too hungry. Some issues to discuss with group members include:
   a. What is your diet like now? What did it used to be like?
   b. Do you sometimes experience cravings for sweets?
   c. How can you satisfy this need? (fresh fruit can be helpful).

   a. Sometimes a source of anxiety can be from a sense of isolation, not having any one to trust or rely on when faced with a difficult life decision.
   b. What makes group members feel anxious or uneasy?
c. Review the Serenity Prayer and how group members can use this in their recovery.

“God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference.”

d. Discuss “existential anxiety,” the feeling of being isolated, of facing difficult decisions and choices but feeling totally alone in making them.

e. Do group members pray, meditate, or turn to a Higher Power in times of stress, despair, confusion, or anxiety?

f. Do group members relate to having difficulty deciding at times what they cannot change versus what they can (and should) change?

g. What do group members think about feel saying the Serenity Prayer at these times, or talking to other 12-Step friends about the dilemmas they face that cause anxiety?

h. Other methods of dealing with anxiety are found in the following 12-Step slogans such as “first things first” and “easy does it.”

i. First Things First: the first priority is to not to take that first hit of a drug.

- At times, individuals in recovery will be in conflict and will have to choose between taking care of themselves versus taking care of someone else.
- The choice may be to please oneself or to please someone else; make oneself happy or make someone else happy.
- Group members need to be encouraged to make their ongoing recovery their first priority, even if that means frustrating or disappointing someone else.
- The group counselor can elicit examples of situations in which group members felt conflicted about taking care of themselves versus taking care of others:
  - What could be the price of pleasing or satisfying others at one’s own expense?
  - What can be done in that situation? Is this consistent with putting abstinence first?

j. Easy Does It: the pressures of deadlines and over commitment create stresses that invite using drugs as a means of coping. This slogan speaks to this particular issue.

- Does the patient identify with the stresses created by having to meet deadlines or competing commitments?
• What in the patient’s life contributes to stress, to time pressure, or to over commitment?
  k. Strategies for dealing with this form of stress are built around developing a system of realistic priorities.
  • Make a list of things to do today, then discard half of it
  • Schedule things twice as far in advance as you usually would.
  • Sit quietly for 15 minutes a day.
  • Talk to someone else (preferably a recovering person) about your feelings or being overextended.

7. **Emotions:** anger and resentment
   a. Anger and resentment are pivotal emotions for most recovering individuals.
   b. Anger that evokes anxiety drives some addicted individuals to use drugs to anesthetize this feeling. Resentment, which comes from unexpressed (denied) anger, represents a threat to abstinence for the same reason.
   c. Resentments, reflecting as they do unexpressed anger, represent past issues. The recovering person cannot afford to live in the past but must live in the present (*one day at a time*).
   d. Therefore, resentments must be confronted and let go in favor of more effective ways of dealing with anger in the present."
   e. Use the following guidelines and the Resentment Worksheet when working on these issues:
      • What situations are patients resentful over?
      • How did they handle these at the time they happened?
      • Can they see how these issues cannot be resolved now but that, on the other hand, they can learn how to express anger better, so as to avoid building up stores of resentments in the future?
      • Can the patient make the connection between unexpressed anger (at the moment) and resentment (holding on to the anger)?
      • What can the patient learn from those experiences so as to not avoid being honestly angry in the future?
      • What would stop the patient from experiencing anger in the future?
      • What makes patients angry in the here and now? Are they willing to make a commitment to expressing their anger honestly and to having faith that it will be better if they do that?
Resentment Worksheet

<table>
<thead>
<tr>
<th>WHAT HAPPENED</th>
<th>HOW I FELT</th>
<th>WHAT I DID</th>
<th>WHAT I SHOULD DO DIFFERENTLY USING PROGRAM TOOLS</th>
</tr>
</thead>
</table>

### Resentment Worksheet

#### Example of Melissa

<table>
<thead>
<tr>
<th>WHAT HAPPENED</th>
<th>HOW I FELT</th>
<th>WHAT I DID</th>
<th>WHAT I SHOULD DO DIFFERENTLY USING PROGRAM TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>My husband blamed me for messing up our budget cause I spent money on drugs. My mom criticizes me for the way I deal with my teenage kids. Got written up by my boss for being late and missing too much work.</td>
<td>Angry and bitter at first. Once I thought about this, I realized he was right. I felt judged and berated. I felt like a victim at first, which pissed me off. I realized she was right and felt guilty for letting her down and not doing my job.</td>
<td>I used to use this in the past as another excuse to get high. I also used this as a reason to get high. I also argued with her and said some rotten things. I made promises to be on time and not miss work, but the more drugs I used, the less dependable I became.</td>
<td>The program says to drop off your resentments at a meeting. My sponsor says I need to evaluate how my family was affected by my addiction. I need to accept that my addiction hurt him and our kids, talk with him, and when I'm ready, make amends. Listen to her concerns and accept that she is concerned about my welfare. I know that I need to make amends to her and my at some time, too. Accept responsibility for my behaviors and make a commitment to do my job, and don't blame others. I will talk with my sponsor each day to report on my work attendance and being on time.</td>
</tr>
</tbody>
</table>
8. **Emotions: grief**
   a. Grief is as important a subject as anger and resentment in the 12-Step literature.
   b. In the course of addiction (and often before drug abuse begins), addicted individuals may experience losses that have gone ungrieved. The counselor should be familiar with the stages of grief.
      - **Denial:** minimizing the importance of what was lost, including denying its importance.
      - **Bargaining:** attempting to replace the lost things with something else without acknowledging this loss.
      - **Anger:** the breakdown of denial and the natural reaction to loss.
      - **Sadness:** the true expression of a loss that has been denied.
      - **Acceptance:** this comes slow as denial breaks down and the individual feels able to come to terms with the reality of the loss (or limitation) and is ready to move on.
   c. Ask group members to identify one loss in their lives that they have worked through in terms of these stages.
   d. Then ask them to identify one loss that they have not worked through, about which they may be in denial.
      - Drug addicted individuals need to come to terms with the loss of drugs (and the related lifestyle), which is experienced in recovery.
      - Another perspective is that group members need to accept their limitation, which is that they cannot control their use of drugs and have to give them up.
   e. Ask group members to write a “good-bye letter” to drugs and addiction in their journals.
      - Dependency on drugs needs to be conceptualized as a relationship that must be broken and grieved in the interest of recovery.
      - This requires sensitivity and respect on the part of the counselor, along with an appreciation for the grief process and an ability to work with patients in a sympathetic manner through their grief over the loss of drugs.

26.3 **Recovery Tasks**

**Meetings**
1. Ask group members to make a list of meetings they will attend in their ongoing recovery.
2. Suggest other kinds of meetings the patient might attend.
3. Discuss how group members can become more active in NA, CA, CMA or AA.

**Telephone Therapy and Sponsor**
1. Ask group members to continue to collect new numbers of AA, NA, CA, or CMA members.
2. Ask group members to commit to call program friends.
3. Ask group members how often they plan to contact their sponsors.
4. For those who do not have a sponsor, discuss plans to obtain one in the near future.

**Readings**
- Continue reading Narcotics Anonymous (Narcotics Anonymous, 1988)
- Living Sober (Alcoholics Anonymous, 1975) we suggest:
  - “Fending Off Loneliness” (pages 33 – 37)
  - “Watching Out for Anger and Resentments” (pages 37 – 41)
  - “Looking Out for Over-relation” (pages 43 – 44)
  - “Being Grateful” (pages 47 – 51)
  - “Eliminating Self-pity” (pages 56 – 59)
  - Other program literature (e.g., meditation books, pamphlets, etc.)

**Grieving**
1. Suggest that group members write a good-bye letter to drugs as if it were a relationship that they have decided to end.
2. Instruct them to write in their journal about losses that they have not adequately acknowledged and grieved, including losses in each of these areas:
   - Relationships
   - Self-esteem
   - People, pets, or things
   - Goals

**H.A.L.T.**
What lifestyle changes is the patient willing to make to address fatigue and nutrition?

### 26.4 Wrap-Up
What was the gist of today’s session?
Do you understand and are you willing to follow through with the Recovery Tasks?
26.5 Troubleshooting

The importance of going to meetings, getting involved in them, and developing relationships with other recovering addicts cannot be overstated. The patient can use the fellowship of recovering addicts as a source of support, advice, and comfort. By now, going to meetings should be a part of the patient’s lifestyle; if it is not, the counselor should spend more time uncovering and working through the patient’s resistance to this. A contracting approach can be a useful technique wherein the counselor and patient agree that the patient will try out a certain number of 12-Step meetings or experiment with some form of participation. Patients’ experiences at meetings, like their reactions to the Narcotics Anonymous Basic Text (Narcotics Anonymous, 1988), need to be processed at each session.

Role-playing can be another effective technique to help the shy or shameful patient overcome internal barriers to going to meetings or participating in them. Have patients practice, for example, saying their names out loud, as if they were doing so at a meeting. Assure the patients that they will not be pressured at meetings to say more than they feel comfortable with.

Once patients have become regular in their attendance, the next step is to encourage them to talk. Meetings and subsequent contacts with fellow 12-Step program members can be used as opportunities to talk about ongoing sources of resentment and grief. Patients who merely attend 12-Step meetings and do not participate or develop communicative relationships with other recovering people are handicapped in their ability to resist denial and are apt to slip into drug use as a means of drowning those emotions.
27.0 STAGE-12 COUNSELOR SELECTION, TRAINING AND SUPERVISION

27.1 Counselor Characteristics and Training Requirements

In the prior research studies that have evaluated therapy approaches, TSF has been implemented by mostly Masters level counselors with substantial experience in and commitment to 12-Step programs as a therapeutic intervention, who also had extensive experience treating a broad range of substance abusers. These counselors were selected to reduce the likelihood of counselor effects on treatment outcomes by utilizing a comparatively homogeneous group of highly skilled counselors. Furthermore, because the counselor training/piloting period for these clinical trials is comparatively brief, it was important to select counselors who already had a high level of expertise and experience in this approach, and thus could achieve optimal levels of adherence and competence rapidly.

The recommended educational and experience characteristics for counselors involved in the STAGE-12 protocol are:

- A bachelor’s or master’s degree or equivalent in psychology, counseling, social work.
- Or, a certification in addiction counseling (e.g., CADC, CAC or equivalent certification).
- At least 3 years experience working with a substance abuse population.
- Familiarity with and commitment to a 12-Step approach.

Personal characteristics of counselors that are associated with improved outcome using TSF or STAGE-12 have not been an explicit focus of research to date. However, we assume the attributes identified by Luborsky and colleagues (1985) as associated with better patient outcomes in psychotherapy would apply to this treatment as well, including personal adjustment, interest in helping the patient, ability to foster a positive working alliance, and high empathy and warmth.

27.2 Role of STAGE-12 Counselor

The counselor in this protocol uses skills to help the group members and individual patients overcome barriers to becoming actively involved in 12-Step recovery programs such as NA, CA, CMA or AA. Skills such as active listening, accurate empathy, problem solving, feedback, and confrontation all have a place in this therapy.

One role is to act as an educator about 12-Step programs. This psycho-education must be tailored to the specific needs of the group members. Recovery tasks and topic material are presented in such a way that the patients can relate in personal ways to the information, and incorporate this in their ongoing recovery. The counselor, as a believer in the efficacy of 12-Step programs, acts as an advocate. Beyond this, the counselor supports the group.
members’ ability to successfully work this program of recovery. In layman’s terms, the counselor is both “coach” and “cheering squad” for the patients. The counselor provides guidance and advice about how best to access the resources of 12-Step programs. This may be based on the wisdom found in recovering literature, or slogans, or the stories of other recovering addicts.

Lastly, the counselor provides empathy and a sense of hope for the group members that recovery is possible. The counselor communicates clearly an understanding of the struggles of early recovery. In doing so, the process of acceptance and surrender are “humanized” so that the patients are given support that they are not alone. By encouraging the patients to reach out to other recovering addicts, the counselor helps them learn that it is possible to go through this process and to recover successfully from addiction with the support of others.

27.3 Familiarity with 12-Step Programs

To be able to deliver this treatment well the counselor needs to do certain things. First, counselors must be familiar with 12-Step programs. This means feeling comfortable with the language of NA, CA, CMA or AA, understanding types of meetings and how the group meetings are conducted, where various 12-Step programs meet, and being familiar with 12-Step recovery literature such as the “Big Book” of AA and/or “Basic Text” of NA. In order to become familiar with 12-Step programs, the counselor may attend several “open” meetings of 12-Step programs in their area and read through recovery literature.

27.4 Group Facilitation

A major portion of the STAGE-12 intervention is delivered in the context of group counseling sessions. Counselors need to be familiar with the general principles of group therapy and its “curative factors,” be comfortable with presenting psycho-educational materials in a group format, and be able to facilitate, direct, and redirect group discussions and interactions as appropriate to the group topic, group membership, and flow of the group.

27.5 Active and Facilitative

STAGE-12 requires an active, supportive and involved presence by the counselor in sessions. A good session involves interaction between the counselor and group members. The group sessions, however, are focused so the counselor must insure that the content of the session is adequately covered during the sessions. The counselor takes an active part in keeping the focus of the session on recovery using the format present in this manual.

When faced with the day to day struggles of the patients, the counselor encourages them to use 12-Step program tools. So, for example, after listening with empathy to a patient during a group session, a counselor may suggest that he or she talk about this problem with a sponsor or peer in the 12-Step program as well as talk about the issue at a 12-Step discussion meeting.
27.6 Confrontation and Feedback

Lastly, the counselor conducting STAGE-12 sessions uses confrontation and feedback constructively. A term for the style of confrontation used by counselors is “care-frontation.” This means that the counselor is careful to confront the patient’s behavior as it relates to the addiction i.e., denial, avoidance, or minimization rather than their person. This means separating the person from their disease and communicating that the patient is a good person who has a disease (addiction) that leads to acting in ways that are hurtful towards oneself and others. By doing so, the counselor can endorse whatever efforts the patients are making on behalf of recovery.

The use of “feedback” is another strategy to confront denial or behaviors that interfere with recovery. Feedback is most effective when it comes from peers so engaging group members in giving feedback to a patient during the group session can be very powerful. Following are some examples of how a counselor can elicit feedback from the group for a specific member.

1. “Devon made it very clear he doesn’t think he needs to stop using marijuana, that giving up cocaine is enough. What do other group members think about Devon’s position on this issue of continued drug use, but not using cocaine?”

2. “Marcella said she ‘forgot’ to keep her recovery journal this past week. Do other group members accept this excuse? What do you think about her ‘forgetting’ to complete her recovery assignment and keep her journal?”

3. “You just heard from Matt that when he wants to use meth real bad, he keeps this to himself. Do you think this is good for his recovery? What do you think about what he said about not sharing his drug cravings with anyone?”

4. “Megan said she’s thinking about dropping her sponsor and getting a new one because her sponsor said some things she didn’t like. What I heard from her is that her sponsor called her on some behaviors she thought were detrimental to Megan’s recovery. I would like other group members to tell Megan their opinions about dropping her NA sponsor.”

5. “So Chris, you think 12-Step meetings are a waste of time, that you get tired of hearing the same stories over and over. What are some opinions of other group members about what Chris thinks about meetings being a waste?”

27.7 Counselor Training

Just as reading a textbook on surgery could not be expected to produce a qualified surgeon, mere review of this manual would be inadequate for a counselor to apply this manual in clinical practice or research. Appropriate counselor training for the STAGE-12 protocol requires completion of a didactic seminar and at least two closely supervised training cases.
The didactic seminar usually lasts 2-3 days, depending on the experience level of the counselors. The seminar includes a review of basic 12-Step principles, topic-by-topic review of the manual, watching videotaped examples of counselors implementing the treatment, several role play and practice exercises, discussion of case examples, and rehearsing strategies for difficult or challenging group sessions.

27.8 Supervised Groups and Training Cases

The supervised group and individual sessions training cases provide an opportunity for the counselor to try this approach and adapt their usual approach to conform more closely to manual guidelines. The number of training group sessions and individual cases varies according to the experience and skill level of the counselor. Generally, we find that more experienced counselors require only a few group sessions and one or two training cases to achieve high levels of competence. Less experienced counselors generally require more supervised group and individual sessions.

For supervision of training cases, each group and individual session is audio taped, then forwarded to the supervisor. The supervisor reviews each session, completes a rating form (described below) evaluating the counselor’s adherence and competence in implementing the treatment session, and provides one hour of individual supervision to the counselor. Supervision sessions are structured around the supervisor’s ratings of adherence and competence, with the supervisor noting areas in which the counselor delivered the treatment effectively, as well as areas in need of improvement. Frequency of supervision can decrease as the counselor gains more experience and demonstrates competence in group and individual sessions.

27.9 Rating and Assessment of Counselor Adherence and Competence

To have a concrete basis on which to evaluate counselor implementation of STAGE-12, both counselors and supervisors complete parallel adherence rating forms after each session conducted or viewed. The rating forms are provided in the appendix. They consist of Likert-type items covering a range of key interventions (presentation of content of group sessions, review of recovery tasks, exploration of the patient’s use of denial, encouragement to make use of 12-Step programs, etc.).

The counselor version of the form, called the STAGE-12 Counselor Checklist (adapted from Carroll et al., 1998), asks the counselor to rate what strategies and interventions were implemented in a given group or individual session, and how much the intervention was used. The STAGE-12 Checklist has a variety of purposes. First, it is intended to remind the counselor, at each session, of the key ingredients of STAGE-12. Second, the STAGE-12 Checklist is intended to foster a greater adherence to the manual through self monitoring of adherence. Third, it can organize and provide the basis for supervision, as the counselor can more readily note and explore with the supervisor the strategies and
interventions s/he has trouble implementing with a given patient or group. Fourth, the completion of the Checklist fosters process research by generating a useful record of which interventions were or were not delivered to each patient in a given session. Thus, for example we can construct a session-by-session map of the order and intensity of interventions introduced to a range of patients (Carroll, K.M., Nich, C., & Rounsaville, B.J., 1998).

The supervisor version of the form, called the STAGE-12 Rating Scale (adapted from Carroll et al., 1998) differs from the counselor version by adding a skillfulness rating. Thus for each intervention, both quantity and quality are rated. The Rating Scale is an essential part of training, as it provides structured feedback to the counselor and forms the basis of supervision. It also provides a method of determining whether a counselor in training is ready to be certified to deliver the treatment. When used with ongoing supervision, it enables the supervisor to monitor and correct counselor drift in implementation of the treatment. Finally, for counselors who have difficulty adhering to manual guidelines but who maintain that they are, pointing out discrepancies between the supervisor-generated Rating Form and the counselor-generated Counselor Checklist is often a useful strategy for enhancing adherence.

For both versions of the scale, it is important to note that not all items on the rating forms are expected to be covered, or covered at a high level, during all sessions. However, items 7–16 reflect the essential STAGE-12 items that should be present at least at a moderate level in the majority of sessions.

### 27.10 Certification of Counselors

Counselors are provisionally certified, or approved to implement the treatment under supervision, following the completion of the didactic training and the successful passing of a post-training knowledge examination. Counselors are fully certified, being able to provide the intervention at reduced levels of supervision when the supervisor determines that the counselor has completed an adequate number of group sessions and individual training cases successfully. After certification, levels of counselor adherence are monitored closely using the STAGE-12 Rating Form. When counselor drift occurs, and the counselor strays from adequate adherence to the manual, supervisors increase the frequency of supervision until the counselor’s performance returns to acceptable levels.

### 27.11 Ongoing Supervision

We require ongoing supervision for all counselors delivering STAGE-12. However, the level and intensity of ongoing supervision reflects the experience and skill of the counselors, as well as the time available for supervision. The minimum acceptable level of ongoing supervision for an experienced counselor is monthly; weekly supervision is recommended for less experienced counselors. In addition, supervisors should review and evaluate using the STAGE-12 Rating Scale, 1–2 randomly selected group and individual sessions per patient. Supervision sessions themselves should include a general review of the counselors current groups and individual cases, discussion of any problems in
implementing STAGE-12, review of recent ratings from the supervisor, and at least one of every two supervision sessions should include review of a session audiotape, with the counselor and supervisor both present.

27.12 Guidelines for Ongoing Supervision

In general, supervision is most effective when conducted at a consistent place, date, and time; the goals of supervision are clear and both participant’s roles are defined; the procedures that will be used for evaluation of the counselors are clarified; and feedback to the counselor is based on session tapes and is focused and concrete (“When you explored X’s last slip, I thought you could have gotten more information about the events that led up to X’s use and connected those to the 12-Step program idea of avoiding slippery people places and things. I think that you need to be more explicit about how X can make use of specific 12-Step program tools” (Witte & Wilber, 1997).

27.13 Common Problems Encountered in Supervision Failure to Balance Manual-Specified Interventions and Patient Needs or Concerns

STAGE-12 sessions integrate 12-Step program tools with effective supportive counseling and education. Novice counselors, particularly those with less experience in treating substance abusers and those who need to maintain a higher level of structure than that to which they may be accustomed, often tend to let group or individual sessions become unfocused, without clear goals, and do not make the transitions needed to deliver 12-Step program tools effectively. Such counselors often do not begin to introduce 12-Step recovery material early enough in the group sessions, which results in rushing through important points, failing to use patient examples or get patient feedback, and neglecting review of the recovery tasks, all of which gives the impression that 12-Step program tools are not very important. Similarly, other counselors allow themselves to become overwhelmed by the constant substance-use related crises presented by patients in groups and fail to focus on the content of the group sessions and the 12-Step recovery tools in that they encourage patients to use as an effective way to help avoid or manage crises. Falling into a crisis-driven approach tends to increase, rather than decrease, patient anxiety and undermine self-efficacy. On the other hand, maintaining a relatively consistent session routine and balancing the patient-driven discussion of current concerns with focus on 12-Step recovery tools is also a means by which the counselor can model the 12-Step principle of putting “first things first”, i.e., putting the focus on recovery, without which nothing else is possible.

Conversely, some counselors become overly fixed and inflexible in their application of teaching 12-Step tools and adherence to the manual. Some counselors, anxious to get it right, present the material in the manual more or less verbatim to patients. This overly wooden approach necessarily fails to adapt the teaching of 12-Step program tools to the particular needs, coping style, and readiness of particular patients. For example, some counselors launch into
teaching about 12-Step program tools, which requires considerable activity and commitment from the patient, with patients who are still highly ambivalent or even resistant to treatment. It is important to remind such counselors that the manual is a blueprint, or a set of guidelines for treatment, to be used to provide a clear set of goals and overall structure to the treatment, but manuals are by no means scripts for treatment. This often entails considerable sufficient familiarity by the counselor with the didactic material, so the counselor can alter the material to adapt to each individual patient or group, and the material can be presented in a way that sounds fresh and dynamic, not manual-generated. Patients should never be aware that the counselor is following a manual.

### 27.14 Balancing Adherence and Competence

There is an important distinction between adherence and competence, that is, the degree to which the counselor follows the guidelines laid out in the therapy manual, and counselor competence, which refers to the counselor's level of skill in delivering that treatment (Carroll & Nuro, 1997). Several investigators have noted that a counselor's adherence and competence are not necessarily closely related (Shaw & Dobson, 1988; Waltz, Addis, Koerner, & Jacobson, 1993). That is, a counselor can follow a treatment manual virtually word-for-word and not deliver that treatment competently or skillfully (i.e., with an appropriate level of flexibility and understanding of a particular group or individual patient, using appropriate timing and language). In some cases extremely high adherence (e.g., a wooden, mechanistic, rote repetition of material in the manual) indicates very low competence in a counselor. High adherence and low skillfulness may also occur in cases where a counselor delivers a technique competently, but at an inappropriate level during a session that is insensitive to the needs of a particular patient. Conversely, there are cases of high skillfulness and low adherence, for example, where a counselor empathetically responds to the patient and provides incisive interpretations at the precise moment they are most likely to be helpful, but rarely touches on material described in the manual (Carroll & Nuro, 1997). Achieving a high level of adherence to the STAGE-12 manual and fostering a positive therapeutic alliance should be seen as complementary, not contradictory, processes.

### 27.15 Going Through the Material Too Quickly

Many of the 12-Step recovery concepts, while seemingly simple and based on common sense, are in fact quite complex, particularly for patients with cognitive impairment, those with dual diagnoses, and those who have a low baseline of coping skills. Thus, a common error made by many counselors is to fail to check back with the patients in group to make sure they understand the material and think through how it might be applied to their current concerns. When this occurs, it often takes the form of presentation of 12-Step recovery material as a lecture, rather than an interactive dialogue between the group members and the counselor. Ideally, for each idea or concept presented by the counselor, the counselor should stop and ask group members to provide an example or to describe the idea in their own words before presenting the next idea. Because
group sessions cover a large amount of content, some areas will be discussed more briefly than others.

27.16 Overwhelming the Group or Individual Patient

For each group session topic, a range of ideas and 12-Step recovery tools are presented. Another problem that arises is that some counselors try to present all of the material, in the order presented in the manual, to each group. For many patients, it is overwhelming. Learning and feeling comfortable with one or two recovery tools is far preferable to having only a surface understanding of several. Similarly, if too much material is presented, the time that can be devoted to practicing particular recovery tools is limited. Introduction of new material can be spread out over several sessions. The topic of “Hungry, Angry, Lonely, Tired”, which contains several 12-Step techniques for managing stressful situations, for example, can be spread out over several sessions.

27.17 Letting Recovery Tasks Slide

Although process data from clinical trials suggests that the majority of patients carry out recovery tasks and those who follow through with recovery tasks have better substance use outcomes, a number of counselors do not sufficiently attend to recovery tasks. This takes the form of a brief and cursory review of completion of recovery tasks in the beginning of group session in which specific examples or details are not elicited. Of course, each group member cannot respond to every question raised during check-in, but it is helpful to elicit examples when a specific issue is discussed. For example, when discussing resistance of a patient to getting an NA, CA, AA or CMA sponsor, the group counselor may ask a member to share his beliefs about asking for help, what he believes are the real reasons he has not done this, and how he feels about asking another person for help with recovery.

27.18 Abandoning the Manual with Difficult Patients or Groups

Many patients present with a range of complex and severe co-morbid problems including relapse to drug use, family problems or mood problems (depression or anxiety). Some counselors become overwhelmed by relapses or concurrent problems and drift from use of the manual in an attempt to address these “other” problems. In such cases, the counselor often takes a less, rather than the more structured approach needed to conduct the group. Generally, if patients are sufficiently stable for outpatient therapy in a structured partial hospital, IOP or day or evening program, we have found that the manual, which provides guidelines for a highly structured approach to treatment, prioritizing of concurrent problems, offering limited case management, and focusing primarily on achieving initial abstinence through participation in 12-Step programs, is adequate to contain even fairly disturbed patients.
References


and participation on drug use outcomes among cocaine-dependent patients. Drug Alcohol Depend, 77(2), 177-184.


Appendix

CTN-0031 Lifestyle Contract
Date: ________________

<table>
<thead>
<tr>
<th>DANGEROUS TO RECOVERY (What needs to be given up)</th>
<th>PATIENT'S FEELINGS ABOUT DANGERS</th>
<th>SUPPORTS RECOVERY (What needs to be substituted)</th>
<th>PATIENT'S FEELINGS ABOUT SUPPORTS</th>
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<tr>
<td>People</td>
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STAGE 12: Recovery Tasks Report

You are responsible for following through on the recovery tasks that are suggested at the end of our counseling session. Complete this “Recovery Tasks Report” and bring it to the next session so that we can review your recovery tasks activity.

A. Suggested Recovery Tasks

1. Mutually agreed upon list of CA, CMA, AA, and NA group meetings to be attended this week:

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<tr>
<th>DAY</th>
<th>MEETINGS</th>
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2. Suggested readings and recovery task activities to be completed this week:

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B. Twelve Step Recovery (CA, CMA, AA, and NA) meetings attended:

1. Date attended: __________  Time: __________  Place: ________________________
   Type of meeting/Topic: ___________________________________________________
   What I heard/saw: _______________________________________________________

_____________________________________________________________________
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What I think about what I heard/saw: ___________________________________
_____________________________________________________________________
_____________________________________________________________________

Questions/Feelings about what I heard/saw: _____________________________
_____________________________________________________________________
_____________________________________________________________________

2. Date attended: __________  Time: __________  Place _______________________
   Type of meeting/Topic: __________________________________________________
   What I heard/saw: _____________________________________________________
_____________________________________________________________________
_____________________________________________________________________

What I think about what I heard/saw: ___________________________________
_____________________________________________________________________
_____________________________________________________________________

Questions/Feelings about what I heard/saw: _____________________________
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Date: __________
B. Twelve Step Recovery (CA, CMA, AA, and NA) meetings attended (continued):

3. Date attended: ___________ Time: ___________ Place: _____________________
   Type of meeting/Topic: _____________________________________________
   What I heard/saw: ________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   What I think about what I heard/saw: _________________________________
   _________________________________________________________________
   _________________________________________________________________
   Questions/Feelings about what I heard/saw: ___________________________
   _________________________________________________________________
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   _________________________________________________________________

4. Date attended: ___________ Time: ___________ Place: _____________________
   Type of meeting/Topic: _____________________________________________
   What I heard/saw: ________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   What I think about what I heard/saw: _________________________________
   _________________________________________________________________
   _________________________________________________________________
   Questions/Feelings about what I heard/saw: ___________________________
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C. Reactions to suggested readings/tapes:

What I read: _______________________________________________________

What I think/feel about what I read: _________________________________

What I listened to: ________________________________________________

What I think/feel about what I listened to: __________________________

D. “Slips” (Dates that I used drugs or drank alcohol; how much; what I did about it):

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E. Cravings or urges to use or drink; when these occurred; what I did:

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STAGE-12 Recovery Activity: Spirituality Worksheet

Thinking about a Spiritual vs. Non-Spiritual Way of Living

Spirituality has to do with meaning and purpose in life; what it means to be human, who we are, and why we are here.

Spirituality does NOT mean mysticism or spiritualism, or an Eastern religious practice.

It is NOT a set of rules about what is good and bad, right and wrong.

It is NOT a church doctrine or religious belief.

Spirituality is a way of life, a way of thinking that helps sobriety.

The following is a comparison of non-spiritual vs. a spiritual way of living and thinking:

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<td>Acquire Things</td>
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<td>THE GOOD LIFE IS……</td>
<td>Money</td>
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<td>GET THE GOOD LIFE BY……</td>
<td>Competing and Getting</td>
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STAGE-12 Resentment Worksheet

<table>
<thead>
<tr>
<th>WHAT HAPPENED</th>
<th>HOW I FELT</th>
<th>WHAT I DID</th>
<th>WHAT I SHOULD DO DIFFERENTLY USING PROGRAM TOOLS</th>
</tr>
</thead>
</table>

STAGE-12 Group Session #1  
First Step Worksheet

The first step of NA, CA, CMA or AA states “We admitted we were powerless over our addiction, that our lives had become unmanageable.” Experience has shown that people who have been able to remain clean and sober have come to terms with this statement as it applies to their lives. In order to assist you in taking this step, try honestly answering the following questions in your written journal. After that, discuss these with your sponsor (if you have one) or your counselor.

The first thing is to admit powerlessness, or, in other words, to say “I can't control my use of drugs, or the consequences of my use of drugs.”

1. How have drugs placed your life, or the lives of others, in jeopardy?

__________________________________________________________________
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2. How have you lost self-respect due to your drug use?

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3. How have you tried to control your use of drugs?

__________________________________________________________________
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4. What types of physical abuse have happened to you, or others, as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
5. How do you feel about yourself for having a drug abuse or dependence problem?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Take an honest look at how the consequences of your drug use has affected you and others. This is “connecting the dots.” Looking back over your drug use answer the following questions.

1. What health problems have you had as a result of your drug use?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. What family/personal problems have you had as a result of your drug use?

__________________________________________________________________
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3. What sexual problems have you had as a result of your drug use?

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4. What legal problems have you had as a result of your drug use?

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5. What financial problems have you had as a result of your drug use?

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6. What work problems have you had as a result of your drug use?

__________________________________________________________________
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Remember that “loss of control” (powerlessness) and problems (unmanageability) are symptoms of the disease of drug dependence. In order to recover, people have admitted their limitations and accepted that the solution is to be open to support from others (NA, CA, CMA or AA) and to stay away from the first use, one day at a time!
COUNSELOR’S SELF RATING ADHERENCE SCALE
FOR STAGE-12 GROUP SESSIONS

Counselor’s Self-Rating Adherence Scale for Group Sessions (CASGS)

Check session topic (check only one):
☐ Topic 1: Step 1 and Acceptance
☐ Topic 2: People, Places, Things
☐ Topic 3: Steps 2 and 3, and Surrender
☐ Topic 4: Getting Active in 12-Step Programs
☐ Topic 5: Managing Emotions

Session date: ___/___/_______
Date Rated: ___/___/_______

<table>
<thead>
<tr>
<th>Review and check-in: To what extent did you...</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Review members’ reactions to last week’s group session recovery tasks (meetings, readings, sponsor, using telephone to contact 12-Step peers, and completing written assignments).</td>
<td>1</td>
<td>2</td>
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<td>4 5 6 7 8</td>
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<tr>
<td>2 Encourage 12-Step participation: meeting attendance, discuss resistances to meetings, and recent experiences of group members at 12-Step meetings.</td>
<td>1</td>
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<td>4 5 6 7 8</td>
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<tr>
<td>3 Discuss group member’s responses/questions to assigned recovery readings.</td>
<td>1</td>
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<td>4 5 6 7 8</td>
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<tr>
<td>4 Discuss group members’ thoughts/urges/cravings for stimulant drugs or other substances and how to manage cravings using 12-Step tools.</td>
<td>1</td>
<td>2</td>
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<td>4 5 6 7 8</td>
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<tr>
<td>5 Discuss slips: what was used, what led to use, and how to avoid slipping using 12-Step tools.</td>
<td>1</td>
<td>2</td>
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<td>4 5 6 7 8</td>
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<tr>
<td>6 Review efforts group members made at getting “active” in 12-Step programs: attending meetings, calling members on the phone, setting up meetings, getting a sponsor, etc.</td>
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<td>4 5 6 7 8</td>
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Comments: _______________________________________________________
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### Counselor’s Self-Rating Adherence Scale for Group Sessions (CASGS) (continued)

#### Content of group sessions and recovery issues:

**To what extent did you...**

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<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
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</table>

**1.** Cover objectives and content of group session in an interactive manner with clients.
- Topic 1: Format of STAGE-12: overview of 12-Step Programs; Step 1; acceptance and denial
- Topic 2: People, places and things (PPT); when to avoid PPT; how to manage PPT
- Topic 3: Surrender; Step 2; Step 3
- Topic 4: Abstinence vs. recovery; strategies to get "active" in 12-Step programs
- Topic 5: Emotions associated with relapse; strategies to manage emotions

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**2.** Discuss acceptance issues or disease concept of addiction.

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**3.** Explore issues of denial and resistances to 12-Step programs.

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**4.** Encourage group members to become active or plan specific 12-Step program activities, or use the 12-Step program tools as a means of managing addiction and related problems.

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**5.** What activities did you assign for recovery tasks for the week (check all that apply)?

- [ ] Attend 12-Step meetings
- [ ] Complete interactive written handouts
- [ ] Use the phone to contact 12-step peers
- [ ] Seek a sponsor
- [ ] Read recovery literature
- [ ] Write in a journal
- [ ] Other (specify): __________________________________________________________________________

**Unsatisfactory**

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**Satisfactory**

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**Excellent**

| 8 |

**6.** Overall, how well do you think you conducted this specific group session?

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**Comments:** __________________________________________________________________________
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COUNSELOR SELF-RATING ADHERENCE SCALE
FOR STAGE-12 INDIVIDUAL SESSIONS

Self-Rating Individual Session #1

Counselor’s Self-Rating Adherence Scale for Individual Sessions (CASIS-1)

Rater: ____________________

Check individual session number (check only one): 1 Session #1  2 Session #2  3 Session #3
   4 Other (specify): ________________________________

Session date: __/____/____ Year: ____________ Date Rated: __/____/____
   day   week   year

Participant number: ____________

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<tr>
<th>Session 1: To what extent did you...</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
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<tr>
<td>1 Review and discuss 12-Step programs’ philosophy of recovery, structure and terminology of meetings, and any concerns of the participant regarding participation.</td>
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<tr>
<td>2 Encourage the participant to identify and agree to attend specific 12-Step meeting(s) prior to the next individual session.</td>
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<tr>
<td>3 Review NA, CA, CMA and/or AA meeting list and discuss with participant.</td>
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<tr>
<td>4 Encourage the participant to set goals for attending 12-Step meetings, “working” Steps 1–3; joining a home group, and getting a sponsor.</td>
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<tr>
<td>5 Encourage the participant to talk with a 12-Step program volunteer by telephone during the session, and make arrangements to attend a meeting with this person (if volunteer was available).</td>
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<tr>
<td>6 Instruct the participant to keep a “journal” to record 12-Step meetings attended (dates, times, locations) and personal reactions (thoughts, feelings, behaviors) about the meetings.</td>
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<td>7 Explore participant’s resistance to 12-Step or other self-help support meetings.</td>
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<tr>
<td>8 Overall, how well did you conduct this individual session?</td>
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Comments: ______________________________________________________
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Unsatisfactory | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8
Fair | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8
Good | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8
Excellent | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8

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Self-Rating Individual Session #2

### Counselor’s Self-Rating Adherence Scale for Individual Sessions (CASIS-2)

#### Session 2: If the participant DID attend 12-Step meetings since the previous individual session, to what extent did you...

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<th>Somewhat 2</th>
<th>Considerably 3</th>
<th>Extensively 4</th>
<th>Not Applicable 8</th>
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#### Session 2: If the participant DID NOT attend 12-Step meetings since the previous individual session, to what extent did you...

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<tr>
<th></th>
<th>Not At All 1</th>
<th>Somewhat 2</th>
<th>Considerably 3</th>
<th>Extensively 4</th>
<th>Not Applicable 8</th>
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### Overall, how well did you conduct this individual session?

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<th>Unsatisfactory 1</th>
<th>Fair 2</th>
<th>Good 3</th>
<th>Excellent 4</th>
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### Comments:

________________________________________________________________________________________________________________________________________________________________________________________________________________________
## Self-Rating Individual Session #3

### Counselor’s Self-Rating Adherence Scale for Individual Sessions (CASIS–3)

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<tr>
<th>Session 3: If the participant DID attend 12-Step meetings since the previous individual session, to what extent did you...</th>
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<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>1. Determine 12-Step meeting(s) attendance since last session, and review reactions to any meeting(s) attended.</td>
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<td>2. Review participant’s written journal from the last session until the present time.</td>
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<td>3. Determine if participant has asked about/for a sponsor at a 12-Step meeting and whether they have gotten a “temporary” sponsor. If they have, reinforce their having done so. If they have not, ask about barriers and encourage the participant to ask at a 12-Step meeting about/for individuals who might serve as a sponsor, and encourage the participant to ask one of these individuals to serve as a “temporary” sponsor.</td>
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<tr>
<td>4. Encourage the participant to attend additional 12-Step meeting(s).</td>
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<td>5. Review and compare what the participant’s views of addiction were prior to treatment and what they are now.</td>
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<tr>
<td>6. Review and compare what the participant’s understanding of NA/CA/A/A/CMA was prior to treatment and what it is now.</td>
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<tr>
<td>7. Review what the participant’s plans are regarding 12-Step meeting attendance for the next 90 days.</td>
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<td>8. Ask whether the participant is willing to continue keeping his/her journal.</td>
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<tr>
<td>9. Review participant’s perceptions of STAGE-12 program (e.g., most/least helpful parts; would the participant recommend this treatment program to someone else with a drug problem; suggestions for improving STAGE-12).</td>
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</tbody>
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### Overall, how well did the counselor conduct this individual session?

| Un satisfactory | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

### Session 3: If the participant DID NOT attend 12-Step meetings since the previous individual session, to what extent did you...

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Focus on the barriers to meeting attendance.</td>
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<tr>
<td>2. Encourage the participant to agree to attend a meeting before next session.</td>
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<tr>
<td>3. Encourage the participant to talk with a 12-Step program volunteer by telephone during the session, and make arrangements to attend a meeting with this person (if volunteer was available).</td>
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<tr>
<td>4. Review and compare what the participant’s views of addiction were prior to treatment and what they are now.</td>
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<tr>
<td>5. Review and compare what the participant’s understanding of NA/CA/A/A/CMA was prior to treatment and what it is now.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>6. Review what the participant’s plans are regarding 12-Step meeting attendance for the next 90 days.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Ask whether the participant is willing to continue keeping his/her journal.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. Review participant’s perceptions of STAGE-12 program (e.g., most/least helpful parts; would the participant recommend this treatment program to someone else with a drug problem; suggestions for improving STAGE-12).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Overall, how well did the counselor conduct this individual session?

| Un satisfactory | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
## Adherence Scale for Group Sessions (ASGS)

**Reviewer:** ____________________  

**Check session topic (check only one):**  
- Topic 1: Step 1 and Acceptance  
- Topic 2: People, Places, Things  
- Topic 3: Steps 2 and 3, and Surrender  
- Topic 4: Getting Active in 12-Step Programs  
- Topic 5: Managing Emotions  

**Session date:** ____/____/_____  
**Date Rated:** ____/____/____  

<table>
<thead>
<tr>
<th>Review and check-in:</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Review members’ reactions to last week’s group session recovery tasks</strong> (meetings, readings, sponsor, using telephone to contact 12-Step peers, and completing written assignments).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>2 Encourage 12-Step participation: meeting attendance, discuss resistances to meetings, and recent experiences of group members at 12-Step meetings.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>3 Discuss group member’s responses/questions to assigned recovery readings.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>4 Discuss group member’s thoughts/urges/cravings for stimulant drugs or other substances and how to manage cravings using 12-Step tools.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>5 Discuss slips: what was used, what led to use, and how to avoid slipping using 12-Step tools.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>6 Review efforts group members made at getting “active” in 12-Step programs: attending meetings, calling members on the phone, setting up meetings, getting a sponsor, etc.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Comments:** _____________________________________________  

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### Adherence Scale for Group Sessions (ASGS) (continued)

<table>
<thead>
<tr>
<th>Content of group sessions and recovery issues: To what extent did the group counselor...</th>
<th>Not At All 1</th>
<th>Somewhat 2</th>
<th>Considerably 3</th>
<th>Extensively 4</th>
<th>Not Applicable 8</th>
</tr>
</thead>
</table>
| 1 Cover objectives and content of group session in an interactive manner with clients.  
  - Topic 1: Format of STAGE-12: overview of 12-Step Programs; Step 1: acceptance and denial  
  - Topic 2: People, places and things (PPT); when to avoid PPT; how to manage PPT  
  - Topic 3: Surrender; Step 2: Step 3  
  - Topic 4: Abstinence vs. recovery; strategies to get “active” in 12-Step programs  
  - Topic 5: Emotions associated with relapse; strategies to manage emotions | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |
| 2 Discuss acceptance issues or disease concept of addiction. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |
| 3 Explore issues of denial and resistances to 12-Step programs. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |
| 4 Encourage group members to become active or plan specific 12-Step program activities, or use the 12-Step program tools as a means of managing addiction and related problems. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |
| 5 Assign recovery tasks for next week: attending 12-Step meetings, completing interactive written handouts, using the phone, seeking a sponsor, reading recovery literature. | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |

#### Unsatisfactory Unfair Fair Good Excellent
| 1 2 3 4 5 6 7 8 |

| 6 Overall, how well did the group leader conduct this specific group session? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 |

Comments: ________________________________________________________________
________________________________________________________________________
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### Adherence Scale for Individual Sessions (ASIS-1)

**Rater:**

Check individual session number (check only one): □ Session #1 □ Session #2 □ Session #3 □ Other (specify): ____________________________

Session date: ____/____/____  Date Rated: ____/____/____

Participant number: _______ _______ _______ _______ _______

### Session 1: To what extent did the individual counselor...

<table>
<thead>
<tr>
<th></th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and discuss 12-Step programs’ philosophy of recovery,</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>structure and terminology of meetings, and any concerns of the</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>participant regarding participation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage the participant to identify and agree to attend</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>specific 12-Step meeting(s) prior to the next individual</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>session.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Review NA, CA, CMA and/or AA meeting list and discuss with</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>participant.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Encourage the participant to set goals for attending 12-Step</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>meetings, “working” Steps 1–3; joining a home group, and</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>getting a sponsor.</td>
<td></td>
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</tr>
<tr>
<td>Encourage the participant to talk with a 12-Step program</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>volunteer by telephone during the session, and make</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>arrangements to attend a meeting with this person (if</td>
<td></td>
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<tr>
<td>volunteer was available).</td>
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</tr>
<tr>
<td>Instruct the participant to keep a “journal” to record</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12-Step meetings attended (dates, times, locations) and</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>personal reactions (thoughts, feelings, behaviors) about the</td>
<td></td>
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<tr>
<td>meetings.</td>
<td></td>
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</tr>
<tr>
<td>Explore participant’s resistance to 12-Step or other self-help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>support meetings.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

### Overall, how well did the counselor conduct this individual session?

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th></th>
<th>Fair</th>
<th>4</th>
<th>5</th>
<th></th>
<th>Good</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Comments:**

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137
### Individual Session #2

**Adherence Scale for Individual Sessions (ASIS–2)**

<table>
<thead>
<tr>
<th>Session 2: If the participant DID attend 12-Step meetings since the previous individual session, to what extent did the individual counselor...</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine 12-Step meeting(s) attendance since last session, and review reactions to any meeting(s) attended.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Review participant’s written journal from the last session until the present time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage the participant to ask at a 12-Step meeting about/for individuals who might serve as a sponsor, and encourage the participant to ask one of those individuals to serve as a “temporary” sponsor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage the participant to attend additional 12-Step meeting(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Instruct the participant to keep a written “journal” to record 12-Step meetings attended (dates, time, locations) and personal reactions (thoughts, feelings, behaviors) about the meetings attended.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Overall, how well did the counselor conduct this individual session?**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session 2: If the participant DID NOT attend 12-Step meetings since the previous individual session, to what extent did the individual counselor...</th>
<th>Not At All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on the barriers to meeting attendance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage the participant to agree to attend a meeting before next session.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage the participant to talk with a 12-Step program volunteer by telephone during the session, and make arrangements to attend a meeting with this person (if volunteer was available).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Instruct the participant to keep a written “journal” to record 12-Step meetings attended (dates, time, locations) and personal reactions (thoughts, feelings, behaviors) about the meetings attended.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Overall, how well did the counselor conduct this individual session?**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

Comments: ____________________________________________________________

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### Adherence Scale for Individual Sessions (ASIS-3)

**Session 3: Individual Session #3**

<table>
<thead>
<tr>
<th>Session 3: If the participant DID attend 12-Step meetings since the previous individual session, to what extent did the individual counselor...</th>
<th>Not at All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Determine 12-Step meeting(s) attendance since last session, and review reactions to any meeting(s) attended.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>2</strong> Review participant’s written journal from the last session until the present time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>3</strong> Determine if participant has asked about and was encouraged the participant to ask if a 12-Step meeting attendance for the next 90 days.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>4</strong> Encourage the participant to attend additional 12-Step meetings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>5</strong> Review and compare what the participant’s views of addiction were prior to treatment and what they are now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>6</strong> Review and compare what the participant’s understanding of NA/AA/CMA was prior to treatment and what it is now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>7</strong> Review what the participant’s plans are regarding 12-Step meeting attendance for the next 90 days.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>8</strong> Ask whether the participant is willing to continue keeping his/her journal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>9</strong> Review participant’s perceptions of STAGE-12 program (e.g., most/least helpful parts, would the participant recommend this treatment program to someone else with a drug problem; suggestions for improving STAGE-12).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Overall, how well did the counselor conduct this individual session?**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
</table>

### Session 3: If the participant DID NOT attend 12-Step meetings since the previous individual session, to what extent did the individual counselor...

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Extensively</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Focus on the barriers to meeting attendance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>2</strong> Encourage the participant to agree to attend a meeting before next session.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>3</strong> Encourage the participant to talk with a 12-Step program volunteer by telephone during the session, and make arrangements to attend a meeting with this person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>4</strong> Review and compare what the participant’s views of addiction were prior to treatment and what they are now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>5</strong> Review and compare what the participant’s understanding of NA/AA/CMA was prior to treatment and what it is now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>6</strong> Review what the participant’s plans are regarding 12-Step meeting attendance for the next 90 days.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>7</strong> Ask whether the participant is willing to continue keeping his/her journal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>8</strong> Review participant’s perceptions of STAGE-12 program (e.g., most/least helpful parts, would the participant recommend this treatment program to someone else with a drug problem; suggestions for improving STAGE-12).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Overall, how well did the counselor conduct this individual session?**

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
</table>