2018

The 12-Steps of Alcoholics Anonymous: A Guide for Occupational Therapists

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The 12-Steps of Alcoholics Anonymous: A Guide for Occupational Therapists

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Occupational Therapy

Grand Forks, North Dakota
May
2018
This Scholarly Project Paper, submitted by Jena Kobus Roeber and Jillian Schaeffer in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Department: Occupational Therapy

Degree: Master of Occupational Therapy

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ACKNOWLEDGMENTS

I want to thank my husband, family, and friends for supporting me throughout this incredible experience. I am very thankful for all of the encouragement and love that you’ve shown me. I want to thank our advisor, Dr. Zimmerman, for challenging us and guiding us through this project. Finally, I want to thank my wonderful partner, Jill Schaeffer, for always talking things through and putting so much hard work into this project—I couldn’t have done it without you!

-Jena Kobus Roeber

I would like to thank my husband, family, and friends for providing me support throughout this journey. I feel very blessed and grateful for the love and encouragement that I have been shown. To our advisor, Dr. Sonia Zimmerman, thank you for your honesty and guidance; you challenged us to develop our best work. Finally, to my partner, Jena Roeber, thank you for always bringing your talent, drive, and willingness to tackle each painstaking detail; I would not have wanted to work on this project without you!

-Jillian M. Schaeffer
ABSTRACT

A 2016 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 15.1 million people ages 12 and older had alcohol use disorder. An estimated 2.2 million people 12 years old or older in 2016 received specialized treatment in the past year, which represents about 10.6 percent of the people in need of treatment (SAMHSA, 2016). Occupational therapy offers a unique role that can be utilized in the treatment of individuals with alcohol use disorder. Wasmuth, Crabtree, and Scott (2014) suggest that occupational therapy can be unique in substance use rehabilitation as real-life activities in natural settings are used to address occupations, roles, and routines that have become dysfunctional through addiction.

An extensive literature review was conducted to obtain information to create evidence-based strategies for occupational therapists use in treating individuals with alcohol use disorder. Research articles, textbooks, and resources from the American Occupational Therapy Association were utilized for this project. Based on the literature results, the 12 Steps of Alcoholics Anonymous: A Guide for Occupational Therapists was created for occupational therapists to foster treatment for individuals in a 12 Steps of Alcoholics Anonymous program. The Model of Human Occupation was used to direct the development of the guide.

The purpose of this scholarly project and the occupational therapy guide is to provide recommendations for occupational therapists to use when working with
individuals in the Alcoholics Anonymous 12-Step program. Recommendations for the occupational therapy process include assessments, group and individual interventions for each of the 12 steps of Alcoholics Anonymous, re-evaluation, and discharge planning. The guide understands that individuals may complete the 12 steps in different timeframes and may require the development of more sessions depending upon the individual client’s progress.
Chapter I

Introduction

The National Institute of Health on Alcohol Abuse and Alcoholism states that in 2015, 15.1 million persons 18 years or older had alcohol use disorder in the United States and an estimated 88,000 people die from alcohol-related causes annually (NIH, 2017). These statistics make alcohol the fourth leading preventable cause of death in the United States (NIH, 2017). Substance use impacts many aspects of life; occupational therapy can provide services to support the process of change while looking at the person as a whole (Moyers, 1988). Wasmuth, Crabtree, and Scott (2014) suggest that occupational therapy can be unique in substance use rehabilitation as they use real life activities in natural settings to address occupations, roles, and routines that have become dysfunctional due to addiction. There are a variety of treatments that individuals can explore to find the best fit for them on their path to recovery; however, accessibility, service delivery, and stigma may prevent treatment from being sought out.

The high prevalence of alcohol use disorder and the number of individuals going untreated in the United States shows that additional recovery programming should be explored. Currently there are limited materials available for the occupational therapist practicing in a 12-step based recovery program. Yet, services provided need to be reflective of current evidence and best practice including preparatory, activity, and occupation-based interventions relevant to each of the 12 steps. Occupational therapy approaches have the potential to guide treatment and support the process of change.
within 12-step programming for alcohol use disorder. The purpose of this guide is to provide recommendations and interventions for the occupational therapists to use when working with individuals in the Alcoholics Anonymous 12-Step program. The guide consists of recommended assessments, detailed intervention plans, re-evaluation, and discharge planning recommendations based on the Model of Human Occupation (MOHO). This guide understands that in 12-step programs, recovery comes from group experience and individual experience.

Occupational therapy can provide a unique, holistic recovery program to individuals going through the 12-steps of Alcoholics Anonymous. Interventions provided by occupational therapists will focus on daily roles, routines, values, interests, social contexts, motivation, and occupational performance to increase quality of life. In order to foster individuals throughout the recovery process of Alcoholics Anonymous, MOHO was used to direct the development of this product. This model considers the person, environment, occupation, and the dimensions of doing. The person is explained as how occupational behavior is chosen, patterned, and performed through volition, habituation, and performance capacity. Volition refers to the process in which an individual is motivated to choose what they do (O’Brien, 2017). Habituation is identified as the patterns and routines of the individual’s life. Performance capacity looks at the mental and physical abilities and experiences of the individual that shapes performance (O’Brien, 2017). The environment consists of the social and physical contexts that
influence daily performance in occupations. The dimensions of doing focus on occupational participation, performance, and skill of the client.

The Model of Human Occupation is a client-centered, occupation-based model of practice that focuses on changes in personal factors or environment of the client that may elicit a behavioral change and facilitate new patterns of performance (O’Brien, 2017). The Model of Human Occupation is appropriate for this population due to the focus on developing a balanced life routine for individuals that includes: work, play, and activities of daily living (Kielhofner, 2002). Individuals diagnosed with alcohol use disorder experience deficits within their performance in daily life due to the use of the substance as a coping strategy. The Model of Human Occupation encourages the use of engaging individuals within occupation as a strategy to increase skills that are necessary to adapt (Kielhofner, 2008). The utilization of MOHO will work to return balance and improve occupational performance to individuals with alcohol use disorder.

In developing the occupational therapy guide, MOHO was incorporated when selecting assessments, developing interventions, discussing re-assessment, and discharge planning. After examination of each of the 12-steps of Alcoholics Anonymous, the concepts of MOHO were implemented and applied to the interventions. Each MOHO concept was defined in its relation to the interventions and its application within the step.

**Key Terms and Concepts**

- **Occupation**: daily life activities in which people engage (American Occupational Therapy Association, 2014).
• **Model of Human Occupation**: a conceptual practice model developed by Gary Keilhofner and used by occupational therapists to evaluate the interactions with humans in the environment through occupation (O’Brien, 2017).

• **Substance Use Disorder**: a cluster of cognitive, behavioral, and physiological symptoms related to substance use, indicating that the individual continues using the substance despite significant substance-related problems (American Psychiatric Association, 2013).

• **Alcohol Use Disorder**: a cluster of behavioral and physical symptoms related to alcohol use, including withdrawal, tolerance, and craving (APA, 2013).

• **Alcoholics Anonymous**: an international fellowship of men and women who have had a drinking problem. It is a non-professional, self-supporting, multiracial, apolitical, and available almost everywhere. Membership is open to anyone who wants to do something about their drinking problem (Alcoholics Anonymous World Services, Inc., 2017).

• **Alcoholics Anonymous Steps**: a group of principles, spiritual in nature, which, if practiced as a way of life can expel the obsession to drink and enable the sufferer to become happily and usefully whole (Alcoholics Anonymous World Services, Inc., 2017).

• **Alcoholics Anonymous Traditions**: a group of traditions that outline the means by which A.A. maintains its unity and relates itself to the world about it, the way it lives and grows (Alcoholics Anonymous World Services, Inc., 2017).
The chapters in this scholarly project include: review of the literature, methodology, product, and summary. Chapter two will examine the review of the literature based on topics related to substance use disorder, settings, interventions, 12-step programming, and occupational therapy. Chapter three will discuss the processes used to develop the resource guide in relation to the literature review with components of MOHO. Chapter four will provide an outline of the product, *The 12-Steps of Alcoholics Anonymous: A Guide for Occupational Therapists*. The full intervention guide is located in Appendix D. Chapter five summarizes the conclusions, limitations, and further recommendations for the guide.
Chapter II

Literature Review

Substance use disorders are a growing concern in the United States. A 2016 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that an estimated 20.1 million Americans ages 18 and older have substance use disorder. Coinciding with this concern, there is an increased need to develop better recovery oriented programs that will allow individuals struggling with substance use increased access to effective programming. Among mental health professionals, the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) is used to define the population that will be served. The scope of the incidence and prevalence will be described, along with a depiction of the varied settings and interventions that are available for individuals with substance use disorder. Additionally, an explanation of the role that occupational therapy can play will be offered in order to establish the profession’s relevance within this realm of mental health.

DSM-5 Definition

The American Psychiatric Association (APA) (2013) describes substance use in the DSM-5 as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. An important aspect of substance use disorders is the underlying changes in the brain circuits that have the potential to persist beyond detoxification (APA, 2013). These brain changes can cause behavioral effects such as relapse and intense substance
craving when the individual is exposed to the substance stimuli (APA, 2013). Eleven criteria are presented in the DSM-5 to organize the diagnosis of substance use disorder (see Appendix A).

Addiction is a term that is often used to describe substance use disorder or specific substance disorders, such as alcohol use disorder. The DSM-5 no longer uses the term “addiction” when discussing substance use disorders, however, this term is often used to define dependence of substance use due to constant cravings (Murphy, Stojek, Few, Rothbaum, & MacKillop, 2014; Murthy, 2017). Gutman (2006) describes addiction as a chronic, relapsing disorder of compulsive use of addictive substances involving long periods of substance use, unsuccessful attempts to reduce or stop use, greater time spent obtaining substances, neglect of personal role obligations, and continued use of the substance despite negative consequences and problems. Addiction was omitted from the DSM-5 substance use disorder terminology as the definition is uncertain and holds a potentially negative connotation, although some clinicians may choose to use addiction to describe more severe cases of substance use disorder (APA, 2013).

Substance use disorder can occur within a broad range of severity based on the number of symptom criteria present (APA, 2013). A mild form of substance use disorder is diagnosed with the presence of 2-3 symptoms, moderate substance use occurs with 4-5 symptoms, and severe substance use disorder is diagnosed by 6 or more symptoms. The severity of substance use may fluctuate for individuals based on a number of aspects,
such as self-reporting, family or friend observations, clinician observation, and length of time in treatment or recovery (APA, 2013).

Substance use disorder can be classified into different substance categories. This literature review will be focused on alcohol use disorder. The DSM-5 describes alcohol use disorder as a cluster of behavioral and physical symptoms, including withdrawal, tolerance, and craving (APA, 2013). There are 11 diagnostic criteria for alcohol use disorder (Appendix B). Individuals with this disorder may try to avoid withdrawal symptoms by continuing to consume alcohol despite adverse effects due to cravings, urges difficult to control leading to a perception of it being extremely difficult or impossible not to drink if it was present (APA, 2013; Murphy, Stojek, Few, Rothbaum, & MacKillop, 2014). Cravings may cause individuals to suffer in school or job performance, child care or household responsibilities, and can put themselves at risk in physically hazardous circumstances such as drinking while intoxicated (APA, 2013).

Symptoms accompanying heavy alcohol use may include mental health changes such as conduct problems, depression, anxiety, mood disorders, and insomnia (APA, 2013; Bell & Britton, 2014). During substance use intoxication periods, it is common for a sedating drug, like alcohol to produce clinically significant depressive disorders, while anxiety conditions are likely to be observed during the withdrawal phase of these substances (APA, 2013). When diagnosing substance use disorder, it is important to note that there must be evidence that the disorder observed is not to be better explained by an independent mental condition that was present prior to the intoxication or withdrawal
Recognizing a mental disorder compared to substance use disorder is important in treatment to best support the individual.

**Incidence and Prevalence.**

According to a 2015 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA), 86.4 percent of people in the United States ages 18 years or older reported that they drank alcohol at some point in their lifetime with 70.1 percent reported that they drank in the past year, and 56.0 percent reported that they had drank in the past month. Globally in 2010, the fifth leading risk factor for premature death and disability was alcohol misuse (World Health Organization, 2014). According to the Center for Disease Control and Prevention (2015), excessive alcohol use is responsible for 88,000 deaths in the United States each year.

Alcohol use disorder is common in the United States with the 12-month prevalence estimated to be 4.6 percent among individuals ages 12-17, and 8.5 percent among adults 18 years and older (APA, 2013). The 2016 SAMHSA survey found that 15.1 million people ages 12 and older had alcohol use disorder. An estimated 2.2 million people 12 or older in 2016 received specialized treatment in the past year, which represents about 10.6 percent of the people in need of treatment (SAMHSA, 2016). This study shows that alcohol use disorder is not only increasing in the United States, but is a highly comorbid, prevalent disorder that often goes untreated.
Settings

Individuals can be treated for substance use disorder in a variety of settings. Treatment is provided on a continuum. A variety of settings and a continuum of care enables individuals to be placed in a treatment program that is most appropriate for the current individual needs, and adjusted once progress has been made. The most common treatment settings include: inpatient, partial hospitalization, outpatient, and community based. Each setting has a set of objectives that create a unique system, which guide treatment and programming to address the goals (Mahaffey & Holmquist, 2011).

Inpatient.

Galanter, Kleber, and Brady (2015) suggest that inpatient treatment refers to multiple forms of treatment that can occur in multiple settings such as a general hospital, psychiatric hospital, or a freestanding treatment facility. These settings may provide a combination of treatment options including detoxification, rehabilitation, and stabilization for individuals that need 24-hour supervision (Galanter, Kleber, & Brady, 2015). Inpatient treatment has been found to be more effective than outpatient treatment for clients with greater severity of symptoms in terms of pretreatment problems, suicidality, and substance use (Harrison & Asche, 2001; Ilgen, Tiet, Finney, & Harris, 2005; Rychtarik, et al., 2000).

In inpatient settings, staffing will be dependent on the location of the facility, the population of the clients, and the operating system of the facility. More medical staff may be necessary if a facility primarily treats clients with complex comorbidity compared
to a facility with more psychiatric staff that primarily treats clients with substance use disorders and psychiatric illnesses (Galanter, Kleber, & Brady, 2015). Clinicians working with clients with substance use disorder recommend that individuals be treated in specialized settings due to availability of resources including knowledgeable clinical staff, peer support, and dedicated and (Galanter, Kleber, & Brady, 2015). Typically, the inpatient setting offers a team of clinical staff to work with individuals towards the objectives of the setting. The team members could include: a psychiatrist, medical doctors, nurses, social workers, counselors, occupational therapists, and adjunct therapies (Mahaffey & Holmquist, 2011).

There are many different objectives that individuals within an inpatient setting are working toward. The primary goals of inpatient care include: stabilization of the clients when in crisis, beginning appropriate treatment, and quickly moving clients to the next level of care (Sharfstein, 2009). Inpatient settings provide a safe environment for clients where they are unable to act on their substance use urges and can gain a clear understanding of their life decisions (Galanter, Kleber, & Brady, 2015; Mahaffey & Holmquist, 2011). The intensive nature of this setting provides adequate time for the client to find stability, begin discharge planning that involves the client's support systems, which will create a successful transition back into the community (Sharfstein, 2009). Mahaffey and Holmquist (2011) discuss interventions within inpatient treatment and the aim to increase the amount that clients advocate for needs and empower them to develop better mental health through the environment with the absence of stigma.
Partial Hospitalization.

Partial hospitalization is a link between inpatient and outpatient care (Beard, et al., 2016). Clients are typically referred to partial hospitalization programs following a stay at an inpatient setting or from outpatient settings to prevent admission into inpatient facilities (Mahaffey & Holmquist, 2011; Beard, et al., 2016). The structure of partial hospitalization is reduced, as well as the level of care (Mahaffey & Holmquist, 2011). In this setting clients must be more stable and need less restrictive treatment; therefore, this structure allows individuals to maintain independence in their lives (Mahaffey & Holmquist, 2011; Beard, et al., 2016). Partial hospitalization is an alternate treatment to hospitalization in which intensive treatment is provided during the day, but patients are able to return home (Beard et al., 2016).

The objectives of partial hospitalization are similar to inpatient settings. The primary goals are to prevent need for inpatient hospitalization, balance medication, provide education, and support for recovery (Mahaffey & Holmquist, 2011; Beard, et al., 2016). Typically, facilities are flexible with interventions to ensure goal completion due to the variety of populations that are served within the partial hospitalization program (Neuhaus, 2006). Due to the flexible nature of care, the team dynamics also shift from inpatient to partial hospitalization. Nurses monitor medication changes instead of distributing medication and provide education individually and in groups, while physicians emphasize medication management (Mahaffey & Holmquist, 2011). Social workers, counselors, occupational therapists, recreational therapists, and expressive
therapists provide the primary treatment of partial hospitalization in the form of group sessions (Mahaffey & Holmquist, 2011; Neuhaus, 2006). Interventions being provided in group settings offers an opportunity to build upon support systems for individuals within the program, this characteristic is not unique to this setting alone, outpatient facilities have similar features within the programming.

**Outpatient.**

There are multiple outpatient treatment settings that provide services to individuals with substance use disorders. These settings include low, moderate, or intensive outpatient programs (IOPs), which are dependent upon the amount of time per day and week spent in treatment. Typically, outpatient programs operate Monday through Friday with those in intensive outpatient programs spending an average of 3 hours a day in the facility (Mahaffey & Holmquist, 2011). Intensive outpatient programs are often needed for individuals who do not meet criteria for inpatient substance abuse treatment, are discharged from 24-hour care, yet need continued services more than the weekly or biweekly sessions in traditional outpatient care (McCarty, et al., 2014). Like partial hospitalization programs, individuals that receive treatment in outpatient settings must be safe and stable enough for less restrictive environments (Mahaffey & Holmquist, 2011). Additionally, in IOPs professionals take on a team approach that is similar to that of partial hospitalization. In IOPs, physicians treat clients weekly to monitor medication management and nurses evaluate vitals related to medication changes (Mahaffey & Holmquist, 2011). Individuals also have access to social workers, counselors,
occupational therapists, recreational therapists, and expressive therapists during the IOP process (Mahaffey & Holmquist, 2011).

Intensive outpatient programs work to educate the individual on early-stage relapse management and coping strategies, ensure that the person has psychosocial support, medication titration, and to address individual symptoms and needs (Mahaffey & Holmquist, 2011; McCarty, et al., 2014). Facilities providing these services may vary from each other in service delivery, treatment planning, crisis management, and effectiveness of care (McCarty, et al., 2014). McCarty, et al. (2014) mentioned two advantages of IOP services when compared with inpatient care including increased duration of treatment and the opportunity to engage and treat consumers while they remain in their home environments.

**Residential Facilities.**

Residential facilities, also known as halfway houses, are a common treatment facility for individuals after attending inpatient treatment or detoxification services (Galanter, Kleber, & Brady, 2015). Each residential facility may differ based on the support services offered and objectives or goals. Peer-support communities are a type of residential facilities that has been an effective approach to reduce relapses of substance use disorders (Boisvert, Martin, Grosek, & Claire, 2008). Residents in peer-support communities have an understanding of the disorder and have been given the fundamentals for developing a recovery lifestyle prior to entering the peer-support
housing community for continuation of treatment and peer support (Boisvert, Martin, Grosek, & Claire, 2008).

Residential facilities provide individuals with support of a sober, clean environment, and social supports for those who are not ready for independent living. Each facility works to prevent relapse and reduce readmission to inpatient treatment settings by providing services that include individual and group therapy sessions with certified counselors, peer-support, AA and NA meetings in the community, structured daily routines of household chores, weekend family therapy groups, public health education, educational videos, volunteer services in the community, exercise activities, and weekly occupational therapy groups (Peloquin & Ciro, 2013). Community residential facilities can vary from providing limited counseling to highly structured programming (Galanter, Kleber, & Brady, 2015).

In peer support communities, recovery is viewed as a global change in lifestyle and identity that occurs in the social learning context of the community (DeLeon, 2000). Residents in the peer support communities share their experience with peers in hopes of bringing people into recovery and to promote a sense of belonging in the community (SAMHSA, 2015). Brief intervention, social skills training, motivational interviewing, 12-step facilitation, and pharmacological therapies are services provided in peer-support communities (Boisvert, Martin, Grosek, & Claire, 2008).
Current Programming

Various substance abuse programs have been described throughout the literature (Franklin, Zhang, Froerer, & Johnson, 2017; Laudet & Humphreys, 2013; McGovern, Fox, Xie, & Drake, 2004). Programs include solutions-focused treatments, psychosocial interventions, and 12-step programs. Psychosocial interventions that have been utilized throughout the research and include therapeutic treatments such as peer-based recovery support, motivational interviewing, cognitive behavioral therapies (CBT), mindfulness training, and brief interventions (Laudet & Humphreys, 2013; McCraith, 2011; McGovern, Fox, Xie, & Drake, 2004; Katz & Toner, 2012; Scheinholz, 2011).

Solutions-focused Programming.

The solutions-focused approach was created by a social worker named Insoo Kim Berg, when she noticed that clients were not continuing to attend sessions (Straussner, 2013). Berg began to ponder the reasons that problems were a focus instead of helping clients find solutions (Straussner, 2013). The solutions-focused approach to treatment was created with three main points in mind. These points include: a collaborative relationship between client and therapist, goals are created to be “successful, meaningful, and attainable”, and lastly, if treatment is not working the therapist is responsible for making a change (Straussner, 2013, p. 203).

Although solutions-focused programming is a relatively new approach to programming, the application to substance use disorders is to divert individuals with substance use disorder onto a path of recovery. Solutions-focused approaches begin by
finding out what the client wants and the process continues from there (Straussner, 2013). In addition to being considered client-centered, the process is collaborative in nature. The clients are required to take part in determining the direction that treatment will go and the progress that is made, while the therapist acts as a guide to the process (Straussner, 2013). Franklin, Zhang, Froerer, and Johnson (2017) conducted a systematic review discussed that solutions-focused techniques have sufficient evidence to support use with individuals with substance use disorder. Franklin, et al. (2017) identified that techniques aimed toward strengths and resources specific to the client show the most positive results; additionally, the element of collaboration with the client sets this approach apart from psychosocial interventions.

**Psychosocial Interventions.**

Multiple psychosocial interventions are used for individuals with substance use disorder. Additionally, a variety of professionals utilize the common interventions. Commonly used psychosocial interventions include: peer-based recovery, cognitive behavioral therapy, mindfulness training, motivational strategies, and brief interventions (Boisvert, et al., 2008; Katz & Toner, 2012; Stoffel & Moyers, 2004).

*Peer-based recovery.*

According to Laudet and Humphreys (2013), peer-based recovery support is designed to facilitate successful recovery and enhance quality of life through the use of individuals that have experiential knowledge. Additionally, the implementation of peer-based approaches with a multitude of diagnosis and the effectiveness within individuals
that have a dual diagnosis of substance abuse and mental illness (Laudet & Humphreys, 2013). Studies have found that a peer-based component to the recovery programming proves to be an effective way to reduce substance use, sustain recovery, and maintain housing (Rowe, et al., 2007; Boisvert, Martin, Grosek, and Claire, 2008).

Boisvert, et al. (2008) conducted a mixed methods study to determine if a peer-support community would be effective in reducing relapse, improved quality of life, self-determination, and behaviors that support recovery. It was found that participants experienced a significant decrease of risk for relapse, and interviews supported the perception of improved affiliation with the community and supporting behaviors (Boisvert, et al., 2008). Peer-based programming establishes a social support system that endures beyond the end of treatment, which provides encouragement to sustain recovery, and prevent relapse (Boisvert, et al., 2008). Elements of peer-based programming can be seen within the structure of Alcoholics Anonymous.

*Cognitive behavioral therapy.*

Cognitive Behavioral Therapy was developed using the work of Aaron Beck referred to as cognitive therapy (CT) (McCraith, 2011). The goal of CT was to foster collaborative relationships with clients when “identifying, reframing, and replacing” cognitive distortions with realistic thoughts or core beliefs, which was thought to then support change in a person’s emotional and behavioral deficits (McCraith, 2011, p. 269). CT is incorporated into CBT, which is considered the umbrella term for cognitive behavioral approaches and has been widely implemented as a treatment across a variety
of psychological disorders and with diverse populations (Butler, Chapman, Forman, & Beck, 2006; Lanza, Garcia, Lamelas, & González-Menéndez, 2014). According to McGovern, Fox, Xie, and Drake (2004), CBT techniques are used successfully throughout substance abuse treatment. The techniques in CBT address the thought process in order to achieve change in behavior; coping skills training is an example of CBT that may be implemented into treatment and helps individuals achieve success (McGovern, et al., 2004).

**Mindfulness training.**

Katz and Toner (2012) propose that various forms of mindfulness training have been successful in reducing substance abuse and achieving abstinence. Mindfulness, rooted in both Eastern and Western spiritual practices, is one of four skills that is related to the amount of awareness brought to life and is taught within dialectical behavioral therapy programs, another comprehensive approach to cognitive behavioral therapy (Scheinholz, 2011). Mindfulness training encourages learning to control one’s mind versus letting thoughts control the person; additionally, mindfulness supports observing, describing, and participation in life moments (Scheinholz, 2011).

**Motivational strategies.**

Motivational strategies are used to enhance a person’s inner motivation for change (Miller & Rollnick, 2002). Saunders, Wilkinson, and Phillips (1995) completed a study and found that motivational intervention was associated with positive behaviors that further support abstinence. Motivational interviewing is an example of a
motivational strategy that is utilized with individuals that are experiencing substance use disorder with the fundamental approaches of collaboration, evocation, and autonomy (Miller & Rollnick, 2002; Vasilaki, Hosier, & Cox, 2006). A meta-analytic review of motivational interviewing literature found motivational interviewing to be an effective treatment to decrease consumption of alcohol. Factors were identified that greatly influence effectiveness, these factors include: age, gender, employment and marital status, mental health, and readiness to change (Vasilaki, Hosier, & Cox, 2006). Motivational interviewing, which is influenced by the transtheoretical model stages of change, is a viable option for professionals to utilize when treating substance use disorder and is an example of a brief intervention (Miller & Rollnick, 2002).

**Brief interventions.**

In a study of interdisciplinary evidence based review, brief interventions are another treatment option consisting of investigating problems, motivational interviewing, providing feedback, provision of resources, and working through worksheets based on drinking behaviors (Stoffel & Moyers, 2004). In this study, brief interventions were found ineffective overall and should be considered carefully for the best outcomes to occur. These interventions do not offer the client enough tools in order to prevent relapse and maintain recovery for extended periods of time (Stoffel & Moyers, 2004).

**12 Step Programming.**

12-step programming is commonly employed throughout the addiction rehabilitation community (Galanter, 2009). The most familiar of these 12-step programs
is Alcoholics Anonymous (AA). AA is among the oldest supports to having a successful recovery from alcohol use disorder, and the most widely utilized. Twelve step programming offers unique attributes to individuals that are seeking treatment.

AA was founded in 1935 by a small nucleus of men, and has since evolved into a global institution (Alcoholics Anonymous World Services, Inc., 2017). To further support the establishment of AA, the creators established the 12-Steps and the 12-Traditions (see Appendix C) to guide the process through which each member of AA will progress through during recovery.

According to Alcoholics Anonymous (2013) the 12-Steps are as follows:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly ask Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

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

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in our affairs (p. 59-60).

Alcoholics Anonymous is a community-based, peer-led, mutual-health organization which uses the 12-step approach to promote and sustain recovery by identifying as an alcoholic, peer support, spirituality, and taking recovery one day at a time (Galanter, Kleber, & Brady, 2015; Stoffel & Moyers, 2004). While 12-step programs are not a cure for addiction or substance use disorder, the programs support abstinence and break up the cycle of addiction (Cara, & MacRae, 2013). Alcoholics Anonymous has been a successful treatment approach since it is delivered as a community-based approach making it highly available to individuals in their communities. The 12-step programming model is utilized for multiple programs reaching various populations, such as Narcotics Anonymous, AL-ANON, Gamblers Anonymous, and Overeaters Anonymous; additionally, 12-step programs have been incorporated into
established public and private treatment programs for substance use (Cara & MacRae, 2013).

Individuals that take part in 12-step programming are offered what could be viewed as an open-ended experience (Galanter, 2009). An individual can take part in the program over the course of their life, and is led by fellow members that help establish a social support network to increase commitment within the group (Galanter, 2009).

Delaney, Forcehimes, Campbell, and Smith (2009) stated that spirituality is presumably an issue that is directly related to problems of alcohol abuse. Delaney, et al. (2009) found that the spiritual practices of AA are partially responsible for the benefits that members are discovering. Spirituality is not limited to having religious affiliations, but extends to having belief and connection to something greater.

Galanter (2009) suggests using a spiritually grounded definition of recovery in 12-step programming. Applying spirituality in this way allows recovery to be presented as a subjective positive experience of observable behaviors. The goal is to increase the potential in individuals for an enjoyable life and to promote resiliency throughout life’s difficulties. Spirituality can be a large part of a person’s recovery, especially if they participate in spiritual communities outside of the treatment facility (Galanter, 2009). Thus, AA can appeal to diverse individuals with differing belief systems.

Dennis, Scott, Funk, and Foss (2005) stated that many individuals with substance use disorder endure several relapses over multiple years on their journey to achieve stabilization. The years of relapses can increase debt, as frequent care is not covered by
insurance and makes the out-of-pocket payments expensive (Dennis, Scott, Funk, & Foss, 2005). The 12-step treatment programs offer a low-cost alternative and can reduce the need for future expensive professional treatments while improving outcomes (Galanter, Kleber, & Brady, 2015). Additionally, research has been conducted to measure the efficacy of twelve step programming. Individuals who receive formal treatment, especially when attending AA, may continue to improve on their drinking outcomes after their discharge (Timko, Moos, Finney, & Lesar, 2000). Timko and DeBenedetti (2007) found that when clients were educated on 12-step concepts and access to meetings and role models in recovery with intensive referral, clients attended meetings more regularly and were more involved in 12-step practices. Moos and Moos (2006) found that longer duration of AA attendance in 1-3 years predicted abstinence, as well as less drinking at 8 and 16 years.

**Occupational Therapy**

Occupational therapy practice began in the mental health setting. “Occupational therapy is founded on the understanding that active engagement in occupation promotes, facilitates, supports, and maintains health and participation” (AOTA, 2014, p. S4). The goals of occupational therapy are to promote physical and mental health and well-being in all persons with and without disability-related needs, and to establish, restore, maintain, and improve function and the quality of life for those at risk or affected by physical or mental disorders (AOTA, 2017). Occupational therapy practitioners working in the mental health setting bring a unique perspective of habilitation and rehabilitation,
while maintaining an increased emphasis on recovery and wellness toward participation in daily occupations and activities (AOTA, 2017).

Throughout the occupational therapy process, theoretical approaches and perspectives are at the core of treatment and evidence-based practices. Occupational therapists have overlapping knowledge and skills with other professions, however, occupational therapists offer distinct contributions in the mental health field by recognizing and emphasizing the complex interplay among client variables, activity demands, and the environment and context in which participation occurs. Occupational therapists are skilled in analyzing, adapting, and modifying the task and environment to support client goals and optimal engagement in occupation (AOTA, 2017).

In 2015, SAMHSA included licensed occupational therapists in the list of staff to be considered by newly created certified community behavioral health clinics (AOTA, 2015). The purpose of this program is to improve the quality and availability of community behavioral health services by supporting states to provide reimbursable services and access to well-funded, integrated, coordinated, client-centered mental health and substance use services at these clinics (AOTA, 2015). The DSM-5 (APA, 2013) states that mental health disorders such as bipolar disorders, schizophrenia, antisocial personality disorder, several anxiety disorders, and depressive disorders may relate to alcohol use disorder providing support for occupational therapy in these certified community behavioral health clinics.
Occupational therapy can be a beneficial asset in the treatment of substance use disorder in each of the settings described earlier. The American Occupational Therapy Association (2014) defines occupational therapy as “the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings”. The DSM-5 (APA, 2013) states in criterion 3 “the individual may spend an increased amount of time obtaining substance use, or recovering from its effects”, which leads to most, if not all, of the individual’s daily activities revolving around the substance, especially in more severe substance use. AOTA (2002) states, daily occupations can be negatively affected by substance use leading to impacted relationships, decreased work or school performance, and decreased activities of daily living that support health, which provides occupational therapy an opportunity to treat individuals with substance use disorder. Occupational therapists “use their knowledge of the transactional relationship among the person, his or her engagement in valuable occupations, and the context to design occupation-based intervention plans that facilitate change or growth in client factors and skills needed for successful participation” (AOTA, 2014). Wasmuth, Crabtree, and Scott (2014) suggest that occupational therapy can be unique in substance use rehabilitation as real-life activities in natural settings are used to address occupations, roles, and routines that have become dysfunctional through addiction.
**OT in 12-Step Programming**

The 12-step description of addiction has been described as a biopsychosocial-spiritual model (Wallace, 1996). Within this model, addiction is thought to have significant effects on the physical, psychological, social, and spiritual features of the individual. Therefore, each area must be addressed through treatment (Cara & MacRae, 2013). Occupational therapists are trained to view the person holistically; therefore, clinicians evaluate the physical, psychological, social, and spiritual elements of each individual and address the deficits or dysfunction present.

In the past, spirituality has been viewed as the expression of an individual’s volition (Canadian Association of Occupational Therapy, 1997). Volition can not only be described as one’s motive to act, but may also include the concepts of values, interests, and personal causation within an individual (Kielhofner, 2008). Substance use is often argued as the cause of a deprivation of volition (Karasaki, Fraser, Moore, & Dietze, 2012). Volition is an aspect that has been debated and discussed in multiple approaches to substance abuse programming (Boisvert, et al., 2008).

Substance use is integrated into many aspects of life allowing occupational therapy to be able to provide services to support the process of change while looking at the individual person (Moyers, 1988). Research shows that occupational therapists can be beneficial in recovery of individuals with substance use by using a combination of strategies such as learning how to manage his or her barriers, modify their environment, process their thoughts and experiences, and increase their quality of life (Gutman, 2006;
Rojo-Mota, Pedrero-Perez, & Huertas-Hoyas, 2017; Stoffel & Moyers, 2004). These strategies could potentially be integrated into the 12-step principles to help clients develop the cognitive performance outcomes and explore meaningful occupations needed to reach abstinence. Occupational therapy can be beneficial in this treatment area by identifying and building the skills necessary to function on an occupational level (Wasmuth, Crabtree, & Scott, 2014; Stoffel & Moyers, 2004).

Cara and MacRae (2013) stated that “the profession’s unique ability to analyze occupational performance and participation to craft a relevant plan of interventions to return the individual to a meaningful life arguably has a fit in recovery programs” (p. 851). Stoffel and Moyer (2004) discussed the application of coping skills during occupational engagement and designing activities that are consistent with 12-step programs in order to change a client’s attitude, perception, and beliefs to be successful in occupational performance with abstinence. Stoffel and Moyers (2004) suggest that a combination of approaches is the most effective in substance abuse rehabilitation.

Summary

In 2010, the fifth leading risk factor worldwide for premature death and disability was alcohol use (WHO, 2014). A 2016 study conducted by SAMHSA, revealed that 21 million people ages 12 or older needed treatment, but only 2.2 million received treatment. Alcohol use disorder is increasing within the United States, with many individuals not being treated. These studies have exposed the need to address the lower number of individuals seeking treatment, as well as the need to increase efficacy of current treatment...
that most individuals are utilizing. Treatment settings vary from inpatient, to partial hospitalization, to outpatient, to residential facilities. The most common treatment employed is the 12-step approach (Galantar, 2009).

12-step programming stands apart from other treatments due to the goal of long-term involvement of group members (Galanter, Kleber, & Brady, 2015). AA is the oldest form of 12-step programming, and the most widely known. AA is a community-based, peer-led, mutual-health, organization that works to promote and sustain recovery among the members; whereas, the members identify as an alcoholic, provide peer support, develop spirituality, and take recovery one day at a time (Galanter, Kleber, & Brady, 2015; Stoffel & Moyers, 2004). Individuals that seek 12-step programming are offered support for abstinence, breaking the cycle of addiction, and what can be viewed as an open-ended experience (Cara, & MacRae, 2013; Galanter, 2009). Timko and Debenedetti (2007) found that educating clients on the concepts of 12-step programs, access to meetings and role models, and provided intensive referral, clients were more involved and attended meetings more consistently.

Substance use is integrated into many aspects of life allowing occupational therapy to provide services beneficial in recovery by using strategies to promote an increased quality of life (Stoffel, & Moyers, 1988). Occupational therapists are trained to view each person holistically, which means that multiple facets of the person are evaluated in relation to deficits or dysfunction present. Occupational therapists provide unique treatment in rehabilitation by utilizing activities in natural settings to address
occupational dysfunction for individuals diagnosed with substance use disorder (Wasmuth, Crabtree, & Scott, 2014).

**Problem Statement**

The high prevalence of alcohol use disorder and the number of individuals going untreated in the United States shows that additional recovery programming should be explored. Occupational therapy approaches have the potential to guide treatment and support the process of change within the population of alcohol use disorder. Occupational therapy can provide a unique, holistic recovery program to individuals with alcohol use disorder. The aim of this scholarly project is to create an intervention guide for occupational therapists providing services in a 12-steps of Alcoholics Anonymous based program. The guide will include occupational therapy interventions that align with each of the 12-steps. The profession’s unique implementation of activity-based and occupation-based interventions will focus on daily roles and routines, support systems, vocational and leisure interests, motivation, and coping skills to increase quality of life. Interventions are designed to foster and motivate occupational performance and participation.

Chapter 3 will discuss methodology used to complete the project. Chapter 4 will present the occupational therapy intervention guide, according to the steps of Alcoholics Anonymous. Finally, Chapter 5 presents the conclusion and recommendations for future development of the intervention guide.
Chapter III

The goal of this scholarly project is to address the lack of materials available to support occupational therapists when working within the 12-step program of Alcoholics Anonymous. The purpose of the literature review is to examine occupational therapy and interdisciplinary literature depicting effective treatment programs available, interventions utilized within treatment, the role of occupational therapy, and skills addressed in Alcoholics Anonymous. Literature was reviewed using multiple online databases, textbooks, and websites.

A variety of online databases were utilized in completion of the literature review, including: Academic Search Premier, CINAHL, Google Scholar, PsycINFO, PubMed, EBSCOhost, OT Search, and AJOT. Occupational therapy textbooks, government websites such as the Substance Abuse and Mental Health Services Administration, health organization websites such as the National Institute of Health and World Health Organization, and The Big Book of Alcoholics Anonymous were also utilized. The main search terms used throughout the research process included: occupational therapy in substance use disorder, occupational therapy in treatment of alcoholics, treatment of substance use disorder, alcohol use disorder, interventions for substance use disorder, mental health intervention in 12-step programs, 12-step programming, and occupational therapy’s role is substance use.

Each article was reviewed for level of evidence and applicability to the purpose of the literature review. Articles were organized according to like topic areas. The topics
reviewed within the literature included: incidence and prevalence, settings providing treatment, interventions, 12-step programming, occupational therapy treatment in substance use disorder, and occupational therapy in 12-step programming.

In regard to the role of occupational therapy within 12-step programming, there was a lack of existing literature and most was qualitative in nature. The search revealed existing literature supporting the use of evidence-based interventions within the occupational therapy scope of practice. These interventions may be used to address the deficits from substance use disorder. The interventions described in the literature included: peer-based recovery, cognitive behavioral therapy, mindfulness training, motivational strategies, and brief interventions (Boisvert, et al., 2008; Katz & Toner, 2012; Stoffel & Moyers, 2004).

Multiple occupation-based models were reviewed, including the Ecology of Human Performance (EHP), Person-Environment-Occupation (PEO), and the Model of Human Occupation (MOHO). Upon further evaluation, MOHO was selected to structure the development of the intervention guide due to the holistic and client-centered nature. The Model of Human Occupation’s unique emphasis on values, interests, and personal causation within the volition of the person linked the literature review with the creation of the product. Motivation, an aspect of volition, and spirituality are factors that greatly impact the recovery of individuals with substance use disorder (Galanter, 2009; Karasaki, Fraser, Moore, & Dietze, 2012). Other factors described in the literature were also linked to the concepts of MOHO, including habituation, which discusses roles, habits, and
routines. The elements of volition, habituation, and performance capacity are addressed throughout the interventions chosen and presented in the intervention guide. Chapter 4 will contain discussion and description of the product.
Chapter IV

Product

The purpose of this intervention guide is to provide occupational therapists with a resource to foster individuals in the 12-steps of Alcoholics Anonymous. Due to the incidence and prevalence of substance and alcohol use disorders within the United States, it is evident that improved access to treatment is necessary to address the unique needs of this population. The guide provides recommendations and interventions for occupational therapists to use in settings that are utilizing 12-step treatment programming.

The 12-Steps of Alcoholics Anonymous: A Guide for Occupational Therapists was developed using the Model of Human Occupation (MOHO). The guide is organized into five sections: introduction, assessments, intervention, re-evaluation, and discharge. Each of the sections reflect elements of MOHO concepts. The recommended assessments are MOHO based assessments. Each of the 12-steps are organized into group and individual sessions, including worksheets or resources for the client’s use. The interventions provided are a sample and due to the longevity of the AA program, occupational therapists may need to develop more interventions to fulfill each step. The re-evaluation includes re-administering recommended assessments and completing an exit interview with the clients to receive feedback. The discharge section includes possible discharge considerations that may be needed.

The entire guide, the 12-Steps of Alcoholics Anonymous: A Guide for Occupational Therapists is presented in Appendix D.
Chapter V

Conclusion

The aim of this scholarly project was to examine the use of 12-step programming and identify gaps in literature related to the occupational therapy’s role in addressing the needs of individuals with alcohol use disorder. There is evidence to support the use of occupational therapy treatment in recovery of individuals with substance use disorder (Gutman, 2006; Rojo-Mota, Pedrero-Perez, & Huertas-Hoyas, 2017; Stoffel & Moyers, 2004). Occupational therapy can assist individuals to build the skills necessary to function in daily life and in meaningful occupation (Wasmuth, Crabtree, & Scott, 2014; Stoffel & Moyers, 2004). Based on the existing literature regarding occupational therapy’s role in substance use disorders, mental health, and 12-step programming, occupational therapists are qualified to address the unique needs of individuals in Alcoholics Anonymous and foster skill development that will improve client outcomes.

Based on the literature review results, The 12-Steps of Alcoholics Anonymous: A Guide For Occupational Therapists, was developed for occupational therapists to guide intervention with clients who are a part of the 12-steps of Alcoholics Anonymous (AA). The Model of Human Occupation (MOHO) was selected to structure the development of the guide with a focus on the person, environment, and the dimensions of doing. The guide offers recommended interventions for occupational therapists to use parallel with the 12-steps of AA, including recommendations for assessment, intervention, re-evaluation, and discharge planning.
Limitations and Recommendations

There are several limitations and recommendations to this guide. First, the guide consists of only one group and one individual session per step of Alcoholics Anonymous. Although the therapist is presented examples appropriate to each step, it limits the opportunity for a complete program to be implemented immediately and requires the occupational therapist to create additional therapy sessions for clients in each step. It is recommended that prior to implementation of the guide within a 12-step setting, occupational therapists develop and plan multiple sessions per step in order to support the length of time individuals may spend in a step.

The second limitation of the guide is that the group sessions are not individualized to each client and their needs. The group sessions were created to meet the needs of the AA steps in general, therefore, they may not be specific to the unique needs of the individuals. It is recommended that the group sessions be tailored to the populations needs and individual sessions be tailored to each client on an individual basis to increase client-centeredness throughout the therapy process.

The third limitation is that the guidelines presented in the 12 Steps of Alcoholics Anonymous: A Guide for Occupational Therapists have not been tested and implemented in practice. The intervention guide was developed with reference to The Big Book of Alcoholics Anonymous and the occupational therapy scope of practice. As this guide has not been implemented yet, it should be integrated into practice with the understanding
that there is a lack of research and should be piloted. It is recommended that the efficacy of the guide be monitored and updated as necessary.

**Conclusion**

There is a significant need for continued research and implementation of occupational therapy’s role in the 12-steps of Alcoholics Anonymous. This intervention guide provides a resource for occupational therapists to use in the treatment of individuals in the 12-steps of AA, while considering the person, environment, and dimensions of doing consistent with the Model of Human Occupation. The guide increases awareness of the role occupational therapists have in substance use disorder and advocates for occupational therapy to be incorporated into the 12-steps of AA. Occupational therapists can use this guide to implement treatment in settings with 12-step programming and community-based organizations for individuals experiencing alcohol use disorder.
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Appendix A

Substance Use Disorder Diagnostic Criteria

1. The individual may take the substance in larger amounts or over a longer period that was originally intended.

2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use.

3. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.

4. Craving is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when an environment where the drug previously was obtained or used.

5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home.

6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance.

7. Important social, occupational or recreational activities may be given up or reduced because of substance use.

8. This may take the form of recurrent substance use in situations in which it is physically hazardous.
9. The individual may continue substance use despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

10. Tolerance is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed.

11. Withdrawal is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance.
Appendix B

Alcohol Use Disorder Diagnostic Criteria

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring in a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal).
   b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.
Appendix C

The Twelve Traditions

1. Our common welfare should come first; personal recovery depends upon A.A. unity.

2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Out leaders are but trusted servants; they do not govern.

3. The only requirement for A.A. membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.

5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.

6. An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

7. Every A.A. group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.

9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.
Appendix D
The 12 Steps of Alcoholics Anonymous: A Guide for Occupational Therapists

Jena Kobus Roeber, MOTS
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Sonia Zimmerman, Ph.D, OTR/L, FAOTA
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Introduction
Purpose

The high prevalence of alcohol use disorder and the number of individuals going untreated in the United States shows that additional recovery programming should be explored. Occupational therapy approaches have the potential to guide treatment and support the process of change within the population of alcohol use disorder. Occupational therapy can provide a unique, holistic recovery program to individuals with alcohol use disorder. The purpose of this guide is to provide recommendations and interventions for occupational therapists to use when working with individuals in the Alcoholics Anonymous 12-Step program. The guide consists of recommended MOHO assessments, detailed intervention plans, re-evaluation, and discharge planning recommendations. This guide understands that in 12-step programs, recovery comes from group experience and individual experience. The guide also acknowledges that everyone will be taking each step at their own pace and in their own way, which the group and individual sessions confirm.

This guide is intended for the use of occupational therapists to align and foster skills for individuals in the Alcoholics Anonymous 12-Step Program. The recommended assessments and interventions are specifically tied to the Big Book of Alcoholics Anonymous (2013) and follow the literature for each step. This intervention guide can be easily incorporated to supplement the traditional Alcoholics Anonymous programming and other services that may be provided. The guide provides the opportunity to occupational therapists to create additional sessions based on the client’s length of time in each step, as multiple sessions for each step may be necessary.
## Intended Population

Substance use disorders are a growing concern in the United States. A 2016 survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that an estimated 20.1 million Americans ages 18 and older have substance use disorder. Coinciding with this concern, there is an increased need to develop better recovery-oriented programs that will allow individuals struggling with substance use better access to effective programming. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) classifies substance use disorder into different categories; the classification of alcohol use disorder is the focus of this guide. A 2015 SAMHSA survey found that 15.1 million people ages 18 and older had alcohol use disorder, with only 1.3 million of those individuals receiving treatment at a specialized facility in the past year.

One of the most familiar rehabilitation programming for individuals with alcohol use disorder is Alcoholics Anonymous (AA). Alcoholics anonymous is a community-based, peer-led, mutual-health organization which uses the 12-step approach to promote and sustain recovery by identifying as an alcoholic, peer support, spirituality, and taking recovery one day at a time (Galanter, Kleber, & Brady, 2015; Stoffel & Moyers, 2004). While 12-step programs are not a cure for addiction or substance use disorder, the programs support abstinence and break up the cycle of addiction (Cara, & MacRae, 2013). An individual can take part in the program over the course of their life, and it is led by fellow members that help establish a social support network to increase commitment within the group (Galanter, 2009). Delaney, Forcehimes, Campbell, and Smith (2009) stated that spirituality is presumably an issue that is directly related to problems of alcohol abuse. Delaney, et al. (2009) found that the spiritual practices of AA are partially responsible for the benefits that members are experiencing.

The 12-step description of addiction has been described as a biopsychosocial-spiritual model (Wallace, 1996). Within this model, addiction is thought to have significant effects on the physical, psychological, social, and spiritual features of the individual. Occupational therapists are trained to view the person holistically; therefore, clinicians evaluate the physical, psychological, social, and spiritual elements of each individual and address the deficits or dysfunction present. Substance use is integrated into many aspects of life allowing occupational therapy to be able to provide services to support the process of change while looking at the individual person (Moyers, 1988). Research shows that occupational therapists can be beneficial in recovery of individuals with substance use by using a combination of strategies such as learning how to manage his or her barriers, modifying their environment, processing their thoughts and experiences, and increasing their quality of life (Gutman, 2006; Rojo-Mota, Pedrero-Perez, Huertas-Hoyas, 2017; Stoffel & Moyers, 2004).
The Model of Human Occupation (MOHO) was selected for this occupational therapy guide based on the occupation-based, client-centered concepts of volition, habituation, performance capacity, and environment. Changes in client factors or environment may elicit a behavioral change and facilitate new patterns of performance (O’Brein, 2017). This model was selected for the collaborative therapist-client relationships, which also allows clients to explore different activities and experience a variety of new occupations to improve skills. For individuals entering the 12-step process, their client factors and environments are constantly changing, therefore the therapist can assist them in analyzing these changes.

Individuals with alcohol use disorder have been found to have an issue with spirituality, and that this issue is directly related to the alcohol use (Delaney, Forcehimes, Campbell & Smith, 2009). Additionally, substance use has been argued as a lack of or deprivation of volition within the person (Krasaki, Fraser, Moore, & Dietze, 2012). The MOHO concepts within the person, specifically values and personal causation, may address a deficit within spirituality and volition. The remaining concepts of the model will address the habituation of the person and the environmental components that are impacting sobriety.


5 Theoretical Principles
1. Occupational actions, thoughts, and emotions arise out of the interaction of volition, habituation, performance capacity, and environment.
2. Change in any aspect of volition, habituation, performance capacity, or the environment can result in change in though, feeling, or doing.
3. Volition, habituation, and performance capacity are maintained and changed through what one does and what one thinks and feels about doing.
4. A particular pattern of volition, habituation, and performance capacity is maintained as long as the underlying thoughts, feelings, and actions are consistently repeated in a supportive environment.
5. Change requires that novel thoughts, feelings, and actions emerge and are sufficiently repeated in a supportive environment to coalesce into new organized patterns.
Key Concepts

1. Person:
   The MOHO conceptualized the person as volition, habituation, and performance capacity. These three components are interrelated.
   - **Volition** is the motivation for occupation, including personal causation, values, and interests.
     - **Personal causation**: one's sense of capacity and effectiveness.
     - **Values**: what one finds important and meaningful to do.
     - **Interests**: what one finds enjoyable or satisfying to do.
   - **Habituation** is the internalized readiness to exhibit consistent behavior guided by habits, roles, and routines that are fitted to temporal, physical, and social environments.
   - **Performance Capacity** is the ability to participate in things that is provided by the status of the musculoskeletal, neurologic, cardiopulmonary, other body systems, mental, and cognitive components.

2. Environment
   - **Physical** environments are those that are natural and built.
   - **Social** environments consist of those that there is a presence of, relationships with, and expectations of persons.

3. Dimensions of Doing
   What people are doing and how they do it.
   - **Occupational Participation** engaging in work, play, or activities of daily living that are part of one’s socio-cultural context and that are desired and/or necessary to one’s well-being.
   - **Occupational Performance** going through the form of occupation, doing an occupation.
   - **Occupational Skill** refers to the skills that are required to perform the occupation (i.e. motor skills, process skills, communication and interaction skills)

(Kielhofner, 2008; O’Brein, 2017)
How to Use the Guide

This guide is divided into the 12-steps of Alcoholics Anonymous (AA, 2013):

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character
7. Humbly ask Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in our affairs.

Each step is then divided into two types of interventions, group and individual, followed by the forms for each.

1. Group Interventions
   a. Forms
2. Individual Interventions
   a. Forms
Each intervention plan consists of four sections, with the fourth containing 5 steps:

1. Prior to the session
2. Objectives
3. Materials
4. Session Procedures
   a. Introduction to the session and AA step
   b. Discussion
   c. Activity
   d. Reflection
   e. Wrap-Up

Some of the intervention plans do not include forms and may stray slightly from the sections above.
### Synopsis of Interventions

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

The interventions for this step were selected to prepare the clients for the recovery process. The group intervention focuses on developing a positive perception to continue a positive outlook through challenges faced in their lives during the recovery process. The individual intervention was selected to maintain alignment with giving up control in step 1. This session offers clients the opportunity to determine positives regarding giving up control during recovery.

**Step 2:** Came to believe that a Power greater than ourselves could restore us to sanity.

The interventions for this step were designed to explore the clients Higher Power and introduce the concept of spirituality. The group intervention was designed to encourage the clients to develop a personal meaning of Higher Power and to create positive, hopeful, or motivating words to incorporate in their daily habits and routines. The individual intervention focuses on understanding spirituality and exploring opportunities to incorporate this in their daily routines.

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

The interventions for this step were created to introduce relaxation strategies and mindfulness techniques to help clients destress and think their decisions through in the moment to turn their will over to their Higher Power. The group intervention utilizes deep breathing to assist clients in achieving a calm state and understanding the positive impact that relaxation can have on their body and mind throughout recovery. The individual intervention focused on completing a mindfulness activity to allow the client to focus on their thoughts and the impact the technique can have on them in their daily lives and throughout recovery. Each intervention includes relation of the exercise to the step by incorporating decision making and inclusion of an understanding person.

**Step 4:** Made a searching and fearless moral inventory of ourselves.

The interventions for this step were selected to support the development of a self-inventory. The group intervention was structured to encourage individuals to express flaws that they feel they have and how they can positively change the flaws. The individual intervention was designed to work problems or negative feelings that they are experiencing with someone or something to find the root cause. This provides opportunity to the client to practice the skill of making a self-inventory to complete step 4.
Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

The interventions for this step were designed to assist the clients in expressing their wrongdoings to another individual. The group intervention was designed to evaluate fears and negative experiences when having serious conversations. Clients are encouraged to help each other turn their fears or negative experiences into positive ones to give confidence to complete this step. The individual intervention was selected to allow the client to practice a serious conversation and analyze how they could change past experiences to improve performance in the future.

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

The interventions for this step were created to support the clients in diminishing their flaws to be able to ask their Higher Power for assistance in riding these defects. The group intervention focuses on identifying a flaw and turning it into a positive, while finding ways to utilize this concept in their daily lives and through the recovery process. The individual intervention was focusing on creating a new perception of themselves by understanding their feelings and identifying flaws to ask their Higher Power to get rid of.

Step 7: Humbly ask Him to remove our shortcomings.

The interventions for this step were designed to assist clients in increasing the skills of humility and developing personal meaning of the step. The group intervention focuses on humility in their daily life and how it can impact their recovery. The individual intervention focuses on developing a personal prayer to remove shortcomings. This intervention emphasizes tailoring the AA prayer to the individual client and their experience.

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

The interventions selected for this step were created to assist the clients in the willingness to make amends to those they have hurt by focusing on understanding that we make mistakes and being able to apologize for those mistakes. The group intervention focuses on assisting the clients in creating a tool that they can use when formulating an apology. The individual intervention focuses on the social skills needed when formulating an apology and assisting the client in identifying their strengths and problem areas related to these skills.

Step 9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

The interventions for this step were focused on developing skills to more successfully interact in situations where confrontation may arise. The group
intervention focuses on developing listening skills and identifying what makes listening difficult, especially when discussing your wrongdoings. This will assist client in developing skills for successful communications. The individual intervention allows the clients to identify what aspects of the conversation partners behavior insights anger or frustration, which may occur when discussing your wrongdoings. Understanding how anger could occur while making amends will allow the client to be able to control that feeling more effectively.

Step 10: Continued to take personal inventory and when we were wrong promptly admitted it.

The interventions for this step were selected to assist the client in growing in understanding in the present and the future. The group intervention allows the client to evaluate their life currently and where they want to be in the future, including the characteristics needed to get there. The individual intervention allows the client to identify where they want their life to be in the future, while developing long-term and short-term goals to get there.

Step 11: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

The interventions for this step were designed to focus on visualization and creating a stronger connection to the clients Higher Power. The group intervention focused on practicing visualization of a spiritual guide of the clients choosing. The group processes how the activity increases connection to their Higher Power and how it could be helpful in their daily lives to prevent relapse. The individual session focuses on identifying spiritual activities that have become meaningful to the client and analyzing when in their daily routines those activities are most helpful.

Step 12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in our affairs

The interventions chosen for this step assist the client in exploring ways they will use the skills learned throughout the 12-steps to move forward and help others. The group session focuses on using the group to brainstorm strategies that each member can employ when spreading the workings of AA to others thinking about starting AA or those in need of AA. The individual intervention focuses on identifying the client’s strengths and problem areas that may be effective when helping others find their way to AA and reflecting upon how the client feels about the duty of helping others in this journey.

(Alcoholics Anonymous, 2013)
Assessments
Recommended Assessments

Occupational therapists focus on using client-centered approaches, starting with the occupational profile. This process occurs by gathering and interpreting data that will assist in the interventions. This data can be gathered through the utilization of assessments. The Model of Human Occupation has many different assessments that can be used for individuals in the 12-step program. While assessments gather data, it is important to use theories and frames of references when focusing on specific occupational dimensions with each client (Hemphill-Pearson, 2008).

The Model of Human Occupation Screening Tool (MOHOST) is an occupation-based tool that utilizes a variety of data-gathering methods, such as observation, interviews, consultation with interdisciplinary staff, and chart reviews. This screening tool allows the therapist to gather data on the client’s strengths and needs. The use of the MOHOST facilitates the implementation of the model’s therapeutic reasoning and concepts, while using more familiar words for the client to understand (Hemphill-Pearson, 2008). Provided below is a list of MOHO assessments that could be used for more specific client needs.

Other Possible MOHO Assessments

<table>
<thead>
<tr>
<th>Assessment of Communication and Interaction Skills (ACIS)</th>
<th>Purpose: Designed to measure an individual’s performance in an occupational task within a social group.</th>
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<td>Administration Time: 20-60 minutes</td>
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<table>
<thead>
<tr>
<th>Modified Interest Checklist</th>
<th>Purpose: Used to gather data related to client interests.</th>
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<td></td>
<td>Administration Time: 15-30 minutes</td>
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<table>
<thead>
<tr>
<th>Model of Human Occupational Screening Tool (MOHOST)</th>
<th>Purpose: An occupation-based tool, identifying client strengths and needs by way of observation, client and caregiver interviews, consultation with interdisciplinary team, and chart review. MOHOST contains 24 items arranged into 6 main concepts based on MOHO. These include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Motivation for occupation</td>
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<tr>
<td></td>
<td>• Pattern of occupation</td>
</tr>
</tbody>
</table>
- Communication and interaction skills
- Process skills
- Motor skills
- Environment

**Administration Time:** 10-40 minutes

<table>
<thead>
<tr>
<th><strong>Occupational Circumstances Assessment—Interview and Rating Scale (OCAIRS)</strong></th>
<th>Purpose: A semi-structured interview that provides qualitative (interview) and quantitative (rating scale) information about the individual’s life and occupational participation.</th>
</tr>
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<td><strong>Administration Time:</strong> 25-50 minutes</td>
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<thead>
<tr>
<th><strong>Occupational Performance History Interview-II (OPHI-II)</strong></th>
<th>Purpose: A semi-structured historical interview that provides an individual with an opportunity to reflect upon and actively construct meaning from past and current occupational participation.</th>
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<td><strong>Administration Time:</strong> 45-60 minutes</td>
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</table>

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<tr>
<th><strong>Occupational Self-Assessment (OSA)</strong></th>
<th>Purpose: Client-centered, self-report that explores a client’s performance, habits, roles, and volition.</th>
</tr>
</thead>
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<tr>
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<td><strong>Administration Time:</strong> 15-35 minutes</td>
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</table>

<table>
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<tr>
<th><strong>Role Checklist</strong></th>
<th>Purpose: A self-report written inventory to assess an individual’s occupational role performance, indicating that an individual’s role identification and value that an individual may attach to their role.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Administration Time:</strong> 10-15 minutes</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Volitional Questionnaire (VQ)</strong></th>
<th>Purpose: Provides insight into a person’s inner motives and information on the environmental aspects affecting volition by understanding how a person reacts and acts within their natural environment.</th>
</tr>
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<tr>
<td></td>
<td><strong>Administration Time:</strong> 15-30 minutes for each observation; 5-10 minutes for rating scale</td>
</tr>
</tbody>
</table>

(Hemphill-Pearson, 2008).
Intervention
Step 1
We admitted we were powerless over alcohol—that our lives had become unmanageable.

The Big Book of Alcoholics Anonymous (2013) discusses step 1 as being convinced that any life run on self-will can hardly be a success. It is important to pull away from self and discover a higher power.

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| Habituation       | Discussing frequency of perception, negative or positive, can indicate whether a habit has been formed in the client’s life.  
  • Habit: Clients are giving up control by changing their preserved way of doing something.  
  • Routines and Roles: Clients are admitting they are powerless over alcohol, which may alter their obligations. Discussion will include asking for assistance to develop healthy routines or habits. |
| Volition          | Discussion on thoughts and feelings about the doing involved in recovery, while interpreting past experiences discussing the anticipation of the future in the recovery process. Clients define their motivation for recovery.  
  • Personal causation: Asking for assistance, leading to admittance of lack of skills for recovery.  
  • Values: Focus is on how one perceives the world, their situations, and the process of recovery. |
Group Session

Admittance and Perception

PRIOR TO GROUP

● Review client’s assessment.
● Prepare a drawing on a white board. The drawing consists of one man looking up with a smile at the stars in the sky, another looking down at a puddle of mud at his feet with a frown. Bars are drawn in front of the two men that resemble those in a jail-cell.

OBJECTIVES

Members will be able to…

● Reflect upon where they are in their lives and past situations.
● Identify the positive and negative aspects of their current stage in recovery.
● Recognize how their perception of life circumstances will influence the recovery process.

MATERIALS

● Form 1-1

SESSION PROCEDURE

● Introduce group sessions and refer to step 1
  ○ Expectations of the group
● Activity: Mud or Stars?
  ○ Hand out form 1-1 for individuals to use throughout the session. Group members will look and reflect on the picture before discussion.
    ■ Encourage clients to add their experiences to their worksheet throughout the session.
● Discussion:
  ○ What is happening in the picture?
    ■ Therapist note: Elicit that both individuals are in the same situation, but they are experiencing the situation differently. The mud represents the difficulties/negative thoughts, while the stars represent the positive outlook on the situations.
  ○ How does the drawing relate to each member?
    ■ Therapist note: Each client’s answer gives an idea of their negative (mud) and positive (star) outlook on recovery.
    ■ Both individuals on the board are looking through the same bars, alcohol use. What are other ‘bars’ that you are looking through
(mental illness, relationship troubles, grief, money difficulties, physical abuse, etc.)?

- Begin to create a list of ‘mud’ examples and a list of ‘star’ examples for the ‘bars’ described on the white space of form 1-1.
  - (For example: alcohol use→ mud = craving the high, can’t afford food for family, and losing a friend; stars = positive self-perception, working on rebuilding relationships, and becoming healthy)

- Reflection:
  - What brought you here? How did you admit you were powerless over alcohol?
  - How do you want to view a difficult or challenging situation throughout your recovery?
    - Is it better to think about the negatives?
      - Anger, frustration, disappointment
    - Or would you rather live your life thinking of the positives?
      - Hope, think about possibilities, and look to the future
  - Discuss the impact of thoughts on mood and experiences
    - Negative thoughts lead to negative emotions (For example: going to a dinner with your in-laws thinking you aren’t going to have fun will prevent you from having fun).
    - Positive thoughts lead to positive emotions (For example: going to a dinner with your in-laws thinking that you are use the chance to make your spouse happy, learn about your in-laws and maybe find new connections, or have a good meal).

- Wrap-Up: Summarize the client’s experiences and situations.
  - What thoughts and feelings will you take from this group to use throughout recovery?
    - Encourage group members to write 3 words describing this at the top of your drawing page to easily look at throughout recovery.

STARS

Mud List

Star List

MUD
Giving Up Control

Prior to Session
● Review client’s assessment.
● Print worksheets for session.

Objectives
The client will be able to…
● Identify their problems and challenges in the past, while under the influence.
● Create a definition of personal motivation for themselves.

Materials
• Form 1-2
• Zip-bag #1 of purple, red, yellow, brown, and blue markers; ruler; white paper.
• Zip-bag #2 of all colors of markers, colored paper and white paper, ruler, glue, and scissors.

Session Procedure
● Introduce session and refer to step 1.
● Discussion
  ○ Identify a time in your life where you felt you had no control.
    ■ What did you want to change about the situation? What did you like?
    ■ How did you come to give up control and admit you are powerless over alcohol?
      ● Therapist note: tie into motivations to move forward and make life changes.
● Activity: Control or No?
  ○ Therapist note: Give client form 1-2 and Zip-bag #1. This activity will be completely controlled for the client to understand how having no control will feel. Allow time for the client to complete the form.
    ■ Next, have the client draw a house and family how they want with Zip-bag #2.
● Reflection
  ○ How did the first part of the activity make you feel with the instructions and bag #1?
    ■ Did you like giving up control?
      ● Was it difficult? Why?
- How did you accept giving up control in this activity?
  - What benefits do you see?
- Did you like the outcome of the first drawing where you had structure?
  - How did this compare with the part of the activity where structure was removed?
- Wrap-Up: Summarize the activity and what the client has shared.
  - How can you apply this activity to your life?
  - How do you think your feelings of giving up control will change throughout the process of recovery? Why?
Instructions

1. Using the ruler and a brown marker, draw a 4”x4” square with a ruler in the center of the white piece of paper.

2. Pick up the yellow marker. Use the ruler to draw a 4”x4”x4” triangle on top of the square so that the bottom of the triangle and the top of the square meet.

3. Inside the square, with red draw a door that touches that bottom line, and is in the middle.

4. Use brown to draw 2 smaller 1”x1” squares in the top half of the square.

5. Use the purple marker to outline the door and the windows (like trim).

6. Draw a stick figure family of 5 in blue. (Be sure to include: 1 woman, 1 man, 2 boys, and 1 girl).

7. Flip paper over.
The Big Book of Alcoholics Anonymous (2013) discusses step 2 as a higher power being the director and individuals as being more interested in what can be contributed to life greater than themselves.

### MOHO Components

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| **Habituation** | In completing the activities, clients are encouraged to develop positive habits in their daily life to promote recovery.  
  - Habits: Discuss healthy habits that can be implemented into daily life.  
  - Routine: Encouraging the inclusion of spiritual or higher power activities in their routine. |
| **Volition**    | Discussing spirituality through a higher power.  
  - Values: Through the client’s experience and perception of what the higher power is. |
| **Environment** | Influence of past and current environment on personal beliefs and values.  
  - Physical: Creating a visual representation for hope and spirituality.  
  - Social: Identifying an individual or a network that will support the client’s through the recovery process. |
Group Session

Higher Power and Hope

PRIOR TO SESSION

- Review clients progress
- Gather materials
- Print or gather examples of positive statements/words for rocks

OBJECTIVES

Group members will...

- Create a personal definition of higher power.
- Write positive, hopeful, or motivating words for their recovery.
- Share experiences with other group members.

MATERIALS

- Rocks of all shapes and sizes
- Paint
- Paint brushes
- Sharpies

SESSION PROCEDURE

- Introduce the session and refer to step 2
- Discussion
  - You’ve been discussing higher power in other sessions, how would you define that today?
  - How do you see your higher power affecting your process of recovery?
    - Identify a list of words that provide you with hope.
  - Is there someone in your life you could see supporting your understanding of a higher power?
  - Do you have any previous experiences that stick out that could have been pertaining to a higher power?
    - How does this impact your life right now?
- Activity: Hope Rocks
  - Each person will receive 5 rocks of all shapes/sizes, along with supplies in the middle of the table for people to share. On the rocks, clients should write hopeful words, statements, or names that can be hopeful or motivating.
    - Therapist note: Encourage clients to place these rocks somewhere they can see them every day to remind them of the journey they are
on. Can be placed right outside their front door, in the car, in a dish next to the bed, in the bathroom, etc. Can keep them in their pocket for easy access if the client comes across a stressful or difficult situation.

- **Processing**
  - Share one rock with the group and how it will help you in recovery.
  - How will you use this rock or activity in your daily life?
- **Wrap-Up: Summarize the clients’ experiences and ideas**
  - Moving forward, what other ways can you incorporate hope in your life to support your recovery?
**Individual Session**

**Discovering Spirituality**

**PRIOR TO SESSION**
- Review clients progress
- Gather materials

**OBJECTIVES**
The client will be able to…
- Examine and identify activities that relate to the client’s higher power.
- Evaluate how spirituality may be incorporated into daily routines.

**MATERIALS**
- Print form 2-1, 2-2, 2-3

**SESSION PROCEDURE**
- Introduce the session and refer to step 2.
- Discussion of Step 2
  - What religious or spiritual traditions have you experienced in the past?
    - What role, if any, did the experience play in your life at that time?
    - And now in the present?
  - What do you feel gives your life meaning?
    - Do you draw strength from anything? Where do you find hope?
    - Is there a time you have felt peace?
- Activity:
  - “Think of the activities that you find meaningful and enjoy doing.”
    - Therapist note: Provide Form 2-1 and 2-2
  - Work through the 2 forms, and begin to record the activities you have identified.
    - How often do you participate in these activities?
- Processing
  - How do you see yourself incorporating these activities in your daily schedule?
    - Provide Form 2-3 and have the client fill in their daily obligations.
    - Provide Form 2-4.
      - Encourage the client to incorporate the activities into their weekly schedule on a regular basis.
Depending on the activities chosen by the client, aid the client in establishing a realistic schedule.

- **Wrap-Up:** Summarize the activity and what the client has developed.
  - How could you continue to use this activity throughout recovery to maintain your understanding of a higher power?
  - Do you anticipate any benefits from incorporating these activities more frequently?

Spirituality

What is spirituality?

- The activities or things that people find meaning and purpose in their life.

<table>
<thead>
<tr>
<th>Spirituality</th>
<th>Religion</th>
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<tbody>
<tr>
<td>Universal</td>
<td>Community</td>
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<tr>
<td>Individualized</td>
<td>Structure</td>
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<tr>
<td>Sense of purpose or meaning</td>
<td>Cultural</td>
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<tr>
<td></td>
<td>Rituals</td>
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<td></td>
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<tr>
<td>Connection to something greater</td>
<td></td>
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<tr>
<td>or beyond oneself</td>
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</table>

What could be considered spiritual?

- Listening to or making music
- Reflect or meditate
- Dance
- Journal
- Yoga

- Be creative:
  - Paint/draw/sculpt
  - Cook/Bake
  - Garden
  - Write stories

My Spiritual-Based Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>How often DID you do this?</th>
<th>How often WILL you do this?</th>
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# Daily Schedule

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>Midnight</td>
</tr>
<tr>
<td>1 AM</td>
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<td>2 AM</td>
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<td>3 AM</td>
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<td>4 AM</td>
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<td>5 AM</td>
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<td>6 AM</td>
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<td>7 AM</td>
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<td>8 AM</td>
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<td>9 AM</td>
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<td>10 AM</td>
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<tr>
<td>11 AM</td>
</tr>
<tr>
<td>NOON</td>
</tr>
<tr>
<td>1 PM</td>
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<tr>
<td>2 PM</td>
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<td>3 PM</td>
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<td>9 PM</td>
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<td>10 PM</td>
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<tr>
<td>11 PM</td>
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# Weekly Schedule

<table>
<thead>
<tr>
<th>9PM</th>
<th>6PM</th>
<th>3PM</th>
<th>Noon</th>
<th>9AM</th>
<th>6AM</th>
<th>3AM</th>
<th>Midnight</th>
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The Big Book of Alcoholics Anonymous (2013) discusses step 3 as an opportunity to relieve bondage of yourself. This step should be taken with an understanding person, whether that is a significant other, best friend, sponsor, or therapist.

### MOHO Components

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| **Habituation** | Identifying decision making patterns allow the clients to analyze their sense of self and how to change their habits and routines.  
- Habits: allows the client to look at their habits and how changes can be made to increase efficiency in their life and recovery process.  
- Routines: creates an opportunity for clients to strategize how they can incorporate these activities in their daily life. |
| **Volition**    | Practicing relaxation techniques to incorporate spirituality through a higher power.  
- Personal causation: works to develop one’s sense of self and their own capabilities when using these tools in recovery.  
- Values: experiencing feelings leading to creation of a sense of meaning in their life. |
| **Performance Capacity** | Through the lived body experience, clients are able to view their body and mind as separate entities. Clients are able to apply these relaxation techniques to their experiences and their future recovery process. |
Group Session

Turning Will Over to Our Higher Power

PRIOR TO SESSION

- Review client progress
- Prepare materials

OBJECTIVES:

Clients will be able to...

- Discuss what differences they notice in themselves after performing deep breathing exercises.
- State when and where they could perform this relaxation technique at home.
- State how deep breathing can aid in their recovery process.

MATERIALS

- A large, quiet, dark room with adequate floor space for clients
- Mats
- Relaxing music

SESSION PROCEDURE

- Introduce session and review step 3
- Discussion
  - Have you done deep breathing exercises, yoga, meditation, visual imagery, or tension-release exercises? If so, explain.
    - Have you done these exercises with someone else? How did that make you feel?
    - Therapist note: Fill in any information above that clients did not define or explain.
- Activity: Deep Breathing
  - Therapist note: Explain what deep breathing exercise entails:
    - How long the exercise will last, that members will be lying down with mats and their eyes closed, listening to the therapist voice and instructions, performing the exercise as it’s being described. The exercise is meant to be relaxing and a time for clients to think about their higher power. If a client feels uncomfortable, they can listen in a sitting position or leave the group.
  - Therapist note: Deep breathing exercise
    - Have clients lay down on the mats
    - Turn off the lights (close shades and doors)
- Put on low, relaxing background music
- Begin telling members to relax and let their thoughts flow freely in and out of their mind as they concentrate on your voice.
- Ask them to focus their breathing as it is naturally happening, being aware of the inhalations and exhalations and the rising and falling of their chest (allow 2-3 minutes).
- Ask the clients to relax each part of their body, one at a time (allow 3-4 minutes).
- Ask them to expel any remaining questions or stress left in their body with each exhalation (allow 2-3 minutes).
- Client’s should now be relaxed; proceed with the following exercises (resume regular breathing in between each):
  - Deep breathing from the diaphragm.
  - Full inspiration with breath holding for as long as possible.
  - Bone breathing—breathing into different parts of the body.
  - Breathing as slow as possible.
  - Breathing in through the nose and out through the mouth.
  - Exhaling any unwanted thoughts or feelings, giving them to your higher power, until they are gone.

- Reflection
  - What positive experiences did you have? How did you feel before and after the activity?
    - What uncomfortable experiences did you have? How did you feel before and after the activity?
  - How did you feel completing this activity with others around you? How can this help you in step 3?
  - How does relaxation and reducing stress relate to making the decision to give up control and begin to relieve bondage of yourself?
  - When you are relaxed, do you approach situations differently? How so?

- Wrap-Up: Summarize session
  - When and where could you use this activity at home?
  - How could this activity be helpful in preventing relapse?

Individual Session

Making Decisions

PRIOR TO SESSION
- Review client progress

OBJECTIVES
The client will be able to…
- Understand their thoughts and feelings in the present moment.
- Identify how decisions are made in their life.
- List 3 strategies to change negative decision-making patterns.

MATERIALS
- Form 3-1

SESSION PROCEDURE
- Introduce session and review step 3
- Discussion
  - How is decision making in your life right now? What do you feel you could change?
  - Do you consult others when making decisions? How could you in step 3?
- Activity: Five Senses
  - Take the client outside or to an area with other’s around.
  - Give Form 3-1 to process and take notes or draw on.
- Reflection
  - What did it feel like to understand your senses fully?
  - What did you notice that you hadn’t noticed before when being outside?
  - How do these feelings relate to your everyday life?
  - What are 3 strategies you can use to change your negative decision-making patterns?
    - Example: take time to think things through before deciding.
- Wrap-Up: Summarize session
  - Can you find time in your schedule to do this daily?
    - How can this impact how you engage in activities throughout the day?
  - How can you use this activity and apply it to your decision making in step 3?

Adapted from https://positivepsychologyprogram.com/mindfulness-exercises-techniques-activities
Five Senses

1. Notice 5 things that you can see. Look around and focus on things you don’t normally notice. This could be a crack on the stairs or a wobbly bench.

2. Notice 4 things that you can feel. This could be the rough surface of the concrete or grass, or the uneven bumps on the bottom of your shoe.

3. Notice 3 things that you can hear. Take a deep breath and close your eyes. What do you hear? This could be a car revving its engine or a person walking closely by you.

4. Notice 2 things you can smell. These can be pleasant or unpleasant, such as a trash can or freshly cut grass.

5. Notice 1 thing that you can taste. You may be chewing on a piece of candy or can open your mouth and notice a taste from the air.

Adapted from https://positivepsychologyprogram.com/mindfulness-exercises-techniques-activities
The Big Book of Alcoholics Anonymous (2013) describes step 4 as a personal housecleaning to look at mistakes made, resentments, and failures. If inventory wasn’t taken of negative aspects of life, then it is difficult to move forward in recovery in a healthy way. Through this step, individuals can identify their own personal fears or actions that created negative experiences or relationships and work to find a solution.

### MOHO Components

<table>
<thead>
<tr>
<th>MOHO Component</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| **Habituation** | Through discussion, clients are encouraged to evaluate their areas of challenge.  
- Roles: reflecting on performance.  
- Routine: identifying strategies to continue to reflect on themselves and their behaviors. |
| **Volition** | Through discussion, volition is supported while working through problems and how it affects them to understand themselves.  
- Personal causation: identifying feelings about their own capacity to perform roles and responsibilities in their life. |
| **Environment** | Identifying social relationships in their life.  
- Social: Identify relationships and why resentment is felt against other individuals. |
Flaws

PRIOR TO SESSION
- Gather supplies

OBJECTIVES
Group members will be able to...
- Identify personal flaws
- Write positive and helpful strategies to minimize the impact on recovery.

MATERIALS
- Paper (white or construction)
- Markers (red, purple, and black)

SESSION PROCEDURE
- Introduce the session and refer to step 4.
- Discussion of step 4
  - Think about yourself.
    - Your strengths? Flaws? Feelings?
    - Things you may have done to someone. Things that may have been done to you. Describe these feelings.
  - Activity
    - Each person will receive a piece of paper and 3 markers (red, purple, and black). On the paper, the clients should write in red flaws, feelings, relationships that need mending, etc.
      - Therapist note: Encourage clients to write as many things that they can think of
    - Next, pass the paper to the person on your left.
      - Therapist note: Direct them to read the characteristics, and describe the feelings that the characteristics evoke in them.
      - Write words to describe your feelings of what’s on the paper in purple.
    - Pass the papers to the left once more. Examine what has been written, using black write how the words on the paper can be positive.
      - Therapist note: Encourage the clients to think about strategies that may help.
    - Return the papers to their original owners.
Therapist note: Instruct the clients to take the time to look over the page that was returned to them.

- Reflection
  - What changes were made to your paper?
  - What feelings were described?
  - What strategies or positive words were you given?
  - How can this experience be related to your life? Recovery? Your relationships?

- Wrap-Up: Summarize the client’s experiences and ideas.
  - Moving forward, what is one way that you will continue to take inventory on yourself? Do you see a benefit in taking the time to look at yourself?
Individual Session

Our Personal Inventory

Prior to Session
- Review client’s progress

Objectives
The client will be able to...
- Identify people, or situations that they are holding resentment toward.
- Evaluate how the situation is impacting the journey of recovery.

Materials
- Print Form 4-1, 4-2

Session Procedure
- Introduce the session and refer to step 4.
- Discussion of step 4
  - Think about situations that you have experienced that seem pivotal to the person you are today?
    - Are those experiences positive or negative?
    - Do you feel resentment? Or blame?
- Activity:
  - Think about the people that you have negative feelings toward.
    - Therapist note: Provide Form 4-1
    - Therapist note: Provide examples with Form 4-2 for individuals that are struggling.
  - Pick at least one specific situation to evaluate further and identify the root cause.
    - What were your motives when approaching the situation?
      - Winning the battle? Proving the other person was wrong?
    - What was your part in the situation?
      - Were you trying to find a solution? Supporting the problem?
- Wrap-Up: Summarize the activity and what the client has concluded.
  - Will this activity help you relieve the resentment that you hold for the others listed above?
  - Do you anticipate any benefits from incorporating this strategy?

Who, What, Why?

Who do you feel resentment toward?

1.

2.

3.

4.

Pick one or two people from the list above to complete the rest of the worksheet. Once complete, return to the line regarding the affect, and write the injury next to the affect. For example: self-esteem, security, ambitions, personal and sex relations.

I'm resentful at:____________________________________________________

________________________________________________________________

What caused this?:__________________________________________________

________________________________________________________________

________________________________________________________________

This affects me how?:______________________________________________

________________________________________________________________

I'm resentful at:____________________________________________________

________________________________________________________________

What caused this?:__________________________________________________

________________________________________________________________

________________________________________________________________

This affects me how?:______________________________________________

________________________________________________________________

________________________________________________________________

Examples

I’m resentful at: Mr. Brown
The Cause: His attention to my wife.
Affects my: Sex relations. Self-esteem (fear).
The Cause: Told my wife of my mistress.
Affects my: Sex relations. Self-esteem (fear).
The Cause: Brown may get my job at the office.

I’m resentful at: Mrs. Jones
The Cause: She’s a nut—she snubbed me. She committed her husband for drinking. He’s my friend. She’s a gossip.

I’m resentful at: My employer
The Cause: Unreasonable—Unjust—Overbearing—Threatens to fire me for drinking and padding my expense account.

I’m resentful at: My wife
Affects my: Pride—Personal sex relations—Security (fear).

The Big Book (2013) discusses step 5 as a vital step in overcoming drinking. Keeping secrets and facts about their life to themselves has brought individuals back to drinking. Leading a double life is common, but being open to an understanding person breaks that. Going through step 5, individuals must be entirely honest with somebody if they expect to live long or happily in the world during recovery. If there is not an understanding person, a psychologist, therapist, or doctor may be that person. Once an understanding person is chosen, the individual must prepare for a long talk to explain why this step is important and that they are engaged in a life-or-death errand.

<table>
<thead>
<tr>
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| Habituation      | Through discussion and the activities, client’s will relate past experiences and how they can alter their behaviors to create positive patterns of behaviors.  
  - Habit: identify strategies to understand different behaviors when starting a personal or challenging conversation. |
| Volition         | Through this step, clients will be able to use their motivation and desire to stop drinking in their serious conversation.  
  - Personal causation: by increasing their awareness of thoughts and feelings, clients they be able to apply knowledge of the activity to personal life experiences. |
| Performance Capacity | The activity allows the clients to practice cognitive abilities, such as planning and memory, and skills related to confiding in another individual to fulfil the 5th step. Positive experience is a main component of how people can perform in other conversations of their life. |
| Environment      | Identifying an understanding person in their life and be willing to open up to them about their story.  
  - Social: preparing to communicate efficiently and effectively with another individual is important in this step. |
Group Session

Starting Conversations

PRIOR TO SESSION
- Gather materials

OBJECTIVES
Clients will be able to...
- Identify positive strategies to decrease fear before starting a serious conversation.
- Practice using conversation starters with other individuals in the group.

MATERIALS
- Paper
- Pens

SESSION PROCEDURE
- Introduce session and review step 5
- Discussion
  - What feelings are present when you need to have serious conversations with someone?
  - What strategies have not worked for you when starting a conversation?
- Activity: Throw It Away
  - Clients will start sitting in a circle.
  - Each client will write on a piece of paper a fear they have when starting a serious conversation or a past negative experience they had with starting a serious conversation.
  - The papers will then be placed into a bucket in the middle of the circle.
  - Starting with volunteers, a client will grab a piece of paper from the bucket, read the paper, and turn the fear or experience into a positive one or give a positive example of how to change that fear/experience.
    - Can have clients use the situation on their paper to actually start a conversation with someone in the group.
- Reflection
  - How did you feel this activity can be used in other aspects of your life?
    - In recovery?
  - Was there something that was said that made you feel like you could change how you look at conversations in your everyday life?
  - How can you decrease fear prior to starting a conversation for step 5?
    - What will you do to make your conversation positive instead of fearful?
- Wrap-Up: Summarize the client’s experiences and ideas.
  - How did this activity help you learn possible ways to start a serious conversation with the person you want to take this step with?
    - Why is making your fear or negative experience positive important in your life?
Starting a Conversation

PRIOR TO SESSION
- Review client’s progress

OBJECTIVES
The client will be able to
- Identify 2 strategies to use to start a difficult conversation.
- Perceive an alternate view of how to address a difficult situation.

MATERIALS

SESSION PROCEDURE
- Introduce session and review step 5
- Discussion
  - Ask the client if they have an understanding individual to work through this step with.
    - Do you know how you will begin talking about your journey to be honest with them?
    - What feelings do you have when thinking about being open with them?
- Activity: Conversation Role-Play
  - Option 1: Role play a situation in which the client had a difficult conversation that didn’t go well.
    - Process after.
  - Option 2: Role play how the client will begin the conversation of opening up with the understanding person.
    - Process after.
- Reflection
  - When discussing challenging topics, is it helpful to practice what we might say?
    - Does practicing make it hard to adjust to what happens in the actual moment?
  - What strategies have you used in the past to open up to people?
    - How did those strategies work?
- Wrap-Up: Summarize the client’s experiences and ideas.
  - How will you be able to take this role-playing activity and use it in your life during recovery?
  - What are other strategies you could use to prepare yourself for difficult conversations?
The Big Book of Alcoholics Anonymous (2013) discusses step 6 as being a reflection of flaws or defects and asking the Higher Power to assist with getting rid of these things.

### MOHO Components

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<tbody>
<tr>
<td><strong>Habitation</strong></td>
<td>Different characteristics and steps that need to be changed to continue with the recovery process are identified</td>
</tr>
<tr>
<td></td>
<td>- Habits: behaviors that the client needs to adjust to further their recovery are acknowledged and discussed.</td>
</tr>
<tr>
<td></td>
<td>- Routines: applying the activities to daily life and recognizing situations that it can be useful in.</td>
</tr>
<tr>
<td><strong>Volition</strong></td>
<td>Clients are able to evaluate their sense of self and identifying characteristics to become more self-aware and self-accepting.</td>
</tr>
<tr>
<td></td>
<td>- Values: by developing a better sense of self, clients are able to develop beliefs and ideas of what is important for them to do.</td>
</tr>
<tr>
<td></td>
<td>- Personal causation: clients are able to identify their sense of self, along with the flaws that interfere in their personal meaning of life.</td>
</tr>
</tbody>
</table>
Ridding of Flaws

PRIOR TO SESSION
- Gather materials

OBJECTIVES
Clients will be able to...
- Identify one flaw or defect that they are having difficulty moving on from.
- Identify 3 ways to move forward from this flaw or defect.

MATERIALS
- Masking tape or duct tape
- Paper
- Pens

SESSION PROCEDURE
- Introduce session and review step 6
- Discussion
  - Therapist note: Ask for a volunteer. Take the volunteer to the back of the room and have them walk to the front of the room with a circular piece of tape stuck to the bottom of their shoe.
  - What happens when he/she tries to walk forward?
    - Therapist note: Elicit getting stuck.
  - What does it mean to get stuck in one spot?
    - How does this relate to a flaw or defect that you have a difficult time identifying or letting go of?
- Activity: Throw Your Flaw Away
  - Sitting in a circle, each client will take a piece of tape and write their flaw or defect on it and stick it to the bottom of their shoe.
  - Therapist note: Ask for volunteers to share.
  - How can you help another person move on from their flaw or defect?
    - Therapist note: As clients assist others with their flaw/defect, have the clients take notes on their papers.
  - What can you do to help yourself move on from this flaw or defect?
    - Therapist note: Once each client has identified ways to move on from what they are stuck on, have them walk to the garbage can, remove the tape from their shoe and have them throw it away. This symbolizes getting unstuck from their flaw or defect.
• Reflection
  o How did this activity make you feel? Positive? Uncomfortable? Why?
  o How can you get “unstuck” from other situations in your life?
    ▪ Therapist note: recognizing that situation is over, change thoughts or feelings, join support groups, etc.
  o How is this activity important in your daily life? How can you use it daily?
    ▪ Therapist note: Being able to understand when something is getting you stuck in one place.

• Wrap-Up: Summarize session
  o How can this activity influence your recovery?
    ▪ Can you continue to relate to getting “unstuck” like this activity?
Individual Session

Letting Go of Flaws

PRIOR TO SESSION
- Gather materials
- Review client progress

OBJECTIVES
Clients will be able to...
- Listen to their feelings and think of their flaws.
- Be more self-aware and self-accepting to get rid of flaws through their higher power.

MATERIALS
- Quiet, dark room (providing a mat is optional)

SESSION PROCEDURE
- Introduce session and review step 6
- Discussion
  - What ways have you used or plan to use to ask your higher power to get rid of your flaws or defects?
- Activity: Presence with Yourself
  - Set the mood—quiet the room, turn out the lights (can lay on a mat or remain sitting)
    - Therapist note: Explain that focusing can help you become clearer about what you’re feeling and how you want to get rid of flaws, while focusing on your recovery and what you want in your life.
  - Start by choosing a flaw or defect you want to get rid of. Bring your attention to your body, while focusing on your throat, chest, and stomach.
    - Ask yourself “How am I, in here, right now?”
    - Give special attention to your senses and feelings. Feel how your flaw feels in your body.
    - Begin to describe the feelings you are feeling in words and images.
    - Be open to understanding how the flaw or defect makes you feel.
    - Feel the presence throughout your body.
    - If you are ready, you can ask for forgiveness from your higher power.
    - Give a gentle thank you to your body for letting you feel in this process.
• **Reflection**
  o How did the activity make you feel?
  o Were you able to reflect on a defect/flaw to give to your higher power?
    ▪ Was this experience positive or uncomfortable? Explain.
  o What else can you do to enhance this activity?
    ▪ *Therapist note: elicit use of a journal after each session, describing what you’re feeling after the activity, etc.*

• **Wrap-Up: Summarize session**
  o How will this activity help you move forward in your recovery?
  o When and how can you use this in your everyday life?

The Big Book of Alcoholics Anonymous (2013) discusses step 7 as a step in developing humility and praying for shortcomings to be removed.

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| Habituation      | Clients examine how behaviors and their intentions behind their actions influence their selflessness.  
|                  | - Habits: clients are asked to develop a sense of humility in determining how they can use this in their daily actions. |
| Volition         | Through discussion, clients are able to identify their sense of self in this step and when changing the intent of their actions can be beneficial.  
|                  | - Values: clients have the opportunity to create a prayer that is meaningful to them and their view of their Higher Power.  
|                  | - Interests: clients are allowed the opportunity to identify what they find enjoyable in their life. |
| Environment      | Clients are expected to consider humility in the recovery process, which impacts their relationships, sense of self, and the recovery process.  
|                  | - Social: clients examine how humility may play a role in developing positive relationships with those in their lives. |
Practicing Humility

**Prior to Session**
- Gather materials

**Objectives**
Clients will be able to...
- Identify how humility looks in daily life.
- Identify the impact that humility has in the recovery process.

**Materials**
- Papers
- Assorted writing utensils
- Envelopes

**Session Procedure**
- Introduce session and review step 7
- Discussion
  - What does humility mean?
  - Reflect upon a person that has made a positive impact on your life. Describe this.
- Activity: **Letter of Humility**
  - *Therapist note: Give clients a piece paper, writing utensil, and an envelope. Have them write a brief note to the person that has made a positive impact on their life.*
  - Instruct them to refrain from writing their name on the letter.
- Reflection
  - How did you feel while completing this activity?
  - Why do you suppose you were asked not to sign the letter?
  - How was the activity an act of humility?
    - What other ways could we show humility to others?
    - *Therapist note: Encourage the group members to share examples of a time that they were shown or showed someone humility.*
  - What does humility have to do with humbly asking Him to remove our shortcomings?
- **Wrap-Up:** Summarize the client’s experiences and ideas.
  - After completing the activity, what is your understanding of humility?
  - How did this activity help you learn possible ways to start exercising humility?
    - How will this impact your recovery?

Identifying Our Own Meaning

**Prior to Session**
- Review client’s progress
- Gather Materials

**Objectives**
The client will be able to
- Develop personal understanding of step 7.
- Develop own personal prayer reflective of self and the goals of step 7.

**Materials**
- Form 7-1
- Paper

**Session Procedure**
- Introduce session and review step 7
- Discussion
  - Ask the client if they have their own definition of step 7 “Humbly ask Him to remove our shortcomings.”
    - What do the words of the step mean?
  - On a piece of paper, ask the client to breakdown the step and develop a personal definition.
    - Question what this step entails.
- Activity
  - Provided the prayer from The Big Book of Alcoholics Anonymous (Form 7-1), the client will write a similar prayer that is more fitting to their understanding and experience.
- Reflection
  - How does it feel to have developed your own understanding of the seventh step? The prayer?
  - Why is it important to explore your understanding?
    - Make the prayer more applicable to you?
- Wrap-Up: Summarize the client’s experiences and ideas.
  - What did you gain from this activity?
  - Do you see potential benefits?
  - How will this activity impact your completion of step 7?
Step Seven Prayer

“My Creator, I am now willing that you should have all of me, good and bad. I pray that you now remove from me every single defect of character which stands in the way of my usefulness to you and my fellows. Grant me strength, as I go out from here, to do your bidding. Amen.’’

Write your own prayer or conversation you would like to have with you Higher Power on the lines below:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The Big Book of Alcoholics Anonymous (2013) discusses step 8 as looking at the inventory created and going out to repair the damage that was done in the past. The book discusses that it should be reminded in this step that at the beginning of the recovery process, it was agreed that any necessary steps would be completed for victory over alcohol.

### Interventions for Step 8

Make a list of all persons we had harmed, and became willing to make amends to them all.

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| **Habituation** | Clients have the opportunity to internalize the use of social skills to apologize and recognize mistakes.  
• Habits: clients have the ability to discuss how these strategies can be implemented in their life to perform in a consistent, positive way. |
| **Volition**    | Clients are provided the opportunity to practice skills necessary to apologize and recognize mistakes.  
• Personal causation: clients have the opportunity to increase self-efficacy in achieving their desired outcomes by apologizing for their wrongdoings. |
Group Session

Apologizing and Mistakes

PRIOR TO SESSION
• Gather materials

OBJECTIVES
Clients will be able to…
• Identify 4 ways they can apologize.
• Acknowledge that it is okay to make mistakes.

MATERIALS
• Forms 8-1, 8-2, 8-3
• Markers
• Binder rings
• Scissors
• Hole punch

SESSION PROCEDURE
• Introduce session and review step 8
• Discussion
  o Therapist note: Give clients form 8-1 and allow 3-4 minutes for completion.
  o Describe a time you made a mistake.
  o Now describe a time you had to apologize for a mistake. How did you do that? How did it turn out?
    ▪ How would you change your apology next time if it did not go well?
    ▪ What are ways you can apologize for something you did?
• Activity: Apology Book
  o Therapist note: Distribute form 8-2 and 8-3 to clients.
    ▪ Form 8-2 has 8 ways to apologize. Have clients create their own ways to apologize on form 8-3. Have clients use scissors to create cards, hole punch the top left corner and use a binder ring to hold the cards together.
• Reflection
  o How did it feel to create the apology book?
    ▪ How can you use this apology book in your life?
Why is it important to think about how you will apologize for mistakes before you take the step to make amends?

What have you learned from your mistakes when thinking about this activity?

- **Therapist note:** Elicit that everyone makes mistakes and we learn from them.

**Wrap-Up: Summarize session**

- What can you do to use what you’ve learned in your life? In your recovery?
Everyone Makes Mistakes!

Think back to a time when you made a mistake. What happened?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

How did you know it was a mistake?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

When you realized it was a mistake, what did you do? Did you fix it? How?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

How did you feel after making the mistake?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

What did you learn from this mistake?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

What would you do differently the next time this happened?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
### WHAT I CAN SAY WHEN I NEED TO APOLOGIZE TO SOMEONE.

<table>
<thead>
<tr>
<th>I want to apologize for _____</th>
<th>I would like to apologize to you.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want to apologize for hurting you.</td>
<td>I want to apologize for ____ because I feel bad.</td>
</tr>
<tr>
<td>I did not mean to hurt you for ____</td>
<td>I was wrong to hurt your feelings.</td>
</tr>
<tr>
<td>I take full responsibility for ____</td>
<td>That was wrong of me to hurt you for ____</td>
</tr>
</tbody>
</table>
Individual Session

Social Skills

PRIOR TO SESSION
• Review clients progress
• Gather materials

OBJECTIVES
Clients will be able to…
• Identify the social skills needed to apologize.
• Identify up to 6 of their strengths in social skills.
• Identify up to 6 of their deficits in social skills.
• Increase their understanding of why it is important to recognize when they have made a mistake.

MATERIALS
• Form 8-4 and 8-5

SESSION PROCEDURE
• Introduce session and review step 8
• Discussion
  o Therapist note: Give client form 8-4. Have them read it and ask questions if needed. Allow time for completion. Discuss their answers.
• Activity: Apologize Role Play
  o Identify a mistake that you made with someone.
  o Therapist note: Role play as the other individual for the client.
  o Begin by re-playing how the mistake occurred.
  o Now role play how the situation could have gone with the skills of form 8-4.
• Reflection
  o Therapist note: Give form 8-5 to the client. Discuss each question based on form 8-4 and the activity.
  o What did you learn from the activity, after learning the skills needed to apologize? How will this affect future mistakes you may make?
• Wrap-Up: Summarize session
  o How can you use these skills throughout your recovery?
  o Do the skills only need to be used when apologizing?
Social Skills
With a focus on Apologizing

Social skills that can help you maintain sobriety:
1. Being able to say “no”.
2. Being assertive and sticking to what you believe.
3. Being able to receive feedback.
4. Being able to apologize when necessary.
5. Being aware of your feelings.

Do you need to apologize for numbers 1 and 2? Why?
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Looking at number 3, what skills do you need to use when receiving feedback?
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
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What skills do you need to successfully apologize when necessary, as in number 4?
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Why is number 5, being aware of your feelings, important in recovery? Why is it important when apologizing?
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Social Skills Strengths and Problem Areas

*With a focus on Apologizing*

Keeping in mind the skills discussed on the “Social Skills: With a Focus on Apologizing” worksheet and in the role-playing:

What skills are you good at?
1. 
2. 
3. 
4. 
5. 
6. 

What skills do you need or want to work on?
1. 
2. 
3. 
4. 
5. 
6. 

Why is it important to know when you made a mistake?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

What will you do next time you make a mistake to use the social skills discussed in these worksheets?

______________________________________________________________
______________________________________________________________
______________________________________________________________
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______________________________________________________________

Interventions for Step 9
Make a decision to turn our will and our lives over to the care of God as we understood Him.

The Big Book of Alcoholics Anonymous (2013) discusses step 9 as the beginning of mending relationships with those that have been impacted by repaying debts that have been owed, and apologizing. Step 9 focuses on talking about our wrongdoings, not the other individuals.

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| Habituation     | Clients are able to identify patterns of behaviors when speaking to others and are provided time to analyze their emotions when talking to others.  
• Habits: allows the client to look at their habits and how changes can be made to increase efficiency in their life and recovery process.  
• Routines: creates an opportunity for clients to strategize how they can incorporate these skills in their daily life. |
| Volition        | Practicing emotional regulation and mindful listening to increase sense of self within social situations.  
• Personal causation: works to develop one’s sense of self and their own capabilities when using these tools in recovery.  
• Values: determining whether use of these skills is meaningful to them individually. |
| Performance Capacity | Through the lived body experience, clients are able to view their body and mind as separate entities. Clients are able to apply these social skills discussed to their experiences and their future recovery process. |
Group Session

Mindful Listening

**Prior to Session:**
- Review progress of clients.
- Gather Materials

**Objectives:**
Clients will be able to...
- Identify what distractions occur when expected to listen.
- Identify how listening will aid in step 9 of the recovery process.

**Materials:**
- Form 9-1
- Assorted writing utensils

**Session Procedure:**
- Introduce session and review step 9
- Discussion
  - How well do we all listen?
    - What makes listening challenging?
  - *Therapist note: Question the importance of listening in step 9.*
- Activity: *Mindful Thinking*
  - *Therapist note: Provide each client with a piece of paper and writing utensil.*
    - What is something that you are stressed about?
      - Write it down.
    - What is something you are excited for?
      - Write it down.
    - Share examples.
    - *Therapist note: Encourage clients to be mindful of their thoughts, feelings, and body sensations when speaking and listening.*
- Reflection
  - How did you feel while speaking? Listening?
  - Did you catch yourself being distracted?
    - What were you distracted by?
    - How did you return your focus to the activity?
  - At any time, did a judgment cross your mind?
  - What feelings did you experience?
    - Speaking? Listening? Currently?
  - How did your body react to those feelings?
    - (i.e. tense, nervous)
  - What could you do to show your conversation partner that you are listening?
    - *Therapist Note: Encourage the clients to take notes on Form 9-1.*
If you practiced mindful listening during each conversation, what would be the outcome?
How would the outcome be different from what you have experienced?

- **Wrap-Up:** Summarize the client’s experiences and ideas.
  - What was the major takeaway from the activity today?
  - Did the activity influence your perception on the importance of listening?
    - How will this impact your recovery?

My Thoughts on Listening

L Look Interested
I Involve Yourself
S Stay on Subject
T Test Your Understanding
E Evaluate the Message
N Neutralize Your Feelings

Managing Triggers

PRIOR TO SESSION:
- Review client’s progress
- Gather Materials

OBJECTIVES:
The client will be able to
- Identify what triggers an angry response.
- Identify strategies that may be used to prevent an angry response.

MATERIALS:
- Form 9-2
- Pens

SESSION PROCEDURE:
- Introduce session and review step 9
- Discussion
  - What are things that provide challenges when talking to those that we have wronged or hurt?
    - Are there certain behaviors that prevent a productive conversation?
    - Do others have habits that immediately cause you to become angry?
  - Reflect on recent or major confrontations.
    - Create a list of things that insight anger or irritate you.
- Activity: What Makes Me Angry
  - Therapist note: Give the client form 9-2. Allow time for the client to work through it.
- Reflection
  - What feelings were you feeling when reflecting on the situation?
    - Why do you think these feelings occurred?
  - Have you ever considered that you DECIDE how to feel?
    - How could you CHOOSE to react differently in the future?
  - What could you do to control your response?
    - Therapist note: Ask them to think of strategies discussed in earlier sessions.
- Wrap-Up: Summarize the client’s experiences and ideas.
  - What did you gain from this activity?
  - How do you see the knowledge learned today potentially benefitting you currently and in the future?

Session adapted from: Butler, C.A. (2001). 100 Interactive activities for mental health and substance abuse recovery (pp. 5-6). Wellness Reproductions & Publishing.
What Makes Me Angry?

When was the last time I had a confrontation with someone significant? Who was it?

What made me angry with this person? What did they do?

When did the confrontation occur? What else was happening in my life when the confrontation occurred?

Why did this make me angry?

How did I react to the situation?

How could I change my reaction to the situation?

What strategies will I use to control my reaction in the future?

Session adapted from: Butler, C.A. (2001). *100 Interactive activities for mental health and substance abuse recovery* (pp. 5-6). Wellness Reproductions & Publishing.
The Big Book of Alcoholics Anonymous (2013) discusses step 10 as growing in understanding and effectiveness by continuing to take personal inventory and setting right any mistakes. This step continues for a lifetime while constantly watching for selfishness, dishonesty, resentment, and fear.

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habituation</td>
<td>Through the activities, clients are provided an opportunity to identify changes that can be made in their life now that will affect where they want to be in the future.</td>
</tr>
<tr>
<td></td>
<td>• Habits: clients are asked to create steps to take in their life to achieve their 2-month goal.</td>
</tr>
<tr>
<td></td>
<td>• Roles: clients discuss possible role changes that will be made throughout the recovery process.</td>
</tr>
<tr>
<td>Volition</td>
<td>Clients are asked to examine their life and the meaning they want from it.</td>
</tr>
<tr>
<td></td>
<td>• Personal causation: clients create a sense of effectiveness and determine goal-directed actions to achieve desired outcomes in life.</td>
</tr>
<tr>
<td></td>
<td>• Values: clients identify what is important for them to achieve in their future.</td>
</tr>
<tr>
<td></td>
<td>• Interests: developing goals provides clients the opportunity to use their interests in creating goals.</td>
</tr>
</tbody>
</table>
Looking into the Future

Prior to Session:
- Gather materials

Objectives: Clients will be able to…
- Recognize how they want to grow in understanding and effectiveness throughout recovery.
- Identify what steps are needed to get to the 2-month picture and what characteristics need to change or remain.

Materials:
- Form 10-1
- Form 10-2
- Markers

Session Procedure:
- Introduce session and review step 10.
- Discussion
  - What characteristics do you notice that you need to change to grow in understanding and effectiveness throughout recovery?
  - What aspects of your life do you want to work on changing for the better?
- Activity: Crystal Ball
  - Therapist note: Hand out form 10-1, asking individuals to draw what their life looks like now. Can draw pictures or write words.
  - After 5-10 minutes, hand out form 10-2 and ask individuals to draw what they want their life to look like in 2 months along with 4 steps they can take in their life right now to reach that goal.
- Reflection
  - How may you continue to monitor your progress and what needs to be done to meet your goal?
  - What differences do you see between the pictures?
    - How do you grow or change from the first picture to the second?
    - Is there any selfishness, dishonesty, resentment, or fear in your picture? Why?
  - How do your roles change between the pictures (as an employee, parent, significant other, child, etc.)?
    - What characteristics change or continue to grow?
  - Share steps that can be taken now to meet the 2-month goal.
    - How will using your self-inventory help you reach this goal?
- Wrap-Up: Summarize session.
  - How will your higher power help you achieve your 2-month goal?
  - What will you do in your daily routine to reach this goal?
What My Life Looked Like Before the Recovery Process
My Life In 2 Months

Steps I can take NOW to work toward this goal.
1.
2.
3.
4.
Individual Session

Search and Find

Prior to Session:
- Gather materials

Objectives: Clients will be able to…
- Recognize how they want to grow in understanding and effectiveness throughout recovery.
- Create a long-term and short-term goal for 2-months from now to continue to take personal inventory and set right any mistakes made.

Materials:
- Form 10-3
- Form 10-4
- Markers

Session Procedure:
- Introduce session and review step 10.
- Discussion
  - What characteristics do you notice that you need to change to grow throughout recovery?
  - How will you use the previous steps to achieve these characteristic changes?
- Activity
  - Therapist note: Hand out form 10-3 and ask individuals to draw what they want their life to look like in 2 months.
- Reflection
  - Is there any selfishness, dishonesty, resentment, or fear in your picture?
  - How do your roles change between the pictures (as an employee, parent, significant other, child, etc.)?
  - Therapist note: Use form 10-4 to help the client create a personal long-term goal, 2 personal short term goals, and steps/characteristics to develop to get there about their defects and asking their higher power to rid them.
    - When can you use this goal activity again?
    - How will creating goals help you in your daily life? In recovery?
- Wrap-Up: Summarize session.
  - How will your 2-month plan and long-term, short-term goals affect your recovery?
  - Will continuing to use the goal activity help you reach your goal?
    - Will it help you maintain focus on what you want to achieve?
My 2 Month Crystal Ball.
Step 10 Goals

Long-Term Goal:
_______________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Short Term Goal 1:
_______________________________________________________________________
________________________________________________________________________

Steps & characteristics to achieve short term goal 1:
_______________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Short Term Goal 2:
_______________________________________________________________________

Steps & characteristics to achieve short term goal 2:
_______________________________________________________________________
________________________________________________________________________
________________________________________________________________________
The Big Book of Alcoholics Anonymous (2013) discusses step 11 as creating a foundation of a peaceful and fulfilled life by developing a more positive way of thinking through prayer or meditative practices as life moves forward.

### Interventions for Step 11

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

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<table>
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<tbody>
<tr>
<td><strong>Habituation</strong></td>
<td>Identifying patterns associated with their Higher Power allows the client to analyze their sense of self and efficacy related to this connection.</td>
</tr>
<tr>
<td></td>
<td>• Habits: allows the client to look at their habits related to gaining knowledge of their Higher Power and how changes can be made to increase efficiency in their life.</td>
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<tr>
<td></td>
<td>• Routines: clients identify spiritual activities they use in their daily life, how they use it, and the emotions associated.</td>
</tr>
<tr>
<td><strong>Volition</strong></td>
<td>Clients are provided an opportunity to develop a guide to spirituality based on prayer and meditation.</td>
</tr>
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<td></td>
<td>• Personal causation: works to develop one’s sense of self and their own capabilities when using these tools in recovery.</td>
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<tr>
<td></td>
<td>• Values: experiencing feelings leading to creation of a sense of meaning in their life.</td>
</tr>
</tbody>
</table>
Group Session

Discovering Our Guide

PRIOR TO SESSION
- Gather Materials

OBJECTIVES:
Clients will be able to...
- Discuss what differences they notice in themselves after performing deep breathing exercises.
- State when and where they could perform this relaxation technique at home.
- State how deep breathing can aid in their recovery process.

MATERIALS
- A large, quiet, dark room with adequate floor space for clients
- Mats
- Relaxing music
- Form 11-1 and form 11-2

SESSION PROCEDURE
- Introduce session and review step 11
  - Therapist note: Begin preparation for closure, as step 12 approaches.
- Discussion
  - Throughout earlier sessions we have discussed deep breathing exercises, yoga, meditation, visual imagery, or tension-release exercises.
    - Therapist note: Visualization may not be appropriate for Veterans consider other options.
- Activity: Visualization
  - Therapist note: Explain the rules of visualization: how long the exercise will last, that members will be lying down with mats and their eyes closed, listening to the therapist voice and instructions, performing the exercise as it’s being described. The exercise is meant to be relaxing and a time for clients to connect with their higher power. If a client feels uncomfortable, they can listen in a sitting position or leave the group.
    - Visualization of a Spiritual Guide
      - Have clients lay down on the mats
      - Turn off the lights (close shades and doors)
      - Put on low, relaxing background music
      - Begin telling members to close their eyes and try to relax
• Try to see nothing but the color black
  o *Therapist note: May tell the clients to visualize a black object.*

- Imagine an image of tension and replace that image with one of relaxation (allow 2-3 minutes).
- Relax tense muscles by visualizing a tension image (i.e. a vice opening as the muscle relaxes) with that muscle, one at a time (allow 3-4 minutes).
- Visualize a peaceful place, creating a private oasis with a private entrance, and many details (allow 2-3 minutes).
- Now begin to visualize a person or animal that will guide them (allow 5 minutes).
  o *Therapist note: begin to read script on Form 11-2.*

• Reflection
  o Were you able to visualize a guide?
  ▪ Who was your guide? Someone you recognize or someone new?
  ▪ How do you feel about your guide?
  o How did you feel before and after the activity?

• Wrap-Up: Summarize session
  o When and where could you use this activity at home?
  o How could this activity be helpful in preventing relapse?
    ▪ Improve your connection to your God as you understand Him?

Rules of Visualization

1. Loosen your clothing, lie down in a quiet place, and softly close your eyes.

2. Scan your body in order to seek tension in specific muscles. Relax those muscles as much as you can.

3. Form mental impressions of your senses. Involve all of your senses: sight, hearing, smell, touch, and taste.

   For example: Imagine you are in the mountains surrounded by pine trees, the sky is blue and spotted with fluffy white clouds. You hear birds chirping, the wind as it rustles the leaves and branches of the trees. Nearby there is a mountain stream, you can feel the moisture in the breeze as it touches your face, and the crunch of the dry pine needles as you take each step. You can smell the sap of the trees and pine. You can taste the stream water.

Visualizing Our Guide Script

Relax and enter your peaceful place, as you have been doing. Invite an inner guide to your place. Wait. Watch your guide’s path. Notice a speck in the distance. Wait. Watch your guides approach. Listen to the footfalls. Can you smell the guide’s fragrance? As your guide gains shape and clarity, if you feel unsafe, send it away. Wait for other guides until you find one you like, even though its appearance may surprise you or seem odd.

When your guide is comfortable, ask him or her questions. Wait for the answers. And answer may be a laugh, a saying, a feeling, a dream, a frown, or a purr. Ask your guy, “How can I relax? What is causing my tension?” When your guide answers, you will probably be surprised at the simplicity and clarity of the answers.

Before your guide lead you, or immediately after, say and affirmation to yourself. Affirm your ability to relax with a simple “I can relax here” or “I can relax it will.”

Summary of My Spiritual Activities

PRIOR TO SESSION
- Review client progress
- Gather Materials

OBJECTIVES
The client will be able to...
  - Identify spiritual activities that have been integrated into their daily life.
  - Create a summary list of personal spiritual activities that may be used as needed.

MATERIALS
- Form 11-3

SESSION PROCEDURE
- Introduce session and review step 11
  - Therapist note: Begin preparation for closure, as step 12 approaches.
- Discussion
  - How do you feel regarding spiritual activities?
    - Do you feel that the activities help you?
    - Do you have any that you use more than others?
- Activity: Creating a Summary List of Spiritual Activities
  - Therapist note: Give Form 11-3 to process and take notes or draw on.
    - Allow time for the client to complete the worksheet.
  - Therapist note: may need to help remind the client of the spiritual activities that were discussed previously.
- Reflection
  - How do you feel now that you have taken time to think about the spiritual activities that you have used in your recovery?
  - Did you notice how frequent/infrequent these had been completed?
  - How well do these strategies incorporate into your everyday life?
    - Do you think you need to participate more? Less? Same amount?
- Wrap-Up: Summarize session
  - This form is a reference to look at, how could you use this in your daily life?
    - How can this help you in your recovery?

Summary of My Spiritual Activities

<table>
<thead>
<tr>
<th>Spiritual Activity</th>
<th>How often do I use this?</th>
<th>What am I feeling when I use this?</th>
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<tbody>
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</table>

Which practice(s) have I found most effective throughout recovery?

The Big Book of Alcoholics Anonymous (2013) discusses step 12 as taking the experience and knowledge gained through the past eleven steps to help others begin their recovery process, and feel connection to those who are having similar experiences.

### Interventions for Step 12

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

<table>
<thead>
<tr>
<th>MOHO Components</th>
<th>Relation to Session</th>
</tr>
</thead>
</table>
| **Habituation** | Clients are examining the past steps and how they can use what they have learned in their daily lives and to make an impact with others.  
- Habits: discussion provides an opportunity for clients to explore actions that they can incorporate into their life to fulfil the duty of step 12.  
- Role: clients are asked to evaluate themselves and their readiness for the new or emerging role that they have to help others with their experience with AA. |
| **Volition** | Discussion consists of client’s ability to spread the message of AA and what that means to them.  
- Personal causation: clients are given the opportunity to evaluate their strengths and weaknesses related to spreading their knowledge gained through AA.  
- Values: clients are asked to discuss if they find this new role important and meaningful to them.  
- Interest: clients are determining through discussion whether or not they feel it will be enjoyable or satisfying to help others. |
| **Environment** | Discussion revolves around influencing and impacting others.  
- Social: clients may develop relationships and supports that revolve around AA. |
| **Performance Capacity** | Clients discuss the ability to participate in continuing the concepts of AA throughout their life and to assist others that may need help with their own experience in AA. |
Group Session

Moving Forward

**Prior to Session:**
- Gather materials

**Objectives:**
Clients will be able to…
- Recognize what they may be able to do to carry on the message of AA.
- Identify the benefits of sharing personal experiences with others.

**Materials:**
- Form 12-1
- Writing Utensils
- White board
- Dry erase markers

**Session Procedure:**
- Introduce session and review step 12.
  - **Therapist note:** Begin preparation for closure, as this is the last step.
- Discussion
  - Reflect on your experiences through the 12-step process.
    - How did your recovery start?
    - What are the positives and the negatives of your experiences?
  - How could your experiences help someone else?
    - Why is it important to consider this?
- Activity: **Future Strategies**
  - What could be done to carry on the message of AA?
    - **Therapist note:** have the members share strategies or positive words that they could use with someone considering joining AA or one that needs to think about AA.
  - **Therapist note:** Hand out form 12-1. Give time for completion.
- Reflection
  - Moving forward, how do you feel about the responsibility to help others?
    - Is the task a burden? Do you feel a sense of duty?
  - Why is it important to consider using your experiences to help another?
    - What reservations do you have?
    - Is there anything that you want to achieve prior to helping others?
- Wrap-Up: Summarize session.
  - What is your plan to carry on the message of AA in your daily life?
    - How will you stay connected to the 12-steps?
  - How will this impact you during recovery and maintaining abstinence?
What can I do?

Considerations that I will make before approaching someone in regard to AA.

What method am I comfortable using to carry AA to others?

How can I support others?

How do I feel about being a sponsor?
Individual Session

How Can I Help?

Prior to Session:
- Gather materials

Objectives:
Clients will be able to...
- Recognize what strengths and weaknesses.
- Create a plan to spread the message of AA.

Materials:
- Form 12-2
- Pens

Session Procedure:
- Introduce session and review step 12.
  - Therapist note: Begin preparation for closure, as this is the last step.
- Discussion
  - Think about your recovery journey.
    - What challenges have you overcome?
    - Which challenges still exist?
  - What steps did you take to get where you are now?
- Activity: Helping Others
  - Therapist note: Provide form 12-2 My Strengths and Abilities.
    - Ask the client to begin thinking about how the characteristics identified on the worksheet will relate to helping others in fulfillment of step 12.
- Reflection
  - How do you feel about your ability to make an impact?
    - Do you have doubts or fears?
    - Do you feel capable or incapable?
  - What does it mean for you to be thinking about step 12?
    - What does it mean for your daily routines? Roles?
    - How do you think you will accomplish this?
  - How can you use this activity in other aspects of your life?
- Wrap-Up: Summarize session.
  - How will your strengths help you make a difference?
    - How will your weaknesses impact your performance during this step?
  - How does step 12 influence your thoughts on recovery?
    - How will it aid in the continuation of the recovery process and abstinence in your daily routines?
# My Strengths and Abilities

## My Strengths

<table>
<thead>
<tr>
<th>List:</th>
<th>How could I use this strength for the benefit of someone else?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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</tbody>
</table>

## My Weaknesses

<table>
<thead>
<tr>
<th>List:</th>
<th>What can I do to develop this area or use it to help others?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</tbody>
</table>

Do you feel as though you could help another? Do you have the desire? Why or Why not?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
________________________________________________________________________
Re-Evaluation
Evaluating Outcomes

Complete the following:

- Re-administer the MOHOST and other assessments that may have been utilized.
- Complete an exit interview to receive feedback from the client if possible.

Assessments should be re-administered to obtain objective information regarding each client’s improvement in areas of strengths, habituation, volition, skills, and the impact of the environment on occupational performance. An exit interview should be completed in order to obtain the client’s subjective experience of completion of the 12-steps of AA with the use of occupational therapy. Information concerning interventions, therapy goals, and the client’s perceptions of the outcomes should be noted.
Discharge
Discharge Considerations

Complete the following:

- Determine need for referrals.
- Provide clients with information of resources prior to discharge.
- Collaborate with interdisciplinary team if possible.
- Complete discharge summary including possible recommendations.

When planning for discharge, therapists should use therapeutic reasoning and clinical judgment when making recommendations. Considering the client’s needs when making referrals is important. Additionally, stability of the client psychologically after completion of the program may need to be considered when planning for discharge and creating recommendations. The completion of the program may cause extra anxiety or psychosocial factors to emerge due to feelings of becoming disconnected from the program and the supports developed within. Encouraging continuation of participation in AA meetings may be essential in minimizing the psychosocial factors that may emerge.
References


