Group Rationale:

Alcohol use disorder (AUD) is a psychological condition in which an individual cannot stop or moderate alcohol use despite adverse social, occupational, or health consequences. Alcohol use is prevalent in the United States, according to the 2019 National Survey on Drug Use and Health (NSDUH): 85.6 percent of people ages 18 and older reported that they drank alcohol at some point in their lifetime and 69.5 percent reported to have consumed alcohol in the last twelve months. A person's risk for developing AUD depends on how much, how often, and how quickly an individual uses alcohol. An increased risk is also present in situations where individuals begin drinking at an early age, when alcohol is seen as more acceptable by their peers and their environment. Genetics and family history of alcohol problems also can be a factor, as well as experiencing abuse or neglect (National Institute on Alcohol Abuse and Alcoholism (NIAAA)). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), AUD criteria

Evidence-based treatments exist and are available to those that have AUD, however, there is no one-size-fits-all treatment given the wide variety of struggles and causes as a result of this disorder. Alcohol is a "cunning and baffling" disease (Alcoholics Anonymous, 1938). In order to effectively recover from alcoholism an individual must change physically, psychologically, behaviorally, socially, and spiritually. In order to begin the process of recovery, an individual must become abstinent from all mind altering substances. Abstinence, however, is not the only requisite for long-term sobriety. Alcoholism is a chronic disease, it does not go away simply by refraining from drinking, it is not acute and cannot simply be "cured."

Lastly, there are also social support groups, such as Alcoholics Anonymous, that can help individuals receive peer support from those in similar situations. While each of these therapeutic tools can independently be helpful, it is necessary to use them in conjunction with each other to ensure holistic treatment and prevent relapse after the individual has stopped.

The chronic disease management (CDM) model is centered around the patient, and attached to long term outcomes rather than short term treatment. The model is integrated and coordinated within the healthcare model which incorporates both primary and specialty care, evidence-based care plans, and availability of care. The CDM model treats substance abuse like any other chronic medical disease (diabetes, COPD, CHF, etc.) and as alcoholism has no cure, instead the primary goal is to effectively manage long-term stability and to prevent relapse. The CDM model helps clients after an initial detoxification of the substance by continuing to treat the chronic condition of addiction and drug abuse. The patient should be exposed to multidisciplinary teams which include a case manager, social workers, clinicians with expertise in the disease and also treatment of common co-occurring disorders, which all ideally would be coordinated with medical physicians in order to most effectively implement necessary treatments (Saitz, et al., 2008).

Current treatments, for the most part, only address the acute substance use issue; they are simply designed to help a patient rid their bodies of the substance, but as a general rule, do not treat any other psychological conditions that are likely to occur with chronic substance abuse. The detoxification of an individual should be seen as only the first step in a longer term

treatment management plan, and is a solution to an acute problem as opposed to a chronic condition.

The misunderstanding of the disease of substance abuse has created a stigma in society wherein there is a standing belief that an individual has a choice to use or not to use substances, and thus when a substance is no longer in the one's system, the disease should be cured and no longer an issue. This, however, is not the case. Substance abuse is not a choice made by individuals, but is a disease and should be treated as such. Just like a type II diabetic can control their eating habits, an alcoholic or substance abuser can control intake, but it takes long-term management, which cannot be implemented purely in a ninety day treatment facility, but instead needs to be understood as a chronic disease of the body, mind, and spirit. (McLellan, 2013).

Because alcoholism is a chronic disease, there is a likelihood for individuals to relapse as they go through their journey of sobriety. Post-treatment relapse is common for substance users and more than half of substance abusers do not achieve recovery following initial recovery treatment (Lu et al., 2019).

Alcoholism is a progressive disease- it develops slowly over a period of time until it ultimately becomes unmanageable for an individual. Recovery from the use of alcohol is a process that continues for the individual's lifetime. This process includes five stages of change which must be experienced by the individual in order to recover from alcohol misuse: precontemplation, contemplation, preparation, action, and maintenance. In precontemplation, individuals begin to experience negative effects from the use of alcohol, however, they do not feel they need to change any behaviors. In the second stage, the disease continues to progress and the individual begins to realize they may have a problem with drinking, but are not sure they

want to endure the pain and rigor necessary for the changes necessary. The third stage, preparation, is where the individual has decided to make a change and is willing and committed, but is still utilizing alcohol to cope and has not developed a detailed form of action. The fourth stage is the action stage; the individual has conceded that they are powerless over alcohol and their lives have become unmanageable. This is the first stage with actual action, wherein the individual will need to go through detoxification from alcohol (which may need medical intervention), once completely detoxified, the individual embarks on a journey that entails exploring and understanding the psychological, social, and behavioral problems that have led them to addiction. There are many different treatment avenues in this step involving long-term residential, short-term residential, outpatient treatment programs, individual counseling, group therapy and 12-step programs such as Alcoholics Anonymous. The final stage is the maintenance stage. This stage is never-ending and must continuously be practiced on a daily basis in order to prevent relapse and to achieve a healthy state of emotional and physical sobriety (Bentley et al., 2016) (Harrell et al., 2013).

While there are many different reasons for relapse, one of the main issues an individual can have is a lack of coping skills that help them to deal with self-care and develop the ability to survive the day-to-day struggles that problem solving skills, something many alcoholics lack. Psychoeducational groups can expand and model traditional coping skills and help with life skills in the areas of leisure and recreation, nutrition, money management, child care, self-defense, and the like. Individuals with an addiction disorder may turn to a substance to relieve the stress to regain their perception of control over the problem when they feel powerless until they gain these skills necessary in order to deal with the issues and struggles that may arise in

daily life. A psychoeducational group is one that provides guidance and information about life issues, thus empowering individuals to solve life problems through intervention strategies. The intervention strategies that can be introduced should help the individual to adapt to a new behavior before breaking down systematically and relapsing and regressing into past patterns of behavior (La Salvia, 1993).

In order to prevent relapse from happening, individuals must be able to process changes within their daily lives, preferably with the assistance of both their peers who are also in sobriety, and other professionals. Learned social functioning, wellness, and coping skills can help to empower those with addiction problems to have basic life skills to confront daily problems that help them enhance their self-esteem. This psychoeducational group is formed to help those suffering from substance use disorder, along with those who are maintaining their sobriety, to learn techniques which will help them cope with these problems and help prevent future relapse (Gorski & Miller, 2013).

Group objectives:

This section will describe 3–6 objectives for the group: The purpose of this group is to address the fear surrounding participation in a group like this, and also the fear participants may have about the potential of relapse. Another objective is to help the members get to know each other and learn to feel comfortable and function in new experiences/social situations. The third objective is to offer an opportunity to experience some growth as individuals, and gain hope regarding the recovery process and their own personal potential to stay sober.

Informed Consent for Psychoeducational Group

Chase M. Scott, Counselor

Please complete this consent form. I want to make sure you are aware that this group is completely voluntary and as such there is an expectation that you will be prompt, respectful, and hardworking in your participation. Your open-mindedness, honesty, and willingness, with me and the other participants in the group will allow you and others in the group to grow and progress on your path to sobriety and healing. Please make sure you have read this, understand, and discussed any and all questions with me before participation. Please also note that everything that is discussed in this group is to remain completely confidential (nothing that is shared in group will be discussed or shared OUTSIDE of group sessions) as to ensure the safest possible space for all participants.

_____ _____ _____

First Name Middle Name Last Name

_____ _____

Email Address Cell Phone #

May I call and leave a voicemail and/or text at this number? Yes____ No____

_____/_____/_____

Birth Date

_____

Participant's Signature

Detailed plan for two groups sessions:

First discussion/Session

Begin with icebreaker:

- The group facilitator can have everyone in the group say their name, where they are from, and their greatest fear about participating in this group. (The group leader can start.)

Awareness Activity:

- The group leader will read the following excerpt about fear from A.A.'s Grapevine, January, 1962:

The chief activator of our defects has been self-centered fear—primarily fear that we would lose something we already possessed or would fail to get something we demanded. Living upon a basis of unsatisfied demands, we were in a state of continual disturbance and frustration. Therefore, no peace was to be had unless we could find a means of reducing these demands. ‹‹ ‹‹ ‹‹ ›› ›› ›› For all its usual destructiveness, we have found that fear can be the starting point for better things. Fear can be a stepping stone to prudence and to a decent respect for others. It can point the path to justice, as well as to hate. And the more we have of respect and justice, the more we shall begin to find the love which can suffer much, and yet be freely given. So fear need not always be destructive, because the lessons of its consequences can lead us to positive values.

- The group leader will then introduce irrational thinking (show diagram) and how that relates to fear. Have the group discuss for 40 minutes whether the fears they first spoke of fall under the category of irrational thoughts or not, what kind of irrational thought it is, and what the restructure would be for those irrational thoughts (the group leader may have to model this last one more often than not).

- Take a 10 minute break for the bathroom, a drink, etc.

2nd Activity:

- Go around the circle again and have everyone say their names and then what they are most hopeful that they will gain out of the group and also one thing they think they will be able to contribute to the group (funny, good listener, empathic, supportive, etc.)

Concluding Activity:

- On a half sheet of paper have the participants answer the following 2 questions (which will already be printed on the paper): 1. What fears and

hopes did others bring up in the group today that you identify with? 2. How did discussing these change your perspective regarding participating in this group?

Materials Needed: pencils, 25 copies of questions on a half sheet of paper, diagram of irrational thoughts, 21 copies of the reading (1 for the leader and 20 for the participants)

Second Discussion/Session

Begin with icebreaker:

- Have all of the participants line up in order of initial sobriety date (first time trying to get sober) and then have everyone say their initial date out loud.
- Have all of the participants then line up in order of their current sobriety date and have everyone say their current date out loud.

Awareness activity:

- The group facilitator will then read the following excerpt from “A.A. Comes of Age”, P.97 to the entire group-

An early fear was that of slips or relapses. At first nearly every alcoholic we approached began to slip, if indeed he sobered up at all. Others would stay dry six months or maybe a year and then take a skid. This was always a genuine catastrophe. We would all look at each other and say, “Who next?”

Today, though slips are a very serious difficulty, as a group we take them in stride. Fear has evaporated. Alcohol always threatens the individual, but we know that it cannot destroy the common welfare. ‹‹ ‹‹ ‹‹ ›› ›› ›› “It does not seem to pay to argue with ‘slippers’ about the proper method of getting dry. After all, why should people who are drinking tell people who are dry how it should be done?

“Just kid the boys along—ask them if they are having fun. If they are too noisy or troublesome, amiably keep out of their way.”

- Have the group participants number themselves in order 1-4, have them break off into small groups according to their number, where they will then have a small group discussion.
- Distribute half sheets of paper with the following questions on them (along with pencils) and have them take 3 minutes to answer them:
  - 1. What are 3 things you are afraid of failing at?
  - 2. What would happen if you *did* fail?

        - The participants will then discuss their answers in their small groups for 15 minutes.

    - Have the small groups all come back together into one large group and discuss for 15-20 minutes what they took away from their discussions in the small groups. Did they find they had fears in common regarding failing and/or relapsing?
    - Take a 10 minute break for the bathroom, drinks, etc.

- Discuss long-term sobriety and that it is possible.
    - The group facilitator will then read an excerpt from the A.A. Grapevine, January 1981:

Around the tables, hope pours forth from the sharing of a bunch of drunks as they reveal what they were like, what happened, and what they are like now. No first-timer can yet have the faith that AA will work for him or her. Faith, I believe, comes later, after there is a spark of hope that he or she can do the same, incredible as it may seem. It isn't the veteran's "I was like you" that does it, but rather the veteran's "This is what I was like" that can give the spark to the newcomer. This drunk would never have accepted "I was like you," for nobody could have been as bad, desperate, amoral, and guilty as I was. Or else I would have thought, "I can't be as *bad* as these guys." But when an old-timer spoke about himself, there appeared--dimly, very dimly at first--the possibility that there might be a connection between drinking alcohol and my misery.

That first glimmer brought me back to meetings again and again, until the day arrived when I had some faith in AA and in the chances it offered me. With the arrival of faith and the surrender to Step Three comes something that is larger than the initial hope; much greater things can happen than we could have imagined in the beginning. If the newcomer can just hear a little of what we are saying, he is well on the road to hope, and we all know what can then happen for him, one day at a time.

    - Talk about the above reading as a large group activity and have a couple of participants tell their own stories of hope for about 20 minutes.

Concluding activity:

- Give them another half sheet of paper (they should still have their pencils) and have them write down their definition of sobriety. Suggest they read it and carry it with them throughout the week when they might be struggling, frustrated, or feeling hopeless.

Materials Needed: 25 Half sheets of paper with questions printed on it, 25 half sheets of blank paper, pencils, 5 copies of the reading on slips or relapses (1 for the leader and 1 for each small group), 21 copies of the second reading about hope.

Outcome evaluation questionnaire:

Thank you so much for your participation in these groups over the past two days. Please answer the following questions honestly in order to help me better serve other groups. Your thoughts are incredibly valuable.

1. What is the most valuable idea or concept you took away from this experience?

2. What would you change in the future in order to make this group experience more effective?

3. Was the counselor effective in his/her presentation and management of the group?

Resource List for both Counselors and Group Participants:

Here is a list of resources that may be helpful in the future:

1. Alcoholics Anonymous (also known as “The Big Book”)

This is the original text of Alcoholics Anonymous and is incredibly useful in both helping someone identify as an alcoholic/addict, and also in becoming familiar with the 12 Steps and the solution presented in meetings.

2. Twelve Steps and Twelve Traditions (also known simply as “The 12 and 12”)

This book contains essays on the 12 steps which provide an in-depth look at each step and also explores emotional sobriety. The 12 traditions are the foundation or “rules” of how AA itself is run.

3. www.SAMHSA.org

SAMHSA stands for Substance Abuse and Mental Health Services Administration. This agency, within the department of Health and Human Services offers great resources for individuals living with mental health and substance use disorder and their families.

4. Codependent No More by Melody Beattie

This book is a great guide to how to overcome “people-pleasing” and codependency in both alcoholics and their loved ones and friends. Melody Beattie was actually the person who coined the term “codependency,” and her book is full of wisdom and insight on how to live an authentic life and have healthy relationships.

5. Grapevine: The International Journal of Alcoholics Anonymous

This monthly magazine put out by Alcoholics Anonymous is a wonderful resource with stories, inspirational thoughts and is essentially “a meeting in print.” The website to subscribe or just learn more is www.aagrapevine.org

Issues in application: A brief statement (1–2 pages) addressing the following:

This group will consist of 20-25 people that have been involved in alcoholics anonymous, yet have not been successful at long-term sobriety. The point of the group is to help those suffering to get "over the hump" and help them to understand and eliminate the relapse cycle.

The setting for this group is either an outpatient substance abuse rehabilitation center or an existing site where alcoholics anonymous meetings are held. The group setting is very practical as there are many current sites that fit either criterion. The amount of people that would be willing to attend this group is large and many are looking for outlets to help them get out of the relapse cycle. This group, however, must trust the confidentiality of all those involved, the people that would be eligible for the group will feel vulnerable and must be ensured that the group will both help them and be an anonymous forum from which to do so.

The primary ethical concern would be confidentiality and ensuring that what is spoken within the group remains there and is not discussed elsewhere. This leads to the primary obstacle I foresee being building a trustworthy environment where people feel at ease to be rigorously honest and vulnerable with people they have just met.

The primary cultural concern is that it's very difficult to get a culturally diverse group of participants as Alcoholics Anonymous tends to unfortunately be homogenous, creating a sense of isolation and "apartness" for people of color.

References

Alcoholics Anonymous World Services, Inc. (1938). *Alcoholics anonymous*.

Alcoholics Anonymous World Services, Inc. (2020). *Twelve steps and twelve traditions*.

Around the Tables. Home | AA Grapevine. (1981, January). Retrieved June 12, 2022, from https://www.aagrapevine.org/magazine/1981/jan/hope

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author. (n.d.).

Bentley, T., Rizer, M., McAlearney, A. S., Mekhjian, H., Siedler, M., Sharp, K., Teater, P., & Huerta, T. (2016). The journey from precontemplation to action. *Health Care Management Review*, *41*(1), 22–31. https://doi.org/10.1097/hmr.0000000000000041

Gladding, S. T. (2020). *Groups: A counseling specialty*. Pearson.

Gorski, T. T., & Miller, M. (2013). *Staying sober: A guide for relapse prevention*. Herald House/ Independence Press.

Harrell, P. T., Trenz, R. C., Scherer, M., Martins, S. S., & Latimer, W. W. (2013). A latent class approach to treatment readiness corresponds to a transtheoretical ("Stages of change") model. Journal of Substance Abuse Treatment, 45(3), 249–256. https://doi.org/10.1016/ j.jsat.2013.04.004

Kim, T. W., Saitz, R., Cheng, D. M., Winter, M. R., Witas, J., & Samet, J. H. (2012). Effect of quality chronic disease management for alcohol and drug dependence on addiction outcomes. *Journal of Substance Abuse Treatment*, *43*(4), 389–396. https://doi.org/10.1016/ j.jsat.2012.06.001

La Salvia, T. A. (1993). Enhancing addiction treatment through psychoeducational groups. *Journal of Substance Abuse Treatment*, *10*(5), 439–444. https://doi.org/ 10.1016/0740-5472(93)90003-k

Lu, C.-Y., Chiang, C.-Y., Yao, Y. C., & Sun, F.-K. (2019). Modeling body–mind–spirit well-being and the possibility of relapse intention in adults who have a history of substance use in Taiwan. *Journal of the American Psychiatric Nurses Association*, *26*(2), 196–205. https://doi.org/ 10.1177/1078390319844565

McLellan, Thomas. Treatment Outcomes in Addiction. How Illness Perception Drives Outcome Expectations. Treatment Research Institute (2013). https://mediasite.video.ufl.edu/Mediasite/Play/69e63b3b4a834e92b7ed37f1a6e827271d?catalog=58a2c26a-048c-42de-8950-c7f68c1e7540

Substance abuse and mental health services administration. SAMHSA. (n.d.). Retrieved June 12, 2022, from https://www.samhsa.gov/

Saitz, R., Larson, M. J., LaBelle, C., Richardson, J., & Samet, J. H. (2008). The case for chronic disease management for Addiction. *Journal of Addiction Medicine*, *2*(2), 55–65. https://doi.org/10.1097/adm.0b013e318166af74

Wilson, B. (n.d.). *As Bill Sees it*. Alcoholics Anonymous World Services Inc.