

A Comparison of Single Focused Twelve Step and Dual Focused Support Groups: With
Observations from the Trenches

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Abstract

A comparison of Single focused 12 step support groups versus dual focused 12 Step support groups is the subject of this paper. The information presented was obtained from people who have attended both types of groups. Extrapolated excerpts are taken from, and compared to, each group. An elaboration is provided by the author regarding how they differ and why. Additionally, advice given by the experts to the dual diagnosed population regarding the role of 12 step support groups is examined and critiqued. Qualitative research will continue and quantitative research will be developed from these findings.

The purpose of this article is to make a comparison between single focused 12 Step support groups (i.e., A.A., N.A.) and the Dual Diagnosed 12 Step support groups (D.D.). All of the information reported was obtained with their permission from people who attended both single focused 12 Step support groups and the dual diagnosed 12 Step support groups, and many of these individuals attended both types of groups during their recoveries.

My involvement as a facilitator began about 12 years ago working as a drug and alcohol counselor, when asked by the original founder of our D.D. 12 Step group if I would cofacilitate it with her. I agreed and my involvement continues. Our D.D. group is modeled after Tim Hamilton's and Pat Sample's book, "The Twelve Steps and Dual Disorders."

In the third year of the group's existence we lost our facilitator who died very unexpectedly. The remaining group members, myself included, agreed that the group would continue in memory of its founder. As the group meetings continued, I began making notes on the various issues that were discussed by its members.

In the over 12 years of the group's existence, I cannot recall there being any more than eight attendees at any one meeting. An overwhelming number of attendees would comment on how much more comfortable they felt within the confines of a small group, as opposed to the usually much larger number of attendees at the single focused support groups.

Attendance in our D.D. 12 Step support group was voluntary. Most co-occurring 12 Step support groups are held in hospitals, halfway houses and various treatment centers. In these settings, attendance is usually mandatory.

During the history of our meetings, attendees would report "I don't believe I shared my personal problems and concerns with a room full of strangers." They in effect reinforce what Timko and Moss (1998) pointed out that "those people who have a mental illness function better in treatment climates that are supportive and encourage personal expression." (p. 1137). I cannot recall even one individual of the hundreds who have attended our D.D. 12 Step meeting ever reporting that she or he discussed mental health issues while in a single focused support group. In fact, most reported they could never discuss issues such as psychotropic medications while in attendance in a single focused group, yet in almost every meeting of our group, medications are frequently discussed.

In my reading of dual disorders published works it's curious that many researchers will refer to A.A. and N.A. Twelve Step support groups as an intricate piece of the recovery process, yet often there is no mention of the D.D. 12 Step support group's efficacy. One such example of this conspicuous omission is a. Scott Winter (1993) who, when addressing the dual diagnosed refers to A.A. and states, "The 12 Step program offers the strength, support, and understanding that only comes from others who have walked that road before. In meetings people feel free to express and explore their feelings. They gain perspective by hearing from others who are

struggling with similar feelings and issues. By attending meeting people with dual disorders get sober and stay that way.”

In our D.D. 12 Step support group and all who have attended it through the years, not one of those individuals ever reported discussing any of their psychiatric issues when attending any single focused 12 Step support group. It seems that Scott Winter may have it wrong.

As a matter of fact, all of those who A.A. or N.A. reported while in our D.D. 12 Step group, they would never speak of their mental health issues while in attendance in a single focused 12 Step support group. They unanimously agreed to having heard while in A.A. or N.A. meetings that taking medications was tantamount to “drugging.” The dissemination of this type of misinformation abounds within the reported experiences of the dual diagnosed that have attended single focused support groups. The dual diagnosed feel anything but freedom in discussing issues relating to their mental health issues in a single focused group. A 12 Step support group designed and intended to discuss such issues is one such as ours, a dual diagnosed 12 Step support group, one that treats both chemical dependency and psychiatric illness. To suggest that these objectives can be achieved by attending a single focused 12 Step support group simply is not accurate.

Another expert on the subject of dual diagnosis, Dennis C. Daley, states “Knowledge gives strength. Taking part in a self-help group gives you the opportunity to learn about bipolar disorder, addiction, treatment, and recovery.” (1994, p. 22). Additionally he adds, “Participating in A.A., N.A., C.A., or D.R.A. offers you the added benefit of a 12 Step program of change.” However, a dual diagnosed person new to recovery or a returnee to it, should not go to A.A., N.A. or any other single focused support group in the hope of learning anything about bipolar illness, because to do so is to look for the impossible. Single focused support groups concentrate solely on matters relating to their addiction, often to the exclusion of mental health concerns and issues of the dual diagnosed population. There is a danger of disseminating misinformation when single focused support groups are lumped together with D.R.A. groups, without an explicit explanation of the exact goals and objectives of each group.

Another example of referring to the 12 Steps and dual disorders, Abraham Twerski states, “When addiction and another emotional condition coexist, it’s not important to know which came first; what is important is that both conditions receive the appropriate attention.” He then quotes Step 1 of Alcoholics Anonymous, which reads, “We admitted we were powerless over alcohol and other drugs – that our lives have become unmanageable.” With all due respect to Rabbi Twerski, after reading this version of Step 1 of A.A., it’s difficult to see how both conditions receive the appropriate attention that Dr. Twerski refer to. Hamilton and Sample’s (1994) definition of Step 1 seems more appropriate: “We admitted that we were powerless over our dual illness of chemical dependency and emotional or psychiatric illness, that our lives had become unmanageable.”

When discussing support groups with my clients or with dual diagnosed people, it's suggested that if they have A.A. issues, take them to A.A. meetings, as that was and is the focus of that group. If, however, they have mental health issues, these should be discussed during D.D. 12 Step support group, as the dual diagnosed 12 Step group was designed to provide an environment in which such issues may be discussed. As Geppert and Minkoff (2003) point out, "When someone has a substance-related disorder and another psychiatric disorder illness, they are said to have co-occurring disorders, comorbidity, or dual diagnosis. People with co-occurring disorder require an accurate diagnosis and appropriate treatment for each illness to ensure the best possible recovery for their two or more disorders." (p. 2)

After many years of working with the dual disordered population, it's my belief that if an individual is in denial of his/her mental illness, even if he or she accepts being an addict or alcoholic, that person is not in recovery. Both illnesses require acceptance and a plan. In alcoholic, that person is not in recovery. Both illnesses require acceptance and a plan. In remembering an individual who after numerous detoxifications and apparent relapses, went out drinking and got into an altercation and afterwards he had a hearing that required him to have a psychiatric evaluation, which revealed that he was bipolar. As part of his court order he was mandated to attend our D.D. 12 Step support group and perform community service as a condition of his probation. Immediately upon his completion of probation, this individual stopped attending our 12 Step support group. When he was attending our D.D. 12 Step support group, he would discuss openly his mental illness and his anger at not being able to control his moods without medication and their side effects, along with his 20 year struggle with alcohol dependency.

One day on my way to our building, this individual passed me and entered the building next to ours where an A.A. meeting was being held at the same time as our D.D. 12 Step support group. Our group wondered why he preferred attending an A.A. meeting instead of our D.D. 12 Step support group. As several years went by, members of our D.D. 12 Step support group would comment to me referring to this individual, "By the way, did you hear so-and-so was picked up again?" In the years that followed he would continue to pick up and afterwards return to attending the A.A. support groups. It's my belief that by his repeated behaviors that he was in denial of his mental illness and if my assumption is correct, he will continue to pick up. He is in relapse and not recovery.

As Gorski and Miller (1986) accurately point out, "not using addictive chemicals is abstinence. But abstinence alone is not recovery, it is not enough. Abstinence simply allows the recovery process to begin. It's the means to an end – the means to normal living. Learning to live normally without addictive use requires more than abstinence" (p. 34). These authors conclude with, "Many relapse-prone people believe that recovery is abstinence from alcohol and drug use and that relapse is the use of alcohol and drugs." (p. 104). Additionally, I believe that when a dual diagnosed individual stops taking his or her psychotropic medications, that person is no longer in recovery; he or she has relapsed.

In their paper, Laudet, Magura, Vogel, and Knight (2000) reported that, “A recent study of the issues challenging dually-diagnosed individuals in recovery found that dealing with emotions and feelings were reported as very difficult by the majority of subjects” (p. 473). We find that in working with addicts and alcoholics without being dual diagnosed, emotions and feelings often have to become the primary focus of attention in recovery.

More representative is a dual-diagnosed attendee of our D.D. 12 Step group in a discussion of the second step said that when he was attending A.A. he had a real hard time with accepting and trusting God. That’s when he was hallucinating; he experienced auditory delusions, one of which was perceived by him to be God, which triggered his anger because he blamed God for giving him schizophrenia which he struggled with since childhood. He further elaborated that for the past 5 years his current antipsychotic medications have held his symptoms at bay, and he now perceives his Higher Power not as a delusional spirit but rather by the manageability of his two illnesses.

Recalling another salient distinction between the single focused 12 Step and the dual-diagnosed, in the discussion of the Fourth Step, Hamilton and Sample (1944) make a subtle yet significant point as they state, “Ordinarily in a 12 Step program we would start focusing on liabilities so that we could first address what is hurting us. But in dual recovery many of us begin by examining assets because we need extra strength to face honestly and courageously the areas of our lives that are causing us pain.” Upon first reading this insightful glimpse into the dual-diagnosed psyche, it reminded me of a dual-diagnosed 12 Step attendee. On one occasion, noticing that she looked particularly down during group when asked, “Marie, is there something that you care to talk about today? She proceeded to tell me that she was removed from her group home because she picked up and that she was temporarily homeless. Her intensive case manager (I.C.M.) was attempting to obtain housing for her. She was informed by her I.C.M. that the only housing available would be independent temporary shelter. Marie explained how she believed that she needed support of the group home’s staff, that she did not trust herself and how her mood swings had intensified in frequency and intensity.

Marie continued, “I have many suicide attempts, sometimes taking an overdose, and other times just thinking about it, and seeking out pain killers. The emergency room will no longer refer me to the psychiatric ward.” Marie continued, “John, certainly last but not least, my mother is coming to visit. That always causes me to feel anxious and guilty, which triggers my suicidal thoughts.” At this point Marie was visibly trembling and weeping. She looked at me and said, “They [all] the staff coming in contact with us, don’t know how fragile we are.” Some two weeks later, Marie was found in an apartment of some unknown acquaintance, dead from an overdose. Remembering Marie, the founder of our dual diagnosed 12 Step group and its original facilitator, I say, “Yes, dual diagnosed people, by all means list your assets first, and approach your liabilities in your own time, at your own pace.”

At times in our dual diagnosed 12 Step group meetings, it becomes necessary for me to take a direct role that extends beyond the role of facilitator. On such occasions when group members report having picked up, myself and some of the group's longer standing members reassure the individual that they can [as Gorski and Miller (1986) point out,] --- "Learn from the past. As a matter of fact, the past is your most effective teacher. It teaches you what works, and what does not work. By allowing the past to teach you how to stay sober, you can avoid addictive use in the future. You can avoid other types of dysfunction, such as emotional or physical collapse." (p. 127). Our message to the individual is simply "use the experience as a learning one and do not assume that you have returned to your starting point." On such occasions it's suggested to the individual and to our D.D. 12 Step support group that if the individual's issues are mental health, then those are the ones that the group will focus on to assist the person to work through those issues. If the issues presenting are addiction-focused, that that becomes the group's attention target.

We attempt to offer what Minkoff (1993) refers to as "meaningful hope" in that the group joins the individual in the midst of his or her despair. Additionally, we make it known to the person that our sole concern is to help him or her self-help one day at a time. Frequently, the help offered by the group extends beyond the group meeting as the individual is given other help resources such as O.V.R. clubhouse, welfare assistance, I.C.M. services, etc.

Often, during group meetings, videos on mental health issues and addictions are viewed by participants. Additionally, handouts on all of the primary Axis I disorders are distributed to any members expressing an interest in developing a further understanding of a particular disorder.

Many of those who have attended both single focused 12 Step support groups and dual focused 12 Step support groups report having a positive experience when attending either A.A. or N.A. support groups. They report that they were helped by listening to others tell their stories of struggles with either addiction or alcoholism. Almost all of the D.D. 12 Step members reported that they never spoke at such meetings, and thoughts of mentioning anything remotely related to their mental illness never seemed appropriate to them.

The most definitive conclusion based on the feedback from these D.D. 12 Step members regarding attendance in any single focused group, is that they are clearly just that – single focused, which for them means if you have alcohol issues, take them to an A.A. meeting, and if you have addiction issues, take them to an N.A. meeting. However if you have mental health issues, the single focused groups are neither intended nor capable of giving you the support that is needed, as alcohol or addiction issues are only a part of your recovery needs.

In conclusion, it's important that the dual diagnosed understand that the single focused 12 Step support groups have limitations which exclude mental health issues. Professionals within

the fields of addiction and mental health also should be aware of the limited scope of the single focused 12 Step support group.

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