Renewed Relevance of Alcoholics Anonymous and Adlerian Psychology

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Abstract

The incorporation of psychological approaches to the Alcoholics Anonymous (AA) is established as a sound way of improving the treatment of alcoholism. Despite mounting evidence of the clinical effectiveness of AA, and its enduring legacy as the prominent approach for healing alcoholism; there remains skepticism regarding its use as a clinical intervention. The literature on the Adlerian orientation has noted the similarity between the two methods, little investigation of the congruence between the two and the implications for an integrated treatment approach has occurred. The purpose of this literature review is to examine how Adlerian theory and positive psychology complement the philosophies and practices of AA. The results support the integration of Adlerian Psychology and AA as ideal for working with clients struggling with alcohol dependence. Furthermore, this literature review suggests that the integration of Adlerian Psychology will enhance and complement the therapeutic dynamics inherent in the AA program, improving the competence of clinicians to treat individuals living the alcoholism and participating in the 12-step programs.

*Keywords*: Adlerian Psychology, Alcoholics Anonymous, Alcoholism, Spirituality
Dedication

To my husband, Eric Teale, for allowing me to turn my dreams into a reality. Thank you for supporting me through my graduate school experience.

To my mother, Terri Lorentz, for giving me the gift of learning and the constant reminder that no one can take it away from you.

In loving memory of my Grandma Claire, who showed me the many benefits of being an educated person and an empowered woman. You’ll always be loved and remembered.
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Renewed Relevance of Alcoholics Anonymous and Adlerian Psychology

The treatment of alcoholism persists as a topic of debate both in society and within the counseling profession. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2010) identified approximately 17.6 million individuals in the United States who abuse or meet the diagnostic criteria for an alcohol substance use disorder. Additionally, 30% of Americans have met the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM 5*) diagnostic criterion for an alcohol-use disorder (Hasin et al., 2013). When issues are addressed in counseling, it is important for clinicians to understand the treatment of alcohol use disorders.

One of the most enduring recommended social forms of relief for individuals recovering from alcoholism is the 12-step program of Alcoholics Anonymous (AA). AA is free and volunteer-supported, spiritually-based, mutual aid recovery program. Since its inception in 1935, membership in AA has surpassed 2 million persons (AA, 2001).

AA is an influential element in many treatment centers treating alcohol use and other substance use disorders; as they have incorporated the concepts of AA into their treatment models (Roberson, 1988). In fact, it is reported that the AA’s first referral came from Carl Jung; who argued traditional psychological treatment as insufficient for addressing the individual’s problem (AA, 1985). That initial referral birthed sustained referrals from psychologists and other mental health professionals to the program that remains today. Moreover, over 33% of AA membership comes from treatment center referrals (Groh, Jason & Keys, 2008). Further, individuals who attend AA are also likely to receive additional treatment or counseling simultaneously with their AA attendance (Groh et al.). Despite this historical link between AA and psychology, a mutual skeptical divide continues (Schenker, 2009). Miller, Forcehimes, and Zweben (2011) noted members of AA hold the belief that treatment of alcoholism can only be
facilitated by an individual with the first-hand experience. Psychologists and other mental health professionals have historically illustrated contempt and disparagement toward AA and the alcoholic patient (Schenker). Also, the mistrust is worsened by a prevailing perspective from mental health professionals that alcoholism is an underlying symptom of mental health disorder instead of recognizing alcoholism as a primary disorder (Miller et al.). Moreover, individuals living with alcoholism are perceived as undesirable clientele and less amenable to therapy (Washton & Zweben, 2006).

**Problem Statement**

The historic disconnection between professional psychological services and the program of AA is further amplified by the opinion of AA lacking evidenced-based effectiveness (Dodes & Dodes, 2014). The core tenet of anonymity and community-based structure of the AA program complicates the reliable collection of data (Magura, Cleland, & Tonigan, 2013). The documented integration of counseling theory with AA; however, provides evidence of its effectiveness in promoting long-term abstinence (Humphreys, Blodgett, & Wagner, 2014; Kelly, Stout, & Slaymaker, 2013).

The program of AA has been so influential that a significant portion of alcohol rehabilitation and treatment centers have incorporated the concepts of AA into their treatment models (Roberson, 1988). Individuals who attend AA are likely to receive outside treatment or counseling, which coincides with their AA attendance (Groh et al., 2008). Another contributing factor to the division between AA and professional psychological care is the lack of adequate preparation and competency in the treatment of addiction in counselor training programs (Hardwood, Kowalski, & Ameen, 2004). This presence of inadequate training limits the professional utilization of AA. Amongst the persons with alcoholism who are seeking out the
help of 12-step programs, such as AA, a percentage of such recovering persons may seek a therapist who is knowledgeable about, supportive of, and friendly to the AA program (Miller et al., 2011; Schenker, 2009). Consequently, for the ethical treatment of their patients, therapists must have a working knowledge the Twelve Steps of AA and the broader AA program for the patient’s benefit. Conversely, there has been a slow paradigm shift embracing the use of integrative methods, including AA (Miller et al.; Schenker). Thus, understanding AA’s program consistent with the well-researched counseling theory of Adlerian Psychology validates its application as a platform of support to achieve long-term sobriety.

**Purpose Statement**

A large body of literature covering the nature of alcoholism, addiction treatment, Alcoholics Anonymous, Adlerian theory, and the integration of theory into substance abuse treatment, provides the basis for the theoretical exploration of the compatibility of Adlerian theory and the philosophy of AA. The goal of this literature review was to illustrate the relevance of AA and Adlerian Psychology. Further, this project demonstrated the ways Adlerian psychology could be integrated into the work with members of AA. This project also discussed the theoretical similarities between the program of AA and Adlerian Psychology. Highlights included the tenants of holism, social interest, and the life tasks.

**Alcohol Dependence**

**Prevalence and Impact**

The NIAAA (2017) defined Alcohol Use Disorder (AUD) as “a medical condition that doctors diagnose when a patient’s drinking causes distress or harm” and diagnosed with the following sub-classifications: mild, moderate, and severe (p. 2). In 2015, the prevalence of binge drinking and heavy alcohol use in people ages 18 or older in the past month was 26.9%, per the
NIAAA. Esser et al. (2014) found the prevalence of alcohol dependence was 10.5% amongst binge drinkers, and “a positive relationship was found between alcohol dependence and binge drinking frequency” from 138,100 adults who responded to the National Survey on Drug Use and Health in 2009, 2010, or 2011 (p. 1). Further results from this survey demonstrated “excessive drinking, binge drinking, and alcohol dependence was most common among men and those aged 18 to 24” (Esser et al., p. 1). Finally, the survey results found alcohol dependence was most common among those with annual family incomes of less than $25,000, but binge drinking was most common among those with annual family incomes of $75,000 or more (Esser et al.).

Esser et al. (2014) recognized the impact of excessive alcohol consumption in the United States. Excessive alcohol consumption costs “the United States $223.5 billion in 2006,” and is “responsible for 88,000 deaths annually” (Esser et al., p. 1). Binge drinking was also credited with countless health and social problems such as new HIV infections, unintended pregnancies, and violence (Esser et al., 2014). The NIAAA (2017) recognized “research indicates that alcohol use during the teenage years could interfere with normal adolescent brain development and increase the risk of developing AUD” (p. 3). Finally, the NIAAA reported that 45.8% of the 72,559 liver disease deaths were among individuals ages 12 and older in 2013.

**Addiction Treatment**

The National Institute on Drug Abuse (NIDA, 2016) determined how addiction treatment must help an individual abstain from drugs, be productive in the family, at work, and in society. The NIDA further identified the essence of success for an individual recovering from alcoholism to be a range of care customized treatment programs with follow-up options with medical and mental health services as needed. Grant et al. (2006) noted current models of addiction understand alcoholism as a biopsychosocial problem. The NIDA identified that successful
treatment as several steps including: detoxification (the process by which the body rids itself of a drug), behavioral counseling, medication (for opioid, tobacco, or alcohol addiction), evaluation and treatment for co-occurring mental health issues such as depression and anxiety, and long-term follow-up to prevent relapse. (p. 2)

Medications. Individuals can use medications to treat alcohol use disorders. Medicines approved by the Food and Drug Administration (FDA) to treat alcohol dependence include disulfiram, oral naltrexone, extended-release naltrexone, acamprosate, and topiramate. Medication in conjunction with the appropriate level of behavioral therapies such as individual counseling can enhance positive results in individuals.

Behavioral therapies. Medications are one tool to stop drinking, but behavioral therapies are especially effective in helping individuals recover from alcoholism (NIDA, 2016). Such therapies can be provided by professionals in varying increments and different settings to help patients modify their attitudes and behaviors related to drug use, including healthy life skills. NIDA recognized how behavioral therapies are used to treat drug addiction, and behavioral therapies help individuals modify their attitudes and behaviors related to drug use, increase healthy life skills, and persist with other forms of treatment, such as medications (p. 4).

Outpatient behavioral treatment. NIDA (2016) defined outpatient behavioral treatment as a program including a wide variety of programs for individuals to visit a behavioral health counselor on a regular basis, which involves individual or group drug counseling, or both. The NIDA further explained how this type of treatment begins with individuals attending multiple outpatient sessions each week and is sometimes intensive at first, then individual’s transition to regular outpatient treatment that meets less often with fewer hours per week to help sustain
recovery. Plus, these programs typically offer forms of behavioral therapy as defined by the NIDA to include:

- Cognitive-Behavioral therapy (CBT), which assists to identify the beliefs, attitudes, and situations that contribute to the individual’s alcohol use.
- Family therapy, which involves not only the individual with alcohol abuse but also his or her family members to reduce substance use and strengthen family relations.
- Motivational interviewing, where professionals employ strategies to increase the individual’s willingness to change his or her behaviors.

Inpatient or residential treatment. Licensed, residential treatment facilities are defined by the NIDA (2016) as facilities offering “24-hour structured and intensive care, including safe housing and medical attention” (p. 5). A variety of therapeutic approaches were presented by the NIDA which are employed in residential treatment facilities to assist the individual to live an alcohol-free lifestyle after treatment. These approaches include (a) therapeutic communities that are structured programs where individuals stay at a residence for 6 to 12 months and are influenced by staff as well as others in recovery, who act as key agents of change; (b) shorter-Term residential treatments have a focus on detoxification as well as providing counseling and preparation for treatment in more of a community-based setting; (c) recovery housing often follows other types of inpatient or residential treatment and provides short-term housing for individuals while still being supervised.

The Alcoholics Anonymous Program

AA is a nonprofessional self-help program whose primary purpose is to assist people to recover from alcoholism using mutual aid and a spiritual approach (AA, 2001). Montalto (2015) defined AA as “a treatment program that places emphasis on goals and activities that are
completed via a 12-step sequence” (p. 1). It was suggested that this platform of support allows anonymity, the ability to be honest, a source of trusted information, and ongoing support. These are often reasons for continued membership amongst individuals to address their difficulties as well as encouraging a positive “alcohol-free” identity. AA’s fundamental approach is the idea of one alcoholic helping another (AA, 2001). Members are encouraged to maintain complete abstinence from alcohol, attend mutual support meetings, work the suggested Twelve Steps (Appendix A), and adopt a program of recovery which integrates the spiritual principles of the program (AA, 2001). The elements of the program, particularly the Twelve Steps, are viewed as the path by which one achieves spiritual awakening and the psychic change needed to recover from alcoholism (AA, 2001; Giuffra, 2015; Montalto).

Individuals carry out the messages of the program to other alcoholics and practice the principles of the program in all of one’s affairs, per the AA website, as cited in Montalto (2015), further explained individuals of AA “learn to share and express their personal turmoil via a group therapy process that advocates accepting surrender to a higher power or altering selfish behavior to more altruistic ends” (2001, pp. 2-3), which provides a safety net that shelters individuals.

**History of Alcoholics Anonymous**

In 1935, AA was founded by Bill Wilson, also known as Bill W. and Dr. Robert Smith, also known as Dr. Bob. In search of relief from his alcoholism, Bill Wilson joined The Oxford Group, which was a Christian fellowship. Per the AA website (2017), the Oxford Group is a “mostly nonalcoholic fellowship that emphasized universal spiritual values in daily living.” The teachings of The Oxford Group influenced the structure of AA and many of the ideas that formed the foundation of AA’s suggested 12-Step program once Wilson left. Wilson and Smith pursued
to develop a more successful approach to helping all alcoholics emphasizing a spiritual conversion to help secure sobriety, enjoy life without alcohol, and individuals could not conquer alcoholism by themselves while surrendering to a higher power.

According to the AA website (2017), despite being a physician, Smith did not acknowledge alcoholism as a disease but responding to Wilson’s convincing ideas, Smith was never to drink again. Wilson and Smith set to work at Akron’s City Hospital in Ohio with other alcoholics, and this is where another individual soon achieved complete sobriety with the new approach (AA.org, 2017). These three men made up the first AA group, and in the fall of 1935, the second group of alcoholics developed in New York (AA.org, 2017). Per AA’s website, it took over 4 years to cultivate 100 sober alcoholics and a third group, which developed in Cleveland in 1939.

**Components of Alcoholics Anonymous**

**The Big Book**

In 1939, Wilson wrote the book *Alcoholics Anonymous*, but is often referred to by members of AA as the *Big Book*. This basic text includes the following: twelve steps of recovery, AA’s philosophy and methods, and case histories of 30 recovered members. The 2nd edition was release in 1955, the 3rd in 1976, and the 4th in 2001. The first part of the book details the program and the second part contains case histories and personal stories of an individual’s experience.

**The Twelve Steps and Twelve Traditions**

In response to AA’s growing popularity, Wilson, subsequently wrote the book *The Twelve Steps and Twelve Traditions* (AA, 2012) in 1952. With the exception of the introduction and the addition of descriptive data that more accurately reflects AA’s current population and
growth, the book remains virtually unchanged since 1952. The book offers an expanded interpretation of the Twelve Steps as well as an in-depth description of the workings of AA society, particularly in relation to the bylaws of the organization known as the Twelve Traditions (Appendix B). The Twelve Steps and Twelve Traditions integrated both sociological and psychological concepts into the broader program (AA, 2001). In the Big Book, Wilson identified selfishness or self-centeredness as the root of the alcoholic person’s problems and personal inventory as the means to address this issue (AA, 2001). In his re-interpretation, he identified out of balance instincts and drives, rather than selfishness, as the root of the alcoholic person’s problems.

Wilson laid out the expectation that the member’s sobriety will be marked by continuing struggles with personal shortcomings and emotional problems. According to Wilson, the inventory process, when embraced from a psychological rather than entirely spiritual construct, can be the instrument with which the alcoholic can work through more global intrapsychic and interpersonal issues which persist even after sobriety is achieved (AA, 2001). Furthermore, Wilson cautioned that the inventory process should not be expected to abruptly extirpate defects, rather that it should be considered an ongoing and open-ended introspection leading to gradual change and growth over time (AA, 2001).

Tradition One seeks to place the common welfare of the organization as the primary concern, noting that individual recovery depends on the unity of the group. Tradition Two defines that there is no central authority in AA, that the literal collective conscience of group members is the governing principle in all matters. There exists a general service organization providing coordination and service, but this office holds no governing powers. Tradition Three
indicates that any person with a desire to stop drinking can consider themselves a member of the organization.

Tradition Four allows for the establishment of an AA meeting by any who choose to do so if the meeting’s practices are consistent with AA traditions. Tradition Five outlines the AA’s limited focus, which is to carry its message to the still suffering alcoholic. Tradition Six prevents using the AA name in any formal capacity, preventing any affiliation that could detract from AA’s primary purpose of carrying its message to suffering alcoholic persons. Tradition Seven precludes the acceptance of any outside financial support, requiring that group members be self-supporting. Tradition Eight prohibits the professionalization of AA. Tradition Nine looks to structure AA as minimally as possible, allowing for some management within, but preventing a centralized government. Tradition Ten keeps AA from becoming involved in or formulating opinions about any outside issues, the intention being to avoid any public controversy. Tradition Eleven prohibits any promotion of the organization, maintaining that AA should remain a program of attraction based on the success of its members (AA, 2012).

Finally, Tradition Twelve identifies that anonymity is the spiritual foundation of the organization (AA, 2012). This is for two purposes. The first is to help maintain the protection of its membership whose reputation or image may be damaged by negative views regarding identification as an alcoholic person. The second is to ground members with a sense of humility and prevent ego inflation that so often results from seeking acknowledgment for one’s accomplishments (AA, 2012).

**Mutual Support**

AA groups provide social support, which are made up of members who share the same problem and voluntarily support one another in their recovery. These groups provide social,
emotional, and informational support for individuals going through the recovery process.

Laudet, Magura, Vogel, and Knight (2000) investigated the association among social support and the recovery status of individuals. The study participants were recruited from individuals attending recovery meetings throughout New York City. Laudet et al. (2000) found persons with higher levels of support and greater participation in mutual aid reported less substance use, mental health distress, and higher levels of well-being. This benefit of participation in AA is that helping others helps the helper. Increased participation of members in turn increases abstinence, and Laudet et al. identified how social relationships are a resource for coping with stress.

**Sponsorship**

Attendees of 12-step mutual help groups such as AA are encouraged to obtain an AA sponsor. Kelly, Greene, Bergman, Hoeppner, and Slaymaker (2016) defined a sponsor as an accompanying AA member who is typically in long term sobriety from alcoholism, who agrees to serve as a recovery role model as well as a supportive guide. The sponsor is a supportive guide through the hands-on application of the 12-steps. Sandoz (2014) explained how sponsors provide guidance in the prayers designed to overcome fear, anger, and resentment as well as preparing a fourth step inventory of fears, resentments, and harms done to others.

Kelly et al. (2016) suggested that these non-professional sponsors might be considered as “lay therapists,” or the AA equivalent of the professional treatment clinician (p. 32). Little is known about the influence of the “therapeutic alliance” between AA members and sponsor, so Kelly et al. conducted a study to develop and assess the AA sponsee-sponsor therapeutic alliance – the Sponsor Alliance Inventory (SAI). This 10-item scale was evaluated on young adults (N=302) and the findings from this study suggested that this scale may be useful in explaining
the impact of the sponsee-sponsor relationship within AA as well as the scope of AA-related benefits (Kelly et al.).

**Role of spirituality**

The idea that recovery is reached through spiritual experiences and an awakening to one’s higher power is a belief that the AA program holds (Witkiewitz, McCallion, & Kiroac, 2016). Bill Wilson and Dr. Bob Smith, the founders of AA and both alcoholics in the 1930s, were unable to achieve sustained sobriety despite their Christian faith. Dossett (2013) identified AA cannot be linked to any outside agendas whether that be religious, political, or the addictions treatment professions. Step six of the 12 traditions sets the stage to understand AA as spiritual and not religious, despite the language being used in AA is explicitly religious. Witkiewitz et al. recognized spiritual growth as a change mechanism in AA, and spiritual practices which may be helpful in reducing hazardous drinking and in the treatment of alcohol use disorders.

**Building a spiritual foundation in the first three steps.** The individual who abused alcohol is affected spiritually, emotionally, socially, mentally, and physically (Sandoz, 2014). Sandoz pointed out how the procedures of the 12-step program enables individuals to recover from these areas, and for the spiritual process of recovery to begin, the essence of the first three steps must be grasped. In step one, the addicted individual admits to powerlessness over alcohol, and how life has become unmanageable. If the individual cannot be honest about the problem as well as exerting a genuine effort to resolve it, then the individual cannot be placed on the path of change and ultimate transformation. Sandoz identified that the process of step one “requires a readiness to place oneself onto a spiritual conveyor belt” (p. 5).

Next, step two is the belief that a Power greater than the self could restore one to sanity, and the need for an open-mindedness to the idea that the individual is not God (Sandoz, 2014).
Sandoz determined that step two is a gradual process of trust and hope in a Higher Power who could restore the self, and be placed on a path to recovery of other individuals with greater lengths of success in sobriety. This leads individuals to step three and the faith needed to surrender individual will over to the care of God as the individual understands Him. This willingness to surrender to the process laid out before the individual, which aids to move from the pre-contemplative stage of change to contemplative then into the action stage (Sandoz).

**Transformation through the action steps.** The steps of four through 12 are referred to as the action steps or having to do something. Although, Sandoz (2014) identified how personal selfishness must be removed before God enters, which occurs in the action steps. This would include step four, where an individual would make a moral inventory of the individual then humbly admit to the individual and others the exact nature of our wrongs, which is step five. Step four allows individuals to have the courage to honestly look at the self, and to look at what an individual’s behavior has become to justify continued use. This can be difficult and teaches individuals to do the next right thing even when no one is looking. Step six includes a willingness to let go of all an individual’s character defects and old behaviors. Then, step seven, individuals move further into action and rely on an individual’s Higher Power. This step is around humility, where an individual asks for help in letting go.

Steps eight, nine, and ten happen when individuals mend personal relationships (Sandoz, 2014). An individual makes a list of all persons whom the individual has harmed, and to make an amends. Sandoz identified the purpose of Step eight was to rid the individual of personal guilt, where the individual must ask God for the grace of self-forgiveness. In step nine, direct amends is made to such persons, whenever possible, as well as asking for forgiveness and cleaning the individual’s side of the street. Individuals are facing their wrongs, correcting them
not just with words, but through action. Then, in step 10, individuals continue to take a personal inventory and gains acceptance for being imperfect. Hopefully, individuals can also promptly admit when an individual makes a mistake.

Finally, steps 11 and 12 are reminders that the individual must continuously grow spiritually, seeking wisdom and God’s will for every individual; otherwise, Sandoz (2014) explained that one would revert to old habits or ways of thinking or behave. Step 11 suggests that individuals continue to improve their conscious contact with the individual’s Higher Power through prayer and meditation. Sandoz argued those individuals returning to the use of alcohol show decreased measures of spirituality and meditation. Then, Step 12, suggests individuals try to carry the message of AA to other alcoholics as well as practice these principles in their daily life. Individuals seek out other individuals and are available to help others in need. Sandoz acknowledged the person in recovery is an ongoing transformation because of the final three steps and changes in an individual’s motivation is evident, “prompting the individual to help others who suffer from the same disease” (p. 5).

The Critiques of Alcoholics Anonymous

Mendola and Gibson (2016) explored features of AA which makes the program a poor fit for individuals who are seeking recovery from alcohol abuse. First, Mendola and Gibson stated that the most significant criticism of AA was the “variability in adherence to core tenets from group to group” (p. 648). This is caused by the nonprofessional design of the program, so quality control measures are minimal, and there are not ways to guarantee that every group adheres consistently to the principles of the program. Consequently, there are positions held by some individual groups or members of the program which are inconsistent with the official position of AA. These positions include members are not allowed to use medications to support
sobriety, AA is the only way someone can get sober, and is a religious organization, specifically Christian, which shames addicts as being morally flawed (Mendola & Gibson).

For some individuals, the concept of finding God and AA’s emphasis on spirituality can be off-putting (Mendola & Gibson, 2016). AA promotes the goal of abstinence, but Mendola and Gibson explained that “moderation is a better goal for some people” (p. 31). Mendola and Gibson identified how some individuals find that the emphasis on powerlessness in step one erodes their confidence in recovery. Then, individuals struggle and are bothered with step four and six, due to AA’s position that alcoholism is an illness as well as a moral failing (Mendola & Gibson). Mendola and Gibson identified how individuals are at odds with the phrasing of moral inventory per step four and defects of character per step six.

**Adlerian Psychology**

Watts (2015) acknowledged Alfred Adler as the developer of Individual Psychology, a theory of personality and maladaptation, and an approach to counseling and psychotherapy. Adler was born outside of Vienna and trained at the University of Vienna as a physician. Corey (2013) elaborated on how at age 4, Adler almost died of pneumonia and was very sickly, then Adler associated this time with his decision to become a physician. Like the Individual Psychology framework, Adler was shaped by an experience in the first few years of his life. Adler initially entered the medical field as an ophthalmologist, then shifted to private practice, and finally specialized in neurology and psychiatry (Corey). He was invited by Sigmund Freud to join the Vienna Psychoanalytic Society in 1902 and was president until 1911 when he resigned to begin the Society for Individual Psychology in 1912. Corey claimed Rudolf Dreikurs was the most significant figure in bringing Individual Psychology, or Adlerian Psychology, to the United States after Adler’s death in 1937.
After years of collaboration, Adler parted from Freud and deserted his theories due to believing “Freud was excessively narrow in his emphasis on biological and instinctual determination” (Corey, 2013, p. 103). Adler believed “humans are motivated primarily by social relatedness rather than by sexual urges” (Corey, p. 103). An individual is motivated by a desire to belong, and to be socially embedded. In the Adlerian perspective, Corey asserted that heredity and genetics are not as important as what an individual chooses to do with the limitations and abilities they possess. Also, in the Adlerian perspective, an individual is shaped by experiences in the first few years of life as well as birth order, family circumstances, and siblings. Our individual ways of making sense of these experiences are the basis of one’s beliefs about self, others, and life in general.

Adler significantly disagreed with Freud’s principles, especially as they applied to family counseling, child-rearing, education, individual psychotherapy, and group therapy (Corey, 2013). Individual Psychology emphasizes how individuals are motivated to find a place in one’s family, school, society, and work. An individual will begin to doubt their place in the group if the individual feels inferior to others or inadequate. Corey (2013) discussed how Adler focused on reeducating individuals and reshaping society. “Adler was the forerunner of a subjective approach to psychology that focuses on internal determinants of behavior such as values, beliefs, attitudes, goals, interests, and individual perception of reality” (Corey, p. 104), which is also known as an individual’s private logic. Individual Psychology is considered a holistic approach where an individual is viewed as more than the sum of the mental, emotional, and physical facilities (Corey).
Basic Concepts

Sweeney (1998) acknowledged Alfred Adler as the pioneer to various other approaches to counseling, therapy, and education. Further, Sweeney reported on the basic concepts of Adlerian psychotherapy, which were continuously included in the approaches of institutions and practitioners. Sweeney suggested the basic concepts of the Adlerian approach include:

(a) individuals are best understood from a subjective perspective and are holistic in their functioning;
(b) one’s lifestyle (one’s convictions about self, life, and others) was the map which individuals use to guide themselves in approaching life tasks;
(c) individuals are social beings who are self-determining, purposive, and creative in making a place for themselves;
(d) a sign of discouragement is unsuccessful coping with basic life tasks;
(e) an individual’s level of social interest constitutes their proneness for being cooperative, responsible, and a member of humankind;
(f) Adlerian theory and counseling interventions are based on social democracy and social equality between genders, minority populations, different generations, and oppressed persons.

Adler was identified by Corey (2013) as the first systemic therapist because Adler stressed how it was essential to understand individuals within the systems in which they live. Each generation encounters different problems; however, each individual views their problem from a frame of reference of his or her own creation. An Adlerian therapist must look for the degree of an individual’s approach to social integration, solving life’s social problems, and showing a sincere interest in others. A collaborative and encouraging stance is taken between the Adlerian therapist and the individual; with an always vigilant therapist alert to the individual’s strengths and working with them to see how they might use those strengths to achieve what the individual wants in his or her life instead of living on the useless side of life.
An individual is demonstrating an inability or a reluctance to cooperate and contribute to others. An inevitable leads to a clash with reality and others. A lack of social interest could be described as neurosis or maladjustment. Clinicians who use this form of therapy strongly believe in the Adlerian concepts of life tasks and social interest and community feeling that ultimately creates change which results in healing.

**Life tasks.** Adler discussed three main life tasks; work, society, and sex (love), which all individuals must face and navigate through (TenBroek, 2013). Mosak and Dreikurs added the spiritual and self-tasks (Mosak & Maniaci, 1999). TenBroek asserted that the tasks “are important to recovery from alcoholism and avoiding relapse” (p. 13). Carlson, Watts, and Maniaci (2006) suggested that Adler believed to be mentally healthy, one should master all the life tasks. The ways an individual meets the challenges of these life tasks, or fails to meet them, has a direct correlation with the individual's healthy adjustment and mental well-being (TenBroek). Additionally, each life tasks requires a certain amount of social interaction or embeddedness. When exploring the life tasks with a therapist, clients are asked to address their personal relationships, their self-esteem, financial security, personal ambitions, and their relationship to the universe (Mosak & Maniaci; TenBroek). Within AA, these areas are proposed to be the causes of the development and maintenance of alcohol addiction. The following is a brief exploration by the two authors of each of the life tasks integrated with AA philosophy.

Carlson et al. (2006) suggested that work task is addressed when what we do for work is meaningful and satisfying. The friendship task (social task per TenBroek, 2013) is addressed when we have satisfying relationships with others. The love or intimacy task is addressed when we learn to love ourselves as well as another (TenBroek). Carlson et al. also discussed the
recreation and spiritual tasks. “The recreation task involves developing the ability to have fun and enjoy life. The spiritual task involved finding one’s place in the cosmos (TenBroek, p. 13). The spiritual task may or may not involve religious practice or belief in some other higher power.

Spirituality and well-being: the role of positive emotions. Van Cappellen, Toth-Gauthier, Saroglou, and Fredrickson (2016) pointed out how spirituality has been shown in previous research to be related to an individual’s well-being. Van Cappellen et al. expanded on this previous research, which explored the social and cognitive aspects of spirituality and presented research trying to understand how spirituality exerts its impact on well-being as well as investigating the role of positive emotions. A quantitative approach was taken by Van Cappellen et al. in two cross-sectional studies presented results the relation between religion, spirituality, and well-being is mediated by self-transcendent positive emotions including awe, gratitude, love, and peace. Van Cappellen et al. proclaimed by “understanding the mechanisms by which religion/spirituality exert their impact on well-being is important because it can inform future interventions to improve well-being within or outside of a religious context”, as well as spirituality, being a protective factor for well-being because it provides a unique opportunity for creating these self-transcendent positive emotions. Van Cappellen et al. denied suggesting that positive emotions are the only mechanism of spirituality affecting well-being, but the future investigation should continue to investigate the benefits for individual’s well-being.

Positive affect in alcohol-dependent patients. Research has shown evidence that attendance at AA meetings is predictive of increased abstinence (Tonigan & Rice, 2010), social support in the form of AA sponsorship and friendship with other members were also significant factors in promoting abstinence and decreased alcohol-related problems. In addition to exploring
the multiple factors which may affect the positive correlation between AA and abstinence, a

growing area of research has been in exploring the ways AA model has been integrated into

various treatments settings and whether this has been found beneficial. McHugh, Kaufman,

Frost, Fitzmaurice, and Weiss (2013) correlated an increased reactivity is associated with alcohol
dependence and with poorer treatment outcome amongst this population. Much remains

unknown about markers of resilience to stress in this population despite the acknowledgment of

the importance of stress reactivity in alcohol dependence (McHugh et al.). A study conducted by

McHugh et al. examined an alcohol-dependent sample of 1,375 patients and is a secondary data

analysis from the COMBINE trial. “This current study examined whether positive affect

buffered the effect of stress on negative affect and alcohol cravings in an alcohol-dependent

sample” (McHugh et al., p. 152). Patients were initially engaged in a randomized, controlled

trial for alcohol dependence (the Combined Pharmacotherapies and Behavioral Interventions for

Alcohol Dependence [COMBINE] Study), and completed measures of alcohol cravings, negative

affect, positive affect, and stress (McHugh et al.). McHugh et al. hypothesized in the secondary

analysis “that positive affect would moderate the association between stress and negative affect

and that positive affect would be negatively associated with craving” (p. 152).

McHugh et al. (2013) indicated the results supported these hypothesizes. The patients

from the study with increased levels of positive affect displayed weaker relations between stress

and negative affect relative to those with lower positive affect (McHugh et al.). Also, positive

affect did not moderate the association between stress and craving, however, it was negatively

associated with craving (McHugh et al.). A protective factor of positive affect on stress

reactivity and extending this effect to an alcohol-dependent sample was proposed from the

results of McHugh et al. For alcohol-dependent patients, McHugh et al. established how the
utilization of interventions that enhance positive affect may be of usefulness if positive affect can aid in resilience to stress.

McHugh et al. (2013) encouraged the need of experimental studies for the future regarding studies examining an interventions effectiveness to enhance positive affect, and the association between positive affect as protective against effects of stress. Additionally, McHugh et al. determined a need for further studies examining if positive affect “moderates the association between stress and other markers of reactivity (e.g., cardiovascular and endocrine responses) and is needed to better understand this relationship” (p. 156). McHugh et al. proclaimed the importance for therapists to utilize interventions with alcohol-dependent patients to reduce stress reactivity due to the possible impact of stress on craving and relapse in this population. By enhancing positive affect, McHugh et al. identified that utilization of these interventions “may be a promising approach in the treatment of alcohol dependence” (p. 156).

Social interest and community feeling. A unique concept of Individual Psychology is the concept of gemeinschaftsgefühl or translated as social interest and community feeling. Corey (2013) defined social interest as “the action line of one’s community feeling, and it involves being as concerned about others as one is about oneself” (p. 106). Dreikurs (1953) provided a specific example to help visualize social interest more clearly:

A man becomes a member of a group, a club, a political party or some other association. His social interest expresses itself subjectively in his consciousness of being a part. Expressed objectively it will show how far he is able to co-operate there. On his social interest depends how soon he contacts others, whether and to what extent he can adapt himself to others, whether he is capable of feeling with and understanding other members. A man who thinks only of himself, of how he is to uphold his own dignity and
of the role he means to play, is sure to cause trouble within his circle of friends and acquaintances. (p. 5)

Dreikurs (1953) further identified how social interest is the expression of an individual’s ability for give and take in any situation and the individual “will never be baffled if he can subordinate ego-centric wishes to the objective needs of the group” (p. 7). Corey (2013) emphasized how Individual Psychology rests on the belief one’s success is largely related to this social connectedness, or *community feeling*, which “embodies the feeling of being connected to all of the humanity” as well as “being involved in making the world a better place” (p. 107).

From an Adlerian viewpoint, life is about survival and belonging.

*Social interest and substance abuse.* Giordano, Clarke, and Furter (2014) identified individuals experiencing the recovery process will often relapse, which is linked to internal vulnerability factors to include a lack of the Adlerian construct of social interest. Adler (1956; as cited in Giordano et al., 2014) argued a lack of social interest in an individual will result in failures of life, including substance abuse, which he described as means to evade the *life tasks.* Adler (1956; as cited in Giordano et al., 2014) claimed despite that these individuals may be active, the individual is not solving life’s tasks in socially useful ways, which include community and cooperation.

Giordano et al. (2014) found several researcher’s findings supported an inverse relationship between social interest and alcohol abuse. Findings from Mozdzierz, Greenblatt, and Murphy (2007; as cited in Giordano et al., 2014) determined veterans in substance abuse treatment with lower levels of social interest have higher drug and alcohol dependence scores than did those with higher levels of social interest. Additionally, Lewis and Watts (2004; as cited in Giordano et al., 2014) found amongst undergraduate students; social interest is a
significant predictor of the quantity of alcohol consumption. Finally, Giordano and Cashwell (2017; as cited in Giordano et al., 2014) found college students who did not abuse alcohol or marijuana had significant differences in social interest levels than those who abused both substances. Giordano et al. (2014) claimed by exploring social interest and social bonding; individuals can address their elements to provide a more holistic understanding of relapse.

**Criticisms and Limitations of Adlerian Psychotherapy**

Corey (2013) claimed Adler chose to practice his theory and educate individuals on Individual Psychology’s concepts over organizing a outlined theory, which led clinicians to determine his concepts “as somewhat loose and too simplistic” (p. 129). Adler’s written presentations and transcripts of lectures he gave are hard to comprehend due to the lack of definition (Corey, 2013). Then, Watts and Shulman (2003; as cited in Corey, 2013) argued the effectiveness of Adlerian theory and the research supporting the theory. This especially holds true on the fundamental concepts to include the development of lifestyle, the unity of personality, and the acceptance of a singular view of self, rejection of the prominence of heredity in determining behavior, especially pathological behavior, and the usefulness of Adlerian interventions (Corey, 2013).

**Limitations from a diversity perspective.** The Adlerian approach, as classified by Corey (2013), is consistent with Western models and “tends to focus on the self as a locus of change and responsibility” (p. 124). Corey (2013) further explained the emphasis on the independent self may be problematic for clients due to other cultures having different conceptions of self. Adlerian concepts of birth order and family constellation are built into the theory, which also aligns with the Western nuclear family, and may be less relevant for those raised in an extended family context (Corey, 2013). From a diversity perspective, “clients from
those cultures who are not interested in exploring past childhood experiences, early memories, family experiences, and dreams” is another possible limitation of the Adlerian model (Corey, 2013, p. 124). Also, Corey (2013) expanded on how clients may be hesitant to divulge information on areas of their lives which they may not see as related to the struggles that bring the client into therapy. Corey (2013) placed emphasis on how a client will be more open to the assessment and treatment process if the therapist exhibits an understanding of a client’s cultural values.

Finally, the counselor is viewed from some clients as an “expert” due to their culture of origin (Corey, 2013). Corey (2013) explained how these clients might be “expecting that the counselor will provide them with solutions to their problems” (p. 125) and the role of the Adlerian therapist may pose as problematic for these clients. By the Adlerian model, the therapist is not the expert in solving client’s problems. Alternatively, Corey (2013) described how Adlerian therapists view their role as a collaboration to “teach people alternative methods of coping with life concerns” (p. 125).

**Argument for AA through Adlerian Psychology**

Historically, the public has misunderstood addictions as a moral failing or a bad habit, not as an acquired health condition with genetic vulnerability to many substances such as alcohol or nicotine (McLellan et al., 2014). Addictions needs to be treated like other chronic illnesses (McLellan et al., 2014). Vederhus, Zenmore, Rise, Clausen, and Hoie (2015) identified when an individual is in recovery for their alcoholism, one must develop self-regulation strategies to maintain rehabilitation as well as cope with triggers and urges over long periods of time. In the management of an individual’s long-term condition, mutual aid groups such as AA is one of the most widely available continuing care options (Vederhus et al., 2015). AA is a form of mutual
aid for men, women, and adolescents. This program affords members an accessible and anonymous community to address their difficulties as well as encourages a positive, alcohol-free identity.

Many questions about long-term recovery and contributing factors to sustained sobriety remain unknown. Laudet, Savage, and Mood (2002) emphasized the need for research about the process of long-term recovery and contributing factors. The preliminary study performed by Laudet et al. represented an initial step for assessing long-term recovery with many limitations including small sample size, self-selected respondents who are members of a recovery community, and the use of short, self-administered instruments. Krentzman et al. (2011) analyzed specific elements of 12-Step involvement that were responsible for positive outcomes and whether these elements varied by gender. The components of doing service work and having a home AA group was predictive of sustained abstinence for over three years for both genders (Krentzman et al.). Krentzman et al. identified being a sponsor was predictive of sustained abstinence over three years for men only. Women were more likely than men to sustain abstinence over three years (Krentzman et al.). Krentzman et al. found these women continuously sustained abstinence through 12-Step involvement including socializing with 12-Step members, reading 12-Step literature, contacting members outside of meetings, step work, and having a sponsor.

Also, Krentzman et al. (2011) explored the experience and outcomes of adolescents in 12-Step programs. These individuals were more likely to achieve sustained abstinence by continuous 12-step meeting attendance and involvement in 12-Step suggested activities (Krentzman et al.). The 12-Step suggested activities included considering oneself a member of 12-Step fellowship as well as working the steps at a baseline (Krentzman et al.). Despite it being
a common practice for treatment facilities to refer teens to 12-Step programs, the effectiveness of these programs with this population is not often studied, which promotes further research needs to be performed at the benefits of 12-Step programs with adolescents (Krentzman et al.).

**Mechanism of Action of AA’s Success**

A debate surrounds the effectiveness of AA treatment programs. Despite AA being one of the most commonly available types of continuing care of individuals with alcohol use disorders, “the mechanism of action of AA’s success is not immediately clear” (Giuffra, 2015, p. 30). Giuffra explained that due to the progression in the understanding of the neuroscience of addiction, two brain areas have been identified and explain the irrational and self-destructive behavior of alcoholics. Also, Giuffra described how the 12 steps of AA help alcoholics reverse these effects. First, the reward system of the midbrain detects and experiences pleasure from a pleasurable stimulant, which far exceeds the normal pleasures of life such as eating or sexual reproduction (Giuffra). Then, the prefrontal cortex, which becomes hypoactive and unable to counteract the urges of the reward system to constantly repeat the “feel good” that comes from using alcohol (Giuffra).

Giuffra (2015) suggested the 12 steps of AA help alcoholics reverse the effects on the brain. As previously discussed, steps one through three encourage the use of a Higher Power, or a replacement decision-maker. Then, steps four through 12 foster the practice of behaviors which includes a life of honesty and service devoted to counteracting the maladaptive behaviors that facilitate the alcoholic’s behavior of repeating what feels good (i.e. getting intoxicated; Giuffra, p. 30). Giuffra defined maladaptive behaviors as lying, stealing, and manipulation; but pointed out that these behaviors are not defects of the alcoholic, they are the symptoms of a hijacked reward system and prefrontal lobes.
Alcoholics Anonymous and Long Term Recovery

Very little is known about recovery, despite knowing that recovery from addiction is a lifelong dynamic process (Laudet et al., 2002). “The majority of studies conducted among substance abusers have follow-up periods from 1 to 24 months – a short time relative to the lifelong challenges of recovery (Laudet et al., p. 305). Laudet et al. questioned whether factors recognized as forecasters of short-term abstinence are also associated with the maintenance of long-term recovery.

A pilot survey was conducted to explore factors associated with the maintenance of long-term abstinence amongst members of the Connecticut Community for Addiction Recovery (CCAR), which are representative the recovery community of Connecticut’s population (Laudet et al., 2002). A five-page self-administered questionnaire was mailed to CCAR’s 90 active members, with a total of 51 completed questionnaires being returned (Laudet et al.). The questionnaire focused on the individual’s history of substance use, substance abuse treatment, and other recovery efforts, including significant recovery experiences. Results indicated that individuals with longer abstinence attended meetings less often, and the frequency of meeting attendance was negatively correlated (Laudet et al.).

Laudet et al. (2002) discussed several benefits of social support, which include providing hope, learning coping strategies, and identifying roles that may contribute to recovery progress. Laudet et al. indicated that individuals in long-term recovery continue to attend meetings, which suggests the beneficial effects of 12-Step groups on short-term and long-term abstinence. Laudet et al. argued 12-Step groups have the advantage of being widely available in communities where members live, which is necessary for many substance users to have lifelong support that formal treatment cannot provide to the chronic, relapse-prone aspect of addictive disorders.
Alcoholics Anonymous and Sense of Community

Stevens, Jason, Ram, and Light (2015) argued one’s social network as beneficial for abstinence and substance use disorder recovery. Stevens et al. performed an exploratory study examining how specific sources of social support relate to general feelings of social support and abstinence-specific self-efficacy. Data was collected via telephone from 31 of 33 participants residing in five geographically dispersed recovery houses. Stevens et al. asked participants to complete social support and social network measures, along with measures assessing abstinence from substance use, abstinence self-efficacy, and involvement in AA (12-Step) groups.

The results from Stevens et al. (2015) study showed individuals who have higher levels of general social support reported higher levels of self-efficacy. General social support includes AA affiliation and sense of community. Participants with a larger social network had lower perceived stress (Stevens et al.). The results from Stevens et al. study have indicated individuals with specific affiliations, such as AA, may reduce stressors that might impair recovery. Stressors include an individual’s negative emotional state and environmental stimuli. Stevens et al. claimed this study has implications for continued research that will promote abstinence and increase social support for individuals in recovery, thus increasing individual well-being and decreasing pointless health care costs.

Further Implications for Clinicians

Facilitating Participation in Alcoholics Anonymous

Labbe, Slaymaker, and Kelly (2014) identified young adults as the largest population of treatment admissions because this group has the highest rates of substance abuse disorders, including alcoholism. To increase outcomes for individuals with severe alcohol problems, Labbe et al. determined continuing care strategies are necessary for clinicians to establish, which
include 12-Step mutual-help organizations (MHO) including AA. Labbe et al. conducted a qualitative study in a large clinical sample of 300 young adults who were investigated on the 12-Step group exposure on entry to, and in the following year, post-residential treatment. Results indicated 12-step meetings such as AA, provided a supportive social recovery environment for young adults and included validation, hope for recovery, a sense of belonging, and optimism about one’s future (Labbe et al.). Labbe et al. encouraged clinicians to emphasize that similar-aged peers in recovery found these aspects most helpful in attending AA and to provide “psychoeducation about the lower rate of abstainers in this age group in the general population, underscoring the difficulties young adults with more severe addiction problems may face in trying to ‘go it alone’” (p. 403). Further, clinicians may need to explain to young adults how AA participation with other similar-aged peers could be beneficial as one can relate to other members (Labbe et al.). Labbe et al. recognized how if clinicians are referring young adults to AA then clinicians might work to identify barriers then settle such problems to prevent the young adult’s participation in meetings.

For young adults who’ve attended 12-step meetings before residential treatment only six percent “of responses were specifically related to 12-step content” to include the structure of the meeting, length, and repetitiveness (Labbe et al., 2014, p. 404). Labbe et al. suggested that clinicians place emphasis on this percentage, and how other young adults may have similar worries about 12-step content, it was not so unpleasant to keep them from attending meetings. Nearly 15% of the young adults surveyed reported a lack of interest or motivation to attend AA meetings and was the second highest category reported. Labbe et al. associated lack of motivation as an individual factor which influences one’s meeting attendance and continued participation, versus the components the make up 12-step meetings. Labbe et al. asserted that
Clinicians must assess an individual's lack of motivation and contributing factors to a person's motivation if a clinician is referring to AA meetings. Labbe et al. discovered the importance of motivational techniques being applied to encourage young adult's involvement in AA meetings.

Finally, psychoeducation is imperative for clinicians to provide to young adults struggling with lack of interest and to clarify misinformation around AA. Beyond misinformation, nearly 15% of the responses of those surveyed by Labbe et al. (2014) lacked general knowledge about AA meetings. Labbe et al. emphasized the need for increased education and discussion about substance use disorders with youth as well as making information more available about AA meetings, which is adapted this age population. Forty three percent of those surveyed had not attended a 12-step meeting because the individual did not understand the need for such treatment (Labbe et al.). Labbe et al. proposed if young adults whom were initiating residential treatment would’ve received a 12-step referral, treatment admissions could possibly diminish.

**Keeping Individuals in Recovery**

In the year 2014, 22.5 million people aged 12 or older needed treatment services for an illicit drug or alcohol use problem according to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health. Of the total 22.5 million people only 4.2 million received any substance use treatment (as cited by the NIDA, 2016). Many individuals even after entering treatment drop out and some of the same concerns that prevent individuals from entering treatment are just as hesitant to continue with care. Some of these concerns include lack of insurance, worries about privacy, problems making or keeping appointments, lack of convenient appointments, denial of a drinking problem, lack of childcare, and the stigmatization from society in seeking treatment (NIDA). As evidenced by SAMHSA’s
National Survey on Drug Use and Health (2014), addiction is a major public health problem, even amongst adolescents. Moving forward, it will be important for clinicians to embrace the existing treatment framework such as medications, behavioral therapies, and mutual help groups including AA which has been shown to have a substantial impact on many individual’s efforts to change their drinking.

Kelly and Yeterian (2011) pointed out how professional resources have struggled to keep individuals with an AUD to remain sober by themselves, “despite considerable advances in pharmacological and behavioral treatments for AUDs, these community groups continue to play a major role in helping millions of Americans achieve recovery” (p. 350). An increase in social isolation can counteract effective treatment interventions. Addiction is an isolating social disease, and AA provides social support during treatment services as well as post-treatment.

Kelly and Yeterian (2011) recognized how AA members run groups themselves in rented venues with professional involvement, and can attend as often as needed without insurance approval or sharing of personal information (Kelly & Yeterian). Then, individuals typically have access to AA at times of higher risk of relapse including evenings or weekends in contrast to professional treatments (Kelly & Yeterian). Finally, AA members are often encouraged to contact other members whenever help is needed (Kelly & Yeterian). To maintain sustained sobriety, a supporting social network that includes individuals from AA appears important and vital in bringing individuals out of social isolation and enhancing sobriety.

**Conclusion**

Some individuals can consume alcoholic beverages without problem, while others had problems with their very first drink, and the debate in how to help problem alcohol drinkers persists. Several statistics on the success and failure of treatment modalities including AA,
psychotherapy, medications, and behavioral treatment programs were reviewed. AA is the best-known mutual aid group where members from around the world meet and support each other. Individuals may share their stories, talk about their challenges, or share their victories. This project established the ways Adlerian psychology can be integrated into the work with members of AA to help these individuals achieve and maintain sobriety. The results of this project indicate to keep individuals in recovery, clinicians must welcome the current framework and facilitate participation in 12-Step groups including AA. Future research is recommended to assess other drivers of abstinence, benefits of AA on emerging populations, promotion of long-term abstinence, and reducing the need for expensive treatment services.
References


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APPENDIX A

The Twelve Steps of Alcoholics Anonymous
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The Twelve Steps of Alcoholics Anonymous

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

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

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

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

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

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

7. Humbly asked Him to remove our shortcomings.

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

9. Made direct amends to such people 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 all our affairs.
APPENDIX B

The Twelve Traditions of Alcoholics Anonymous
APPENDIX B

The Twelve Traditions of Alcoholics Anonymous

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. Our 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.