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Description
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Disciplines
Mental and Social Health | Occupational Therapy

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Starting a Dual Diagnosis Anonymous Meeting: 
The Role of the Clinician

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Abstract

Due to the symptoms of mental illness, some individuals are not accepted or find it very difficult to engage in traditional 12-step groups, the most widely available peer support groups for substance abuse/addiction. This paper describes the collaboration between a mental health professional and 12-step group members in the formation of a specialized 12-step meeting, Dual Diagnosis Anonymous. An overview of specialized 12-step groups is provided, difficulties the author encountered during the formation of the meeting are described, and specific recommendations for clinician involvement based on the author’s experience are presented.

Keywords: Dual Diagnosis, Co-occurring disorders, Dual Diagnosis Anonymous, Mental illness, 12-steps, Substance Abuse, Addiction

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Introduction

The 2004 National Survey on Drug Use and Health identified that persons with serious psychological distress, derived from any form of mental illness, account for 9.9% of all adults 18 years old or older (21.4 million people) in the United States and that 21.3% (4.6 million people) of those adults either abused or were dependent on drugs and/or alcohol, compared to only 7.9% of adults without serious psychological stress. Treatment for the combined issues of serious psychological distress and substance abuse or dependence was provided to only 6.0% (274,000 people) of adults with co-occurring disorders in 2004 (Office of National Drug Control Policy, September 8, 2005). According to Stoffel & Moyers (2001), individuals with schizophrenia develop drug problems at a rate six times greater than the general population and they develop alcohol problems at a rate three times greater than the general population. Stoffel & Moyers further identify that individuals with bipolar disorder develop substance problems at a rate nearly eight times greater than the general population. Cheney & Sweetwood (2003) state it is estimated that at least 50% of individuals with severe mental illness abuse alcohol and other drugs in the United States.

Current evidence-based practice literature supports that outcomes can be enhanced for individuals who have substance use problems in addition to mental illness when individuals are actively engaged in professionally provided outpatient treatment and 12-step groups in combination (Stoffel & Moyers, 2004; Ouimette, Moos, & Finney, 1998). Ouimette, Moos, & Finney (1998), found that the presence of an axis I diagnosis did not change the outcomes of the combined treatment and concluded that combined treatment was indicated regardless of psychiatric
status. Further, they recommended that; “clinicians and program administrators may wish to develop strong connections with the 12-step and other mutual-aid self-help groups in the community” (p. 521).

The purpose of this paper is to provide a case example of how a clinician supported the formation of a specialized 12-step group to meet the needs of individuals with the co-occurring disorders of serious mental illness and substance abuse while protecting the unique nature of a peer support group. Specific recommendations and cautions regarding the role of the therapist, based on the author’s experience, will be outlined.

12-Step Group Basics

Twelve-step groups are based in the belief that problem behaviors, such as substance abuse, are best addressed by support from others who have been through the process themselves rather than by professional intervention alone. Alcoholics Anonymous World services (1972) identifies; “Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism” (p.2). Other 12-step groups based on the premise of Alcoholics Anonymous share a similar group membership and purpose.

Twelve-step groups are spiritually based and require the belief in a “higher power,” but the definition of this is left to the individual participant and is not necessarily determined by religious practices (Alcoholics Anonymous World Services, 2003). Individuals who are uncomfortable with the idea of a spiritual God may choose to use the term as an acronym for “Good Orderly Direction” (Dual Diagnosis Anonymous World Services Inc., 2003, p. 34). Independence from outside organizations, including religious organizations and formal treatment programs, is one of the hallmark traditions of Twelve Step groups (Alcoholics Anonymous World Services, 2003).

Specialized 12-Step Groups

Although the combination of professionally provided outpatient treatment and 12-step participation has been identified as a best practice, participation in 12-step groups can be difficult for individuals diagnosed with a mental illness. Corbett M. (identified in the traditional 12-step manner of first name and first initial of last name), one of the founders of Dual Diagnosis Anonymous (DDA), identifies that he has witnessed the difficulties that individuals with active mental illness symptoms can have at 12-step meetings on multiple occasions. He identifies that taking psychiatric medications is often frowned upon at traditional 12-step meetings and that he and another individual, Ruben, were once asked to leave a meeting due to what was identified as the disruption of the meeting caused by Ruben’s uncontrolled rocking, mumbling, and pacing, all symptoms of Ruben’s mental illness (personal communication, March 24, 2005).

In a comprehensive review of the current literature regarding 12-step programs and mental illness, Bogenschutz, Geppert, & George (2006) identify that specialized 12-step groups have grown out of the difficulties described by Corbett M, as well as other difficulties experienced by individuals who are dually diagnosed in traditional 12-step meetings. These specialized 12-step groups include organizations such as Double Trouble in Recovery (DTR), Dual Recovery Anonymous (DRA), and Dual Diagnosis Anonymous (DDA). Bogenschutz (2005) identifies “the extant studies consistently show a positive relationship between 12-step attendance and recovery (including decreased substance use) among DDI [dually diagnosed individuals], and suggest that specialized 12-step programs may be more acceptable and more helpful to DDI” (p. 12).

The basic premise of specialized 12-step programs is that the individual must accept that they have both a mental illness and a substance abuse problem and that control of these conditions is beyond the reach of the individual alone but that recovery is possible through the combined actions of the individual, fellow group members, clinicians, and a higher power that is defined by the individual (Double Trouble in Recovery, n.d.; Dual Diagnosis Anonymous World Services Inc., 2003; Dual Recovery Anonymous, 2004).

Specialized 12-step groups are based on a modified version of the original 12 steps (see figure 1 for an example from DDA) developed by founders of Alcoholics Anonymous. DDA also incorporates the addition of the five steps of DDA (see figure 2) that were developed by Corbett M. in order to address the complications of the co-occurring disorders of mental illness and substance abuse (Dual Diagnosis Anonymous World Services Inc., 2003; Cheney &
Sweetwood, 2003). In addition to the 12 steps, specialized 12-step groups are guided by modified versions of the twelve traditions of Alcoholics Anonymous (see figure 3 for an example from DDA).

Role in the Community

Specialized 12-step groups provide an alternative for the dually diagnosed who have not found acceptance in other 12-step or self-help programs. The text Dual Diagnosis Anonymous For Adults states; “It is our hope that this program will be a refuge to those people who have failed to gain acceptance in other twelve step programs, or have been stigmatized because of an illness that we did not choose and would not wish upon anyone” (Dual Diagnosis Anonymous World Services Inc., 2003, p. 59).

Cheney & Sweetwood (2003) identify that individuals with dual diagnosis often lose connection with their communities due to the effects of the combined illnesses. This loss of connection with communities further aggravates both of the illnesses, making symptoms of both more prominent and distressing. Specialized 12-step groups provide for a first connection back to community that can lead to other connections. Reconnecting with communities is a critical step towards recovery for the dually diagnosed who have become isolated and alone with their combined illnesses.

The Therapist Role

Therapist Interactions with 12-Step Groups

Health care professionals have had an integral, yet distant, role with 12-step groups since the beginning of the movement. The text Alcoholics Anonymous recommends those doing service work should “approach through a doctor or an institution...” when meeting a potential new member for the first time (Alcoholics Anonymous World Services, 2003, p. 91). Once connection is made, however, 12-step participation is typically separated from professional treatment.

In recent years, the role of the professional has expanded to include assisting clients in making use of 12-step groups as a part of the recovery process through twelve step facilitation therapy, although the therapist does not actually attend 12-step meetings but rather assists the client in preparing to attend meetings (Nowinski, Baker, & Carroll, 1999). Traditionally, professionals do not attend 12-step meetings in their professional capacity. The lack of involvement of professionals is based in the 8th tradition which states that groups; “should remain forever nonprofessional” (Alcoholics Anonymous World Services, 2003, p. 562; Dual Diagnosis Anonymous World Services Inc., 2003, p. 120). Double Trouble in Recovery (1997) addresses this issue directly by recommending that clinicians not accompany their clients to DTR meetings. Dual Recovery Anonymous (2004) identifies that clinicians my conduct “educational sessions” based on DRA practices but clearly states that these meetings are not the same as DRA Fellowship Meetings and must not be identified as such.

In areas where there is no DDA, DRA, or DTR group functioning however; it may be beneficial for professionals to play a limited role in establishing a specialized 12-step fellowship by stepping out of their traditional roles. According to O’Brien & O’Brien (n.d.) “…community building happens when people step outside the roles prescribed by the formal and informal administrative structures and the assumptions that typically organize life for people with substantial disabilities” (Five commitments that build community section, ¶ 1). This was the case in Yamhill County, Oregon when it was determined that the community would benefit from the initiation of a specialized 12-step group. Initially, the author and other clinicians attempted to facilitate the initiation of a chapter by providing information about DDA, DTR, and DRA to clients who were already active in the 12-step community, as well as those not involved with other 12-step groups. For a period of approximately 2 years information was provided and participation in consumer conferences that included sessions on starting 12-step groups for dual diagnosis was promoted, but no group was started locally. As no progress towards the formation of a specialized 12-step group was evident, the author contacted DDA co-founder, Corbett M. for guidance.

In order to promote DDA in Yamhill County, the author partnered with Corbett M. in the development of a local chapter. Through this partnership, a meeting location, at a local apartment complex that provides clean and sober
housing for those who are dually diagnosed, was identified, the new meeting was promoted, and the first meeting was held with Corbett M. as the meeting chair. The author provided transportation to the meeting and participated in the meeting for the first several months as a guest. Initially, the author attended meetings and facilitated success by setting out meeting materials, making coffee, pointing out the start time, and encouraging individuals to volunteer to take on specific group roles, such as meeting chair. Members looked to the author for directions and had to be frequently reminded that the author was a guest and not the one in charge. Over time, the frequency with which members sought guidance from the author decreased and members looked to one another for guidance.

As a core group of members became evident and individuals became comfortable with the standard procedures of the meeting, the author reduced his involvement by reminding group members of the location of items, such as meeting materials and coffee, and relinquished responsibility of preparing for meetings to group members. Over a period of approximately 12 months, the author took on more and more of an observational role and reduced his attendance at meetings to every other week, then one meeting per month, and now, over three years after the first meeting, the author continues to provide limited transportation to the meeting but no longer attends the meeting on a regular basis.

The previous example of a partnership between professional staff and the co-founder of DDA demonstrates that professionals can be more involved in the development of a DDA chapter than has been historically expected. Professional involvement comes with the risk of changing the nature of the group however, so caution is to be observed whenever professionals are involved in the founding of specialized 12-step groups.

**Lessons Learned Regarding Therapist Involvement in Specialized 12-Step Meetings**

The following recommendations are based on the author’s experience partnering with Corbett M. in the founding of a DDA chapter. Before initiating any group development, clinicians should be well versed in the 12-step movement and should have a thorough understanding of the 12-steps and 12-traditions of Alcoholics Anonymous, the basis of all 12-step groups. Clinicians should attend a variety of open 12-step meetings as a guest and develop relationships with those involved in the local 12-step community. Clinicians should also be well versed in the modified steps specific to specialized 12-step groups. Recommended readings that the author found very helpful include:


The author found that when participating in a 12-step meeting as a guest, clinicians should never chair a meeting. A therapist may perform reading duties and encourage others who have experience to chair a meeting, but should not take on the meeting chair role themselves in order to minimize dependence on the therapist for group leadership. The therapist must be diligent in remaining a guest and a guest would never take on a leadership role. The author recommends that clinicians remember always that specialized 12-step groups are peer support groups, not a professional intervention. The author’s experience revealed that if a therapist has any reservations about being at the meeting, those reservations should be shared during introductions and the group’s recommendations/requests regarding participation should be respected. In addition, given the role the therapist has outside of the group with potential members, the therapist should ask if any member is uncomfortable with the clinician’s presence during introductions. If there are any reservations from group members about the clinician’s presence, the therapist should excuse himself/herself from the meeting without question or discussion.
Initially, the therapist may involve himself/herself in basic housekeeping duties in order to facilitate meeting success. These duties may consist of tasks such as making coffee, setting out snacks, placing meeting materials in a convenient location for the meeting, or assisting with clean-up after the meeting. As soon as possible however, the author recommends that these duties should be relinquished to the group members in order to reduce dependence and promote group autonomy. Initially, the group may have enough to do in just participating in the meeting, but group members should be encouraged to take on all the necessary responsibilities for group success as they build skill in meeting participation.

**Potential Pitfalls**

The author found that there are potential risks inherent in clinician involvement with a self-help group. Outside the group, the clinician is in the role of providing guidance and direction, but inside the meeting the clinician is a guest and it may be difficult for some individuals, therapists and group members alike, to deal with the different roles. It is the author’s opinion that the clinician must avoid taking the leadership role at all costs, stopping at nothing short of abandoning the effort to facilitate the formation of a meeting if dependence begins to develop, in order to differentiate these new roles. It is helpful to have a person identified as the first group chair, before scheduling the first meeting, who is well versed in 12-step groups. The first meeting chair should have the opportunity to become familiar with specific group literature and the meeting structure prior to the first actual meeting. If at all possible, the individual should participate in other specialized 12-step meetings prior to the first meeting of the new chapter; however, familiarity with other 12-step meetings may have to substitute.

A clinician attending a specialized 12-step meeting may be privy to information from group participants that is of a sensitive nature. The author found that the clinician must always be respectful of the condition of anonymity, what’s said in a meeting stays in the meeting and is not shared or documented outside of the meeting. If there are concerns about mandatory reporting of information, those concerns should be shared with the group and group recommendations regarding clinician attendance should be respected, including clinician exclusion from the meeting.

Not all clinicians are going to be comfortable with the author’s recommendations. Clinicians not comfortable stepping out of the traditional roles may be better off providing educational sessions rather than attempting to help form a specialized 12-step meeting.

**Group Withdrawal**

As soon as group stability has been achieved, the author recommends that the clinician should remove himself/herself from the regular day to day operation of a specialized 12-step meeting. It should be clear from the beginning that the therapist presence is a temporary one and that the goal is for independent operation of the meeting. Starting on the first day, the clinician should be looking for ways to promote independence and group self-reliance rather than dependence on the clinician for group success. The clinician may occasionally visit the group after regular attendance has ceased, but attendance as a guest should always be cleared with the group during the introductions portion of the meeting.

**Conclusions and Recommendations**

Twelve-step groups are gaining a growing body of evidence that they are an effective option for promoting recovery from substance abuse and addiction. Individuals with mental illness have been shown to benefit at a rate that is comparable to those without mental illnesses but the unique needs of individuals with mental illnesses may not be met well in traditional 12-step groups. Specialized 12-step groups have grown out of the unique needs of those diagnosed with the co-occurring disorders of mental illness and substance abuse. This article has outlined the benefits of specialized 12-step meetings for those with co-occurring disorders as well as demonstrated a method for professionals to be involved in the formation of a specialized 12-step meeting while respecting the unique role that peer support has in the promotion of recovery. The author’s experience suggests that clinicians can take a more active role in the formation of specialized 12-step groups without compromising the unique contribution that peer led support groups can provide to reducing substance abuse. It is hoped that the
author’s experience will open the door to clinician involvement in facilitating the formation of more specialized 12-step chapters in order to meet the needs of this unique community of individuals.

References


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Figure 1

The 12 steps of Dual Diagnosis Anonymous

1. We admitted we were powerless over our dual diagnosis, and 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 others who are dually diagnosed, and to practice these principles in all our affairs.

Source: Dual Diagnosis Anonymous of Oregon, 2006, Meeting Info, Meeting Readings.
Figure 2

The 5 Steps of Dual Diagnosis Anonymous

1. We admitted that we had a mental illness, in addition to our substance abuse, and we accepted our dual diagnosis.

2. We became willing to accept help for both of these diseases.

3. We have understood the importance of medication, clinical interventions and therapies, and we have accepted the need for total abstinence and sobriety from all non-prescribed drugs and alcohol in our program.

4. We came to believe that when our own efforts were combined with the help of others in the fellowship of DDA, and God, as we understood Him, we would develop healthy drug and alcohol free lifestyles.

5. We continued to follow the DDA Recovery Program of the Twelve Steps plus Five and maintained healthy drug and alcohol free lifestyles, and helped others.

Source: Dual Diagnosis Anonymous of Oregon, 2006, Meeting Info, Meeting Readings.
Figure 3

The Twelve Traditions of Dual Diagnosis Anonymous

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

2. For our group purpose, there is but one ultimate authority – a loving god, of our understanding, as He may express Himself in our group conscious. Our leaders are but trusted servants; they do not govern.

3. The only requirement for DDA membership is a desire to develop healthy drug and alcohol free lifestyles.

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

5. Each DDA group has but one primary purpose - to carry its message of hope and recovery to those who still suffer from the effects of Dual Diagnosis.

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

7. DDA, as such, ought to exercise extreme caution and diligence in accepting outside contributions or other sources of funding, lest we be distracted from our primary purpose. Every local chapter of DDA should strive to be self-supporting.

8. DDA should remain forever non-professional, but our service centers may employ special workers.

9. DDA, as such, ought never be organized; that we may create advisory boards, service boards and committees directly responsible to DDA and those DDA serves.

10. DDA has no opinion on outside issues; hence the DDA name ought never be drawn into public controversy.

11. Our public relations policy is based upon attraction rather, than promotion. Our group consciousness suggests that this policy is founded upon the principle that DDA’ers recover and
that this recovery is evidenced among us in the quality and life satisfaction of those of us who follow the DDA way.

12. Confidentiality and Anonymity are the spiritual foundations of all our traditions ever reminding us that trust is a cornerstone of our fellowship and to place principles before personalities.

Source: Dual Diagnosis Anonymous of Oregon, 2006, Meeting Info, Meeting Readings.