PATHS TO THE PERSON

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PATHS TO THE PERSON

COMMUNITY ASSIGNMENTS IN ACHIEVING INDIVIDUAL PREVENTION GOALS

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To the Holy Father John Paul II
– Servant of the dignity of the human person –
the Founder of the Pontifical Council for Health Care Workers

Chapter XXI

SELF-HELP GROUPS

(IWONA NIEWIADOMSKA)

1. The Fundamental Nature of Self-Help

Mutual aid groups play a vital role in promoting human health, particularly with respect to individuals experiencing various life difficulties. Their members voluntarily meet with each other because they are in need of help and thus expect that they will be able to confide their problems to other members. Problems shared with others are key elements in the development of group cohesiveness. This, in turn, allows group members to take the risk of expressing their hidden emotions and to create bonds which will guarantee support, acceptance and the normalization of their experiences. Thanks to the existence of group norms, social modeling and by observing others, a mutual aid group member changes the way they perceive their own problems, views and experienced emotions. In this way the social surrounding created by members of such a group becomes, on the one hand, an important system of their social support and, on the other, a factor leading to the change in their behaviour (Schoenholtz-Read 2003, pp. 161-163; Czabała, Sęk 2000, p. 618). These mechanisms result from such elements of mutual aid groups as (Riessman, Carroll 2000, pp. 38-44):

– **changing any deficiencies and difficulties into assets** – people who have managed to overcome their problems possess knowledge on their causes and on the ways of coping with them; this is the condition of giving support to those who face similar problems;

– **interchangeability of roles** – in a mutual aid group the roles of the donor and the recipient are interchangeable; depending on the circumstances each member has a possibility of giving advice to others or following other people's advice; therefore, actual power within the group is evenly

divided, which means that there does not exist any power elite and there is no bargaining between the ruling and the ruled;

– **internal orientation** – members of a mutual aid community above all make use of each other's experiences and, only to a lesser extent, of conventional knowledge coming from external sources (e.g. professionals); internal orientation spreads over the logistics involved in running the group; this is so because most of its members stick to the principle of self-sufficiency and self-reliance in terms of satisfying various needs (e.g. housing or material needs);

– **focus on activity –** the main characteristic of this type of group is that its members aim at undertaking action, handling matters quickly, making an effort, being responsible, resourceful, and approaching problems instead of taking a role of helpless victims;

– **sticking to the principle 'helping others helps me'** – supporting other people brings benefit to those who offer that support as their own self-evaluation increases and their general feeling improves.

On the basis of the above-presented regularities one can draw a conclusion that facing difficult situations in common improves the abilities of the group members to (Walesa 1988, p. 345; Gaś 1993, p. 68): a) consciously share their feelings and values, b) feel empathy for other people's experiences, c) take into account the surrounding reality, d) overcome their fears and doubts, e) make decisions in a responsible manner, f) make their choices in a flexible way.

The first known mutual aid movement was Alcoholics Anonymous (AA) founded in 1935 in Akron, Ohio (USA) by two alcoholics – Bill W. (a stockbroker) and Dr. Bob (a surgeon). Before that they used to be members of the Oxford Group which aimed to revive first-century Christianity by realizing four absolutes: honesty towards oneself and others in speaking and acting, permanent readiness to help others, purity of one's body, mind and intentions, love of God and one's neighbour. Some of these principles were incorporated in the formation of the Twelve Step programme (Niewiadomska 2006, p. 49).

AA's functioning is based on the "Twelve Traditions" presented below (AA in a penitentiary 2002, p. 133):

1. Our common welfare should come first; personal recovery depends upon Alcoholics Anonymous unity.
2. For our group purposes there is but one ultimate authority—a loving God as He may express Himself in our group conscience.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.

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

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

7. Every AA group ought to be fully self-supporting, rejecting outside contributions.

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

9. AA, as such, ought never to 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 AA name ought never to 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 personal traditions.

In summing up the moral norms of the Twelve Traditions it has to be noted that Alcoholics Anonymous is a movement whose goal is for its members to overcome their common problem of alcoholism, to support others in remaining sober and to 'spread the message' to drinking alcoholics by sharing their experience, internal strength and hope with them. The sole and absolute authority in the group is a loving God and the sole condition of becoming a member – readiness to stop drinking. Members of the AA movement form (20-30-person) groups which have regular meetings at least once a week. There are two types of meeting: closed (available for alcoholics only) and open (available for people from outside). Alcoholics Anonymous is not an organisation as such. Each of its groups is independent in all aspects of its activity except for those which concern other AA groups or the whole movement. An appropriate number of groups can be formed into intergroups, and intergroups have a possibility of creating a Region with the aim of improving contacts between specific groups (Niewiadomska 2006, pp. 49-50).

The National Office serving AA is managed by a selected group of representatives of all the groups from all the Regions. It functions as an organisational-control authority (e.g. by supervising the observance of the movement's principles and traditions, maintaining contacts with the international AA movement, supplying proper literature, supporting and organising new groups). The National Office is not an official authority or body; it only performs service and ancillary functions towards its members. The

activity of mandataries should at different levels be honorary and charitable in character. However, in certain cases AA groups are allowed to employ indispensable staff members. On account of the self-help character of the AA movement, individual groups should remain self-sufficient. Therefore, they cannot accept outside donations but should be maintained on people's voluntary donations. One of the consequences of the fact that the AA movement is self-sufficient is that, on the one hand, it cannot become involved in any public polemic, join any religious creed, party or institution and, on the other, it should never support, finance or lend its name to any organisation or company (Niewiadomska 2006, p. 50).

The above-mentioned rules of the AA movement and the profound influence of the Twelve Step programme made the number of AA members in the 1990's rise to as many as 2 mln worldwide – the AA groups had meetings in over 96 thousand groups existing in 141 countries. The first Polish AA group 'Eleusis' was formed in the mid-1970's. In 1984, the first Contact Point and the first helpline were set up in Warsaw. In the October of the same year the first all-Poland AA convention took place. At the turn of the 21st century there existed about 1,500 AA groups in Poland (Niewiadomska 2006, p. 50).

Also, it has to be noted that mutual aid communities formed for their members to support each other in solving various problems most frequently base their activities on the Twelve Traditions and the AA Twelve Step programme. For example, in the mid-1940's in the USA there were formed first Family Clubs for families struggling with the problem of alcoholism. In 1954 The Board of Directors of Al-Anon groups was registered (people co-addicted to alcohol). In 1957 in the USA the Alateen community was founded aimed at children and teenagers up to 18 years old who came from alcohol-ridden families. In 1976 in the USA the group Alateen was converted into the Adult Children of Alcoholics Community. Following the principles and programme of AA, there appeared other types of mutual aid group in order to solve various specific problems, e.g. Drug Addicts Anonymous, Overeaters Anonymous, Sex Maniacs Anonymous, Workaholics Anonymous, Gamblers Anonymous, Nar-Anon (relatives of drug addicts), Gam-Anon (families of people addicted to gambling), Work-Anon (family members of workaholics). At present the popularity of mutual aid communities is so immense that 'it is difficult to imagine any type of psychic problem, behaviour disorder or life event for which there would not exist an appropriate group' (Yalom, Leszcz 2006, p. 444).

2. The AA Twelve-Step Programme's Method of Functioning

In the Twelve-Step programme, abstinence is understood as a process of recovery based on maintaining an indvidual's relationship with God, improving their interpersonal relationships and personal development in order to positively adapt to reality, acquire constructive prevention resources in difficult situations and gain more self-acceptance (Brown 1992, p. 228). Producing these changes is possible by realising the steps which are the following (Brown 1992, pp. 305-315):

Step 1.: We admitted we are powerless over alcohol—that we have lost control of our lives.

An individual's loss of control over their drinking leads to dangerous consequences in all the aspects of their life. Alcoholics who have begun to regain their health claim that accepting one's helplessness is a necessary condition for beating their addiction. The moment they reconcile themselves to the fact that they are unable to control their own life, helps them to realise their real need of help. AA members claim that self-confidence impedes the sobering-up process in those who are at the beginning of their recovery. However, when they realise their helplessness they come to feel a considerable need for finding support in a Higher Power and a necessity to accept help offered by another human being.

Step 2.: We come to believe that a Power greater than ourselves can restore us to sanity.

The realisation of the second step enables AA members to free themselves from:

– their egocentricity,
– their belief in the self-control over their own behaviour,
– the mechanism of the denial of their disease.

Step 3.: We made a decision to turn our will and our lives over to the care of God as we understood Him.

Members of the AA movement describe this stage of their recovery as 'a step towards action' because it concerns their decision to limit their own willpower.

Step 4.: We made an in-depth and fearless moral inventory.

The above principle is the starting point of an individual's autotherapy. From now on the person begins to change their self-image, which enables them to conquer their hypocrisy and to slowly approach the realistic perception of their own self. Taking this step teaches them how to evaluate themselves in an honest way, recognising their own vices and virtues. Additionally, this stage brings about the change in their self-acceptance.

Step 5.: We admitted to God, to ourselves, and to another human being the exact nature of our mistakes.

AA members admit that confessing their wrongdoings to God and another human being liberates them from the feeling of isolation and loneliness, which strengthens their bond with others. At this stage individuals develop the feeling that they are part of a community and frequently begin to experience the so-far-unknown feeling of belonging. At the same time, by breaking down the barrier of self-deception and beginning to feel accepted by others, they gradually come to feel greater self-respect.

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

At this stage there again arises the problem of submissiveness which is indispensable for a sobering-up alcoholic to show readiness to acquire new behaviour patterns and to undertake activities with a view to effecting changes. Step 6 involves the person's giving their consent that as a now-responsible and ready-for-change individual they will cooperate with the High Power which is helpful in achieving their established goals.

Step 7.: We humbly asked Him to remove our shortcomings.

The above principle motivates an individual to undertake actions resulting from Step 6. According to AA members this step is the key to humility which helps the individual to acknowledge authority.

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

Already while making a list of the persons an alcoholic has harmed they begin to free themselves from the feeling of guilt because they:

– discover the truth of their own participation in the harm inflicted on others,

– declare their readiness to compensate for the suffering they have caused.

Step 9.: We made personal amends to such people wherever possible, except when doing so would injure them or others.

The above principle concerns the individual's relationships with others as well. AA members emphasise that atonement is good not only for the harmed but also for the person who has done wrong because the act of restitution drives them to assume the responsibility for their wrongdoing. At this stage undertaking activities itself is important as it involves:

– their apology,

– confessing to their guilt

– compensating for the inflicted harm.

The sense of taking this step also lies in the fact that the individual is ready to accept the consequences resulting from the harm they have done

to other people. It has to be mentioned that in the person's process of recovery the foundations of the previous seven steps constitute the basis for steps eight and nine because amendmends made by an egocentric person do not bring psychic relief to them.

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

This directive presents the individual's moral account, i.e. the frank evaluation of their own conduct which should from now on become their everyday routine. On the one hand, this enables the person to avoid returning to their drunken behaviours and attitudes and, on the other, it allows them to develop such abilities as slowing down the pace of their life or doing their self-reflection in a more effective way.

Step 11.: We sought through prayer and meditation to improve our conscious contact with God, praying only for knowledge of His will for us and the power to carry it out.

Stage 11 gives the AA programme a religious and spiritual character. Participation in the community allows the recovering person to become accustomed to the existence of the Higher Power. Their starting the relationship with God helps them to:

– conquer their wilfulness,
– strengthen their bonds and affiliations,
– break free from their conviction that the world is hostile and cruel.

At the beginning of their sobering-up process all of these steps seem strange to the individual and they only focus on their own helplessness. However, the more they recover from their addiction the deeper sense they can find in these principles. Stage 11 carries a message that their work on themselves expressed by means of the Twelve Steps is a never-ending process – the realised principles should constitute the individual's constant philosophy of life, giving them a plane of reference in relation to their behaviour.

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

The final principle is the key to action. At this stage AA members have been endowed with sobriety and new faith. The best way to maintain the new attitude is to promote it among other people. Carrying 'the message' gives them satisfaction and a possibility to regain their self-respect. The acquired sense of community reinforces them in their sobriety because theye are now convinced that each AA member has various experiences from the time of their drinking which they can share as well as power and hope from the period of their sobriety.

In making generalisations about the way the Twelve Steps recovery programme works it has to be noted that the programme introduced a new way of thinking and clear norms of behaviour. New AA members are required to follow these principles both in their individual progress and in group work (Niewiadomska 2006, p. 51). After incorporating the rules some members of a mutual aid group experience 'a rebirth', which is comparable to a religious conversion or the re-establishment of an individual's links with the religion they once abandoned. This religious conversion can be a gradual or abrupt process, due to which a wrecked and unhappy 'self' becomes united, consciously righteous and happy by basing its life on a religious reality (Tobacyk 1989, p. 235). Religiosity, including people's opinions and convictions concerning miraculousness, emotional experiences and predisposition towards specific behaviours, is not a structure excluded from the individual's whole psychic life but something that dynamically shapes their personality (Prężyna 1988, p. 262). Religious conversion is the sign of a change of man's attitude to life. In a situation when an individual suffers severely, their motivation for conversion is expressed by: 'please, help me.' If, however, they continue by saying: 'do not change me,' then such a plea is not sufficient enough for them to experience a real transformation because this does not express their deep desire for authentic conversion, necessary readiness to work on themselves as well as the rejection of their false ways of thinking and addictions (Jaworski 1999, p. 48). Empirical studies imply that religious conversion is a central reorganisation of an individual's personality characterised by adaptive consequences for their individual functioning. This in turn ensures that the individual has a greater sense of life and their personal abilities, which at the same time increases their adaptive skills (Tobacyk 1989, p. 241). Individuals who have undergone religious conversion claim that they (Tobacyk 1989, p. 242):

– have completely changed their activitites after their religious experience,
– experience more control over their own life,
– changed their attitude towards their family and friends into a more positive one,
– derive more satisfaction from their life,
– accept themselves more.

Religious conversion frequently makes AA members change their attitudes towards (Brown 1992, p. 37): a) increasing their self-reflection, b) forming new opinions, c) reorientating their value preferences, d) changing their self-perception, e) reducing their hostility towards the surrounding world, f) increasing activity in their family, professional and social life.

Non-drinking alcoholics stress the fact that they constantly have to work on their new attitude and strengthen their relationship with God in order to fight off their tendency to be egocentric and to use defensive mechanisms. This kind of attitude can be expressed by the following statement: 'God, help me be who I am' (Johnson 1992, p. 169). A person who entrusts themselves to God no longer feels helpless in case of any difficulties. This gives them hope for the future, which is a must for any alcoholic who wants to maintain their abstinence. One of the elements of that hope is the person's desire to accept a system of moral values that would show them how to live and how to find the foundations on which they could base their life, crises and everyday problems. The realisation of the Twelve Steps is then a sort of personal declaration in relation to the Higher Power, which justifies a specific direction of the development of a human being, as well as the efforts they make and the requirements they set for themselves (Ostrowska 1990, p. 163).

3. The Role of a Mutual Aid Group in an Individual's Recovery Process

In the sobering-up process it is important to keep balance between an addicted individual's concentration on the psychoactive substance and the processes of the reinterpretation of themselves and broadening and deepening their relations with their surrounding (Brown 1992). In achieving their established goals social support plays the basic role because throughout this interaction there takes place an exchange of emotions, information and instruments of action (Sęk, Cieślak 2004, pp. 18-19). The alcoholic's stay in a detox clinic is a temporary phase from their drinking to abstinence. During this period the support on the part of professionals is vital in the sobering-up process. However, when the therapy comes to an end, the role of the alcoholic's family and mutual aid groups increases in sustaining their recovery.

The functioning of drinking alcoholics. Active alcoholism is a behavioural disorder understood as an act of taking a psychoactive substance by an alcoholic who, at the same time, is unable to abstain from this type of behaviour. The addiction syndrome is chronic in character – it develops gradually and enables the individual to function in quite an ordinary way (Niewiadomska 2002, p. 221). The person often does not realise that they are addicted because (Gorski, Miller 1991, p. 38):

– at the early stage there are no physical problems or problems connected with their behaviour,

– at the advanced stage the experienced difficulties are not associated with their drinking,

– at the chronic stage – as a result of a thinking disorder – their ability to evaluate the encountered situation is lowered. The main reason for excessive drinking is an alcoholic's decrease in their tolerance of stress (Quingley, Marlatt 2000, p. 124). Among the frequent causes of high psychic tension (stress) in addicted persons are the following (Mellibruda 2000, p. 707):

1) **autodestructive attitude** – connected with their low self-esteem, negative self-image, negative image of their own life and suicidal thoughts;

2) **deficits in interpersonal relationships** and destructive schemes of interpersonal relationships resulting from: the persons' defensive or aggressive attitude, their readiness to withdraw from their contacts, their suspiciousness and lack of trust as well as antisocial or asocial features;

3) **the collapse of their value system** and the lack of any constructive life vision, which are frequently accompanied by doubt and nihilism;

4) **deficits in their intrapsychic abilities** – particularly their low self-awareness and difficulty in understanding their own feelings and wishes;

5) **deficits in task competences** which in consequence lead to professional and family problems.

The above-mentioned factors cause that addicted individuals frequently use evasive strategies in order to deal with their problems. These strategies are implemented by abjuring of their consciousness the stress factor and its effects and by externalising their emotions connected with the stress but without making any attempts to resolve their situation (Brennan, Moss 2000, pp. 147-151). Alcoholics' behaviour who drink if faced with difficult situations – manifested by concentrating on their past, lacking in any strategy of solving their addiction problem, pitying themselves, blaming themselves for any misfortunes, isolating themselves from other people, using chemical substances to anaesthetise their problems – follows the pattern of learnt helplessness whose basic determinant is their passiveness and unwillingness to undertake any actions as well as their subjective conviction that no individual can prevent their painful experiences (Niewiadomska 2001, p. 173). The reasons for the persons' passiveness lie, on the one hand, in their subjective anticipation of a failure and, on the other, in their difficulty perceiving the connection between the undertaken activity and its effects (Rosenhan, Seligman 1994, pp. 392-395). Apathy appears most frequently when the individuals experience a failure in performing tasks important to them and at the same time subjectively reckon that they do

not possess any characteristics or features necessary to work out the constructive ways of handling their difficult situation. Passive anticipation of a failure is permanent in its character, i.e. in case the individual experiences a similar situation in the future, there is a high probability that they will react in an analogous way.

The life of addicted persons is thus dominated by their experience of helplessness, frustration, lonelinesss, hostility, aggressiveness and sadness. With each new excess they suffer a more intense feeling of fault and shame. Their negative emotional reactions are so severe that, as a result, they form a negative self-image and chronically lower their self-esteem (Michalik 1992, pp. 15-16).

However, the more a person's addiction develops, the less sensitive they become to their own psychic discomfort and to other peoples' suffering because by using the defensive mechanism of rationalization they build up a 'wall' between themselves and reality. In the face of a failure, every person tries to justify their behaviour, but in confrontation with a real situation they can quite easily withdraw from the previously-used defense mechanisms. In an addicted individual, the process of rationalization works more strongly, which leads to the person's exhibiting more and more strange bahaviours and a drastic lowering of their ability to evaluate the existing facts. The less the person is self-satisfied, the more frequently they display the phenomenon of self-delusion. In the end, the alcoholic falls victim to their own defense mechanism because, on the one hand – by using different excuses – they maintain their self-esteem but, on the other – when they use rationalization, they bring about important changes in their value preferences, the violation of the existing moral norms and the loss of control over their own conduct (Johnson 1992, pp. 40-44). This regularity is confirmed by acts of violence, disorders in interpersonal relationships and material poverty observed in the families struck by the problem of alcoholism (Hankała 1997, p. 66). The advanced stage of the individual's addiction is characterised by their gradual loss of control over their own behaviour and by the fact that any temporary cessation of alcohol drinking results in their suffering. The person becomes more and more isolated, gradually loses their emotional and intellectual abilities and reduces the range of their psychic experiences to constant thinking about alcohol (Brown 1992, p. 48; Johnson 1992, p. 55). People from their social surrounding begin to notice their health, marital, professional and/or legal problems which are most frequently interpreted as their lack of responsibility. They most frequently do not understand that the individual does not choose these types of behaviour because they constitute one of the elements of the person's addiction (Gorski, Miller 1991, p. 37).

Changes in alcoholics' behaviour during their treatment. An alcoholic's recovery is not the reverse of the process of their becoming addicted to alcohol. It occurs when the person has new experiences which enhance each other; therefore, taking up abstinence is a specific development process (Brown 1992). The first stage of alcoholism treatment is detoxication, i.e. eliminating the toxic substance from the alcoholic's organism. The symptoms of the acute abstinence syndrome which follow detoxication can be very dangerous. As a rule, during the detoxication stage, the patient is given a replacement substance whose doses are gradually reduced until all the abstinence symptoms disappear. The alcoholic is not fully detoxicated until the replacement substance has been discontinued and completely removed form the patient's body. Detoxication itself is not treatment yet because alcohol addiction influences all the spheres of human life – physical, psychic, spiritual and social. Individual and group therapies are the basic element in withdrawal management centres. Their aim is to make it easier for their patients to develop those abilities which will help them to maintain sobriety and will prove useful in the long process of their recovery (Gorski, Miller 1991, pp. 41-43).

An alcoholic who undergoes intensive therapy in hospital undergoes significant changes in their functioning. Their dynamics can be divided into four stages (Johnson 1992, pp. 129-135).

During **the first stage,** the patient is supposed to become aware of the state they are in. Their decision to take up abstinence signifies that they have accepted the fact that they are an alcoholic and have realised that they lost control over their drinking. Only then does their logical structure break down. Up to that moment their belief that they are able to control their drinking had been based on that structure (Gorski, Miller 1991, p. 40; Brown 1992, p. 142). Taking up abstinence can be treated as a new phase of the development of an addicted individual because at that moment they completely reorganise their intellectual and behavioural spheres which are accompanied by emotional balance disorders. The person who, while drinking, seemed to function at a higher cognitive and emotional level can now exhibit symptoms of losing their previous abilities. At this stage, the patient's relationships with their surrounding are usually painful and difficult as they mount resistance to the idea of giving up drinking and overcoming denial (Brown 1992, pp. 130-131).

During **the second stage** the alcoholic becomes conformable to their disease. The patient is frequently passive and they do not take on any responsibility for their own development. The results of a survey among a group of 80 sobering-up alcoholics have shown that the moment they become aware of their failure by admitting to the fact that drinking got

out of their control they experience progressive disorientation in terms of their own selves and the surrounding world (Brown 1992, p. 138). As a result of their adaptive problems the patients may exhibit negative psychic states in the form of, e.g. fear, helplessness, depression, suicidal thoughts or sleep disorders. They also present a strong need to become dependent on the persons able to show them the direction of their behaviour in a given situation. Therefore, it is important to organise that person's behaviours with which it is possible to fill their feeling of emptiness, to compensate for their loss and to relieve the symptoms of their depression (Brown 1992, pp. 171-177).

At the **third stage**, the individual begins to accept their own responsibility for their recovery. On the one hand, they have more self-respect and begin to demonstrate the need for starting close relationships with other people. On the other hand, they lack a realistic attitude towards their future and they do not take into account all the dangers threatening their abstinence after leaving hospital. Another important element of their sobering-up process at this stage is the appearance of a new defence mechanism manifested through their denial of the existence of any difficulties (Brown 1992, p. 77). The alcoholic's poor insight into their own selves and their inability to keep sober on their own constitute the basis for their decision to be extremely dependent on others. Therefore, the patient needs a secure and protective surrounding and efficient help on the part of professionals.

While summing up the second and third stages of addicted persons' stay in detoxication centres, one can state that at these stages their recovery can fluctuate between two extreme states of mind: that of a 'honeymoon' which is accompanied by rapture, pleasure and the denial of their problems and, more frequently, that of depression which can indicate that the patients mourn their loss of alcohol or that they experience the feeling of guilt after a long period of alcohol drinking (Brown 1992, pp. 175-176).

Stage four is characterised by the increase in the self-reflection in the alcoholic. The patient begins to appropriately fear their future and to deliberately seek the strategies which will enable them to more efficiently overcome any difficulties encountered when they leave hospital. They also realise that it is only their participation in the open treatment programme and in mutual aid groups that will help them to both break from their previous habits and to acquire new life abilities (Brown 1992, pp. 43-76).

In generalising the issues concerning the alcoholic's stay in hospital, it has to be noted that this type of situation can be interpreted as a critical life change event. Such a conclusion can be drawn on the basis of the following observations (Sęk 2001, p. 252):

1) The alcoholic's decision to undertake treatment concerns vital and high values. Therefore, this moment is emotionally significant for the individual. The greater burden the therapy imposes on the alcoholic the more these values are endangered.

2) Changes taking place during the recovery process and which the individual subjectively perceives as threats frequently lead to their feeling of helplessness and to the high risk of the disorders in the person's functioning.

3) The beginning of the person's abstinence disrupts the functioning of the configuration: the individual-the environment, causing in the alcoholic such a destabilisation state and such disorders of the balance in the established forms of their adaptation that the hitherto forms of their behaviour prove insufficient and useless. Therefore, their discontinuation of drinking requires vital changes in their adaptive mechanisms. This is the way through which the most critical character of the undertaken therapy is expressed.

4) Depending on the subjective interpretation of the facts, the withdrawal therapy can cause ambivalent feelings in terms of content. Its evaluation undergoes dynamic changes in the course of the patient's attempts to cope with their critical life change event.

5) The patient's stay in a detoxication centre can become the turning point of their life on condition that the individual introduces changes in their behaviour. The possibility of there taking place the turning point in alcoholics' critical life change event is the element which clearly distinguishes it from stress phenomena.

The mechanism of coping with the psychic burden experienced by alcoholics undertaking treatment is complex in its character. At first their stay in hospital evokes primary evaluation in the form of 'losses' and threats. Only at the second stage do the individuals evaluate their preventive possibilities in a given situation. It is a secondary evaluation in which the person subjectively concludes that the situation is hopeless, possible to deal with or that they lack the possibilities of tackling it or that it is a chance for them to prove themselves, or that it is a chance for them to solve their addiction problem. Only when the individual carries out those two types of evaluation, i.e. primary and secondary, which are accompanied by diverse emotions and physiological reactions, does this determine their further preventive behaviour (Sęk 2005, pp. 101-102).

The fact that undertaking abstinence is frequently a critical life change event is confirmed by the difficulties the patients encounter in their attempts to cope with stress. Alcoholics that have just begun to sober up are frequently unable to differentiate between small and big stress and

therefore overreact to even small psychic tension. They often feel tense in situations that normally should not be worrying to anyone, which, in consequence, provokes behaviours incompatible with those situations. Such reactions are the effect of the vicious circle principle in which the symptoms of the patients' chronic abstinence syndrome are intensified by their stress and the intensity of the withdrawal syndrome increases the level of their psychic tension (Gorski, Miller 1991, p. 52). Disorientation, the feeling of chaos, concentration and memory problems as well as difficulty in solving problems are the typical symptoms of the first stage of the sobering up process which disappear with the patients' recuperation. However, their unawareness of this fact may arouse the feeling of shame and guilt, loss of self-respect, which intensifies the tension and aggravates their abstinence syndrome symptoms (Gorski, Miller 1991, p. 53).

Changes in the behaviour of alcoholics at the initial stage of their abstinence. At the initial stage of the addicted persons' recovery, covering the first two years of their abstinence, one can observe the following regularities in their functioning (Cierpiałkowska 2000, pp. 171-174):

– high intensity of their physical and psychic need to drinik alcohol,

– the process of their deepening identification with other addicted persons,

– learning new behaviours from other sobering-up alcoholics.

At the initial stage of abstinence, an individual experiences the weakening of their defence mechanisms. Therefore, sobering-up alcoholics begin to perceive in different spheres of their lives the problems which are the effect of their long-term drinking. These conclusions frequently lead the recovering persons to (Cierpiałowska 2000, p. 174): a) internal conflicts, b) a high level of apprehension, c) depression, d) the feeling of guilt, e) anger, f) suicidal thoughts, g) the feeling of helplessness and lack of faith in the possible change of their situation.

Support of mutual aid groups at the initial stage of abstinence. The basic task and challenge at this stage of a sobering-up process is for the non-drinking alcoholic to deepen their identity. Only at two levels – concrete (place, people) and symbolic (idea, programme) – does the recovering person's identification give them sufficient internal bases for diverting their attention from alcohol and for directing their activities towards other spheres of life (Cierpiałowska 2000).

AA members, who base their activities on the Twelve Step idea, aim at changing their own conduct and at eliminating any behaviour causing problems. The only condition of their participation is their resolution. The AA community offers two forms of help which are of vital importance for

supporting the alcoholics' sobering-up process (Cierpiałowska 2000, pp. 197-200):

– care for the potential and newly added members of the community (relationship: initial sponsor – potential AA member),

– assistance in the members' completion of the Twelve Steps (relationship: programme sponsor – AA community participant).

At the initial phase of an individual's abstinence **the relationship: intitial sponsor – potential AA member** assumes the crucial importance. The significance of this type of contact results from the fact that most alcoholics join the AA movement while in the state of growing crisis accompanied by all its symptoms, i.e. the feeling of intense physical and psychic suffering, confusion and/or loneliness and the lack of hope for any change. For this reason the vital role plays the first relationship between the AA member and the person who has begun to sober up. This kind of relationship can take place outside the group – e.g. in the case of social or professional relationships. The initial meeting can take various forms but most frequently the initial sponsor helps the person at the intitial stage of their abstinence to determine the character and graveness of their problems. The role of the initial sponsor is frequently reduced to that of a person who only talks about their own alcoholism by presenting facts from their 'drinking autobiography', and who listens attentively and acceptingly (Cierpiałowska 2000, pp. 197-198). Due to such conversations, the alcoholic at the initial stage of their sobering-up is able to notice the similarity between their own problem and the difficulties experienced by the sponsor and other AA members. The sponsor, who listens acceptingly, allows their interaction partners to discover common experiences, gain in mutual understanding and build up mutual trust. After determining the similarities of each other's problems the sponsor briefly presents the benefits they have personally derived from their participation in the AA movement and encourages the person at the initial stage of their recovery programme to take part in AA meetings.

The functioning of addicted persons at the persistent stage of their recovery. At this stage sober alcoholics are characterised by (Cierpiałowska 2000, pp. 181-184):

– more stabilised sense of their new identity – 'I am an alcoholic',

– more realistic and appropriate way of perceiving their 'own self',

– more frequent occurrences of their positive self-evaluation,

– more frequent manifestations of their habitual abstinence behaviours,

– greater awareness of their experienced emotional states,

– growth in their ability to recognise situations conducive of their greater desire to drink alcohol.

The support of mutual aid groups offered to individuals at the persistent stage of their recovery. Social support offered to alcoholics at this stage is based on the relationship: programme sponsor – AA member. On joining the AA movement the new member can choose their programme sponsor, who is, most frequently, a person with a long-term participation. The programme sponsor can fulfil many functions towards their charge but their activity mainly focuses on the following (Cierpiałowska 2000, pp. 198-200):

– helping them in difficult situations,
– giving them hope in times of doubt,
– providing them with constructive advice derived from their own autobiography,
– shaping the person's under their care way of thinking,
– modelling their behaviours.

If an addicted person is supported in this way, their relationship with an individual facing a similar problem gives them hope for overcoming their own addiction and of upholding their faith in keeping abstinence. The sponsor with a long period of sobriety is the most convincing proof of the fact that it is possible to achieve this aim by becoming involved in the Twelve Step programme. Additionally, through establishing a relationship with the sponsor based on mutual respect, the charge can overcome their loneliness. In addition, this relationship usually gives them many opportunities to work through different problems appearing in their interpersonal relationships, especially in contacts with their closest persons. Meanwhile, throughout the relationship both the programme sponsor and their charge aim at upholding their abstinence. Therefore, the sponsor's behaviours – especially their ability to cope with difficult situations – constitute an important model of abstinence behaviours of the aided person. This type of relationship is also crucial for the sponsor due to, above all, factors such as: (Cierpiałowska 2000, pp. 199-200): a) strengthening their own abstinence by analysing their personal experiences from their periods of drinking and sobriety, b) reducing the risk of idealising their past – thanks to their personal reports involved in their 'drinking autobiography', c) constant confirmation of the new identity of the non-drinking alcoholic, d) gaining a position and prestige – a person who in the past experienced negative social reinforcement and has found themselves in a situation where they are a programme sponsor, now becomes an authority. Due to this they can find sense in becoming engaged in AA activities.

It has to be noted that long-term engagement in AA activities contributes to an individual's change of prevention strategies in difficult situa-

tions. In relation to drinking alcoholics such changes are mainly characterised by (Niewiadomska 2001, pp. 173-174):

– greater concentration on the occurring events;
– more frequent making attempts to solve their experienced problems;
– more frequent seeking support and help in others;
– less frequent relieving stress by using medicaments or other psychoactive substances;
– less frequent pitying themselves;
– better emotional self-control in problematic situations.

The efficiency of the influence of mutual aid. The role of mutual support in the persistent sobering-up process is confirmed by the results of scientific studies. First, it has been observed that hospital and ambulatory treatments have low efficiency – mainly because they focus their activity on the medical effects of addiction instead of psychological problems (Brennan, Moss 2000, pp. 154-156).

Second, AA communities have been discovered to have high efficiency in upholding abstinence by addicted persons – 67% of the members who participated in AA meetings for more than a year managed to keep abstinence, and 85% of the persons connected with the movement for more than two years maintained their sobriety (Ouimette et al. 1999, pp. 545-551).

Third, persons who have managed to uphold alcohol abstinence for more than 8 years were characterised by the stability of their life environment. Among the factors stabilising their existence, apart from the well-functioning relationship with their life partner and having a job, were also their engagement in AA activities, hope for the future, greater self-respect as well as the appearance of new authoritites (Vaillant, Hiller-Sturmhofel 2000, p. 43).

Fourth, the comparison between alcoholics engaged in the AA movement and individuals upholding abstinence who are outside the movement has led to the conclusion that mutual aid community members are characterised by (Longabaugh et al. 1998, pp. 1313-1333);

– lower intensity of anxiety,
– better social adaptation;
– more effective prevention strategies in solving their problems,
– a sense of stronger social support.

Additionally, comparative analyses of an individual's completion of the Twelve Steps and of other forms of help offered to addicted persons have shown a long-term effectiveness of this programme. Its effectiveness was more strongly connected with (Morgenstern et al. 1997, pp. 768-777):

– regular participation in meetings,
– possessing a sponsor,

– increasing engagement in community activities,
– deepening their religiosity,
– increasing the sense of meaning of their own actions,
– improving the organisation of their personal life,
– modifying their opinions,
– modelling constructive behaviours.

Bibliography:

AA w zakładzie karnym. Więzień do więźnia. [AA in a Penitentiary. A Prisoner Talking to a Prisoner]. (2002). Warszawa: Fundacja Biuro Służby Krajowej AA w Polsce.

Brennan P., Moos R. (2000). Wzorce picia u schyłku życia. [Drinking Patterns in the Evening of an Individual's Life]. In: *Alkohol a Zdrowie. Picie alkoholu w różnych okresach życia. [Alcohol and Health. Drinking Alcohol in Different Human Life Stages].*Warszawa: PARPA, 141-161.

Brown S. (1992). *Leczenie alkoholików. Rozwojowy model powrotu do zdrowia*. [Treatment of Alcoholics. A Developmental Model of Recovery]. Warszawa: Instytut Psychiatrii i Neurologii.

Cierpiałkowska L. (2000). *Alkoholizm. Przyczyny, Leczenie, profilaktyka. [Alcoholism. Causes, Treatment, Prophylaxis].* Poznań: Wyd. UAM.

Czabała Cz., Sęk H. (2000). Pomoc psychologiczna. [Psychological Help]. In: J. Strelau (ed.). *Psychologia. Podręcznik akademicki. Jednostka w społeczeństwie i elementy psychologii stosowanej, [Psychology. Academic Textbook. An Individual within a Society and Elements of Applied Psychology.]* v. 3. Gdańsk: GWP, 605-622.

Gaś Z. (1993). *Rodzina wobec uzależnień. [A Family in the Face of Addictions].* Marki-Struga: Michalineum.

Gorski T., Miller M. (1991). *Jak wytrwać w trzeźwości. [How to Maintain Sobriety].* Warszawa: Instytut Psychiatrii i Neurologii.

Hankała A. (1997). Przemoc jako przejaw patologizacji więzi międzyludzkich. [Violence as a Manifestation of the Pathologization of Interpersonal Relationships]. In: B. Hołyst (ed.). *Przemoc w życiu codziennym. [Violence in Everyday Life].* Warszawa: PTHP, 62-75.

Jaworski R. (1999). *Ku pełni życia. [Towards a Full Life].* Płock: Instytut Wydawniczy.

Johnson V. (1992). *Od jutra nie piję. [I'll Quit Tomorrow].* Warszawa: Instytut Psychologii Zdrowia i Trzeźwości.

Longabaugh R., Wirtz P., Zweben A., Stout R. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction* 93, 1313-1333.

Mellibruda J. (2000). Psychologiczna problematyka uzależnień od alkoholu i narkotyków. [Psychological Issues of Alcohol and Drug Addictions]. In: J. Strelau (ed.). *Psychologia. Jednostka w społeczeństwie i elementy psychologii stosowa-*

nej, [Psychology. An Individual within a Society and Elements of Applied Psychology]. v. 3. Gdańsk: GWP, 691-710.

Michalik M. (1992). To jedno życie... Więzi międzyludzkie i alkohol. [This One Life... Interpersonal Relationships and Alcohol]. *Problemy Alkoholizmu [Problems of Alcoholism].* 12, 15-16.

Morgenstern J., Labouvie E., McCrady B., Kahler C., Frey R. (1997). Affiliation with Alcoholics Anonymous following treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology* 65, 768-777.

Niewiadomska I. (2001). Rola wartości w utrzymywaniu abstynencji anonimowych alkoholików. [The Role of Values in Maintaining Abstinence by Alcoholics Anonymous]. In: Cz. Cekiera, I. Niewiadomska (ed.). *Profilaktyka uzależnień drogą do wolności człowieka. [Prophylaxis of Addictions as a Way towards Human Freedom].* Lublin: TN KUL, 165-177.

Niewiadomska I. (2002). Reakcje na stres alkoholików pijących i alkoholików we wczesnej fazie abstynencji. [Stress Reactions of Drinking Alcoholics and Alcoholics at an Initial Stage of their Abstinence]. In: L. Kułakowski, I. Antolak-Kułakowska (ed.). *O godność osoby ludzkiej. [For the Dignity of the Human Person].* Radom: „*Spes Vitae*", 219-239.

Niewiadomska I. (2006). Anonimowi Alkoholicy. [Alcoholics Anonymous]. M. Kamiński, W. Przygoda, M. Fiałkowski (ed.). *Leksykon teologii pastoralnej. [The Lexicon of Pastoral Theology].* Lublin: TN KUL, 49-52.

Ostrowska K. (1990). Znaczenie kształtowania postaw moralno-światopoglądowych w profilaktyce przestępczości nieletnich. [The Role of the Formation of Moral Attitudes and World Views in the Prophylaxis of Juvenile Delinquency]. In: Z. Sobolewski, F. Kozaczuk (ed.). *Zapobieganie demoralizacji nieletnich. [Prevention of the Demoralisation of Juveniles].* Rzeszów: Wyd. WSP, 159-173.

Ouimette P., Finney J., Gima K., Moos R. (1999). A comparative evaluation of substance abuse treatment. III. Examining mechanisms underlying patient – treatment matching hypotheses for 12-step and cognitive-behavioral treatments for substance abuse. *Alcoholism: Clinical and Experimental Research* 23, 545-551.

Quigley L., Marlatt G. (2000). Picie alkoholu wśród ludzi dorosłych w młodym wieku. [Drinking Alcohol among Young Adults]. In: *Alkohol a Zdrowie*. Picie alkoholu w różnych okresach życia. *[Alcohol and Health*. Drinking Alcohol in Different Human Life Stages]. Warszawa: PARPA, 112-127.

Prężyna W. (1988). Funkcja motywacyjna wartości religijnych w osobowości człowieka. [The Motivational Function of Religious Values in Human Personality]. In: A. Biela, Z. Uchnast, T. Witkowski (ed.). *Wykłady z psychologii w Katolickim Uniwersytecie Lubelskim w roku akademickim 1985/86. [Lectures on Psychology at the Catholic University of Lublin in the Academic Year 1985/86].* Lublin: RW KUL, 235-244.

Riessman F., Carroll D. (2000). *Nowa definicja samopomocy. Polityka i praktyka. [A New Definition of Mutual Aid. Politics and Practice].* Warszawa: PARPA, 38-44.

Schoenholtz-Read J. (2003). Wybór interwencji grupowej. [Choosing an Intervention Group]. In: H. Bernard, R. MacKenzie (ed.). *Podstawy psychoterapii grupowej. [The Basics of Group Therapy].* Gdańsk: GWP, 161-163.

Rosenhan D., Seligman M. (1994). *Psychopatologia, [Psychopathology].* v. 1. Warszawa: PTP.

Sęk H. (2001). *Wprowadzenie do psychologii klinicznej. [Introduction to Clinical Psychology].* Warszawa: Wyd. Nauk. „Scholar".

Sęk H. (2005). Rola wsparcia społecznego w sytuacji kryzysu. [The Role of Social Support in a Crisis Situation]. In: D. Kubacka-Jasiecka, T. Ostrowski (ed.). *Psychologiczny wymiar zdrowia, kryzysu i choroby. [The Psychological Dimension of Health, Crisis and Disease].* KrakóIn: Wyd. UJ, 87-107.

Sęk H., Cieślak R. (2004). Wsparcie społeczne – sposoby definiowania, rodzaje i źródła wsparcia, wybrane koncepcje teoretyczne. [Social Support – Ways to Define Support, Types and Sources of Support, Selected Theoretical Concepts]. In: H. Sęk, R. Cieślak (ed.). *Wsparcie społeczne, stres i zdrowie. [Social Support, Stress and Health].* Warszawa: Wyd. Nauk. PWN, 11-28.

Tobacyk J. (1989). Przeżycie nawrócenia religijnego jako mechanizm rozwoju osobowości. [Experiencing a Religious Conversion as a Mechanism of an Individual's Personality]. In: A. Biela, Z. Uchnast, T. Witkowski (ed.). *Wykłady z psychologii w Katolickim Uniwersytecie Lubelskim w roku akademickim 1986/87. [Lectures on Psychology at the Catholic University of Lublin in the Academic Year 1985/86]* Lublin: RW KUL, 261-276.

Vaillant G., Hiller-Sturmhofel S. (2000). Naturalna historia alkoholizmu. [Natural History of Alcoholism]. In: *Alkohol a Zdrowie*. Picie alkoholu w różnych okresach życia. *[Alcohol and Health]. [Drinking Alcohol in Different Human Life Stages].* Warszawa: PARPA, 25-50.

Walesa Cz. (1988). Psychologiczna analiza decyzji życiowo doniosłych. [A Psychological Analysis of Significant Life Decisions]. In: A. Biela, Z. Uchnast, T. Witkowski (ed.). *Wykłady z psychologii w Katolickim Uniwersytecie Lubelskim w roku akademickim 1985/86. [Lectures on Psychology at the Catholic University of Lublin in the Academic Year 1985/86]* Lublin: RW KUL, 277-350.

Yalom I., Leszcz. M. (2006). Psychoterapia grupowa. Teoria i praktyka. [Group Psychotherapy. Theory and Practice]. Kraków: Wyd. UJ.