

An Existential Approach: An Alternative To The AA Model of Recovery

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Abstract

Alcoholics Anonymous (AA) is the most widely used organization for the treatment of alcoholism. AA's philosophy has changed how many people view themselves and their substance use. The majority of substance abuse programs in the United States use the 12 steps, either by making them the basis of their treatment program, or by introducing AA to clients as a means of recovery. Research is not clear, however, as to whether working the AA program is helpful in achieving sobriety. Based on a review of the literature, this article examines differences between AA and professional counseling, and explores AA's philosophy. An existential approach to therapy is reviewed with regard to case conceptualization, assessment and interventions in treating individuals suffering with alcohol-related issues.

Regardless of their area of expertise, counseling professionals will most certainly be faced with clients who present with substance use disorders (Polcin, 2000). Numerous studies suggest a lifetime prevalence rate of 8%-14% for alcohol dependence (American Psychiatric Association, 1994), and it appears that at least 29% of clients who present with a current mental health problem are also plagued with a history of substance use disorder, and in such populations as clients with a diagnosis of

schizophrenia, for example, they have a 47% lifetime history of substance abuse or dependence (Regier, et al. 1990).

In the past, it has been noted that mental health professionals have not performed well in their treatment of substance abuse disorders (Brown, 1985; Khantzian, 1985; Vaillant, 1995). Professionals argued that the spread of self-help groups such as Alcoholics Anonymous (AA) occurred because of the ineffective responses by mental health professionals to substance abuse problems (Khantzian, 1985). According to Shaffer (1986), professionals were confronted with an array of treatment models, professional and self help, for substance abuse problems, and none of them appeared to demonstrate a high degree of effectiveness. Additionally, some reviews of the history of the treatment of substance abuse have argued that the traditional psychodynamic approach to treating individuals with substance abuse issues as a symptom of an underlying psychiatric disorder has been especially ineffective (Polcin, 1997). According to Velleman (1989), there is no single approach or one agency that can help those individuals who suffer with substance abuse problems, and he indicates that accurate assessment of individuals is essential; professionals must match the client with the best possible service. Beck, Wright, Newman and Liese (1993) stated there is no conclusive evidence about the most effective treatment for all people with alcohol problems, and concluded that

treatment outcomes for individuals with alcohol-related problems are determined by a number of aspects that include: the process of treatment; post-treatment adjustment; the characteristics of those individuals seeking treatment; the nature of the presenting problem, and the interactions between these variables. It is recognized that in the United States, a majority of professional programs for substance abuse use the 12 steps, either by making them the basis of their treatment programs or by introducing them to clients as a means of recovery (Bradley, 1988). The use of AA by professional treatment programs is seen as beneficial to the clients (Hulbert, 1992; Irwin & Stoner, 1991; Miller & Mahler, 1991).

The purpose of this article is to provide an overview of the fundamental differences between Alcoholics Anonymous (AA) model of recovery and professional substance abuse treatment, and also to examine the philosophy of AA. Additionally, an existential approach to substance abuse treatment as an alternative to the AA model of recovery for treatment of alcohol abuse will be investigated as a process for helping addicted clients sort out and clarify ways in which they construct meaning in their lives.

An Overview of the Differences between AA and Professional Treatment

The differences between AA and substance abuse treatment could easily be drawn if the boundaries of both of these separate units were clearly defined. While AA's boundaries are defined by the Twelve Steps and the Twelve Traditions, the professional boundaries of what makes up "treatment" are much

less clearly codified. These entities seem to be increasingly defined by professional and commercial interests and not by clinical science (White, 1998).

In a review of self-help and support groups, Kurtz (1997) highlights the distinctions between treatment and mutual-aid groups. Kurtz explains that self-help and support groups focus on the mobilization of resources within the self, within the family, and the wider community. These groups are personal, egalitarian, and anti-bureaucratic and shun expert advice in lieu of personal and collective experience. According to Kurtz, many practitioners in the field have some difficulty in distinguishing among self-help, support, or psychotherapy groups, and she explains that the most distinct difference between self-help and support groups is that self-help groups aim at effecting change. Since both self-help groups and psychotherapy groups help their members achieve personal change, they differ by the inclusion of a professional therapist and not relying on the group.

White (1998) offers elaborations on the points made by Kurtz (1997) and adds additional reflections on the differences between AA and professional treatment in numerous areas. According to White, professional treatment services take place within the context of a business environment; AA-directed recovery takes place within a voluntary social and spiritual community. The field of professional treatment is tied together by professional and institutional self-interest; AA is bound together by what White has called a "kinship of common suffering." Theories underlying alcoholism treatment begin with

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different conceptions of the etiology of alcoholism and proceed from these conceptions to numerous derived treatment strategies; AA simply says to the alcoholic, "Stop drinking and here is how to avoid taking the next drink." Professional treatment asserts that it is rooted in psychology and medicine, while AA claims to come from medicine and religion. The focus of treatment is characterized as a process of "getting into oneself", self-exploration and self-healing. AA is about the individual getting outside oneself and focusing on resources and relationships beyond the self. Treatment involves self-development; AA is about self-transcendence. Treatment involves discovery or initiating sobriety while the goal of AA is recovery or sustaining sobriety. With respect to locus of control in addiction treatment, it is often difficult for the client to have control over the degree of intimacy in the client-therapist relationship, because of the inherent inequality of this relationship; in contrast, AA members, every day, decide if, when, where, how long, and at what level of intensity contact with AA will occur.

The degree of invasiveness is reduced in AA through such mechanisms as the discouragement of cross-talk and avoiding taking other people's "inventories." In treatment a high level of personal self-disclosure is encouraged. Treatment seeks specific details related to the problem; AA asks for conclusions. The story model of AA is a life summary; the story model of treatment is an expression of the particular aspects of how one came to be wounded. Relationships in substance abuse treatment are professionally governed; a fiduciary service

relationship in which the professional is obliged to take on special ethical and legal duties and obligations for the care of the client. The treatment relationship is hierarchical whereby it is assumed that control resides in the therapist and the institution. On the other hand, AA relationships are equal and have a sense of reciprocity, and assume that strengths and vulnerabilities are shared by all members, and that the members are there because they need to be there. Treatment relationships are time-limited; relationships in AA are open-ended, and have the potential of being life-enduring. In substance abuse treatment, clients receive a service; in AA one receives membership in a recovering community. In treatment a diagnosis is made by one or more trained professionals of the nature of the problems presented by the person seeking help. The professionals are aware that errors in diagnosis can result in harm done to the clients, and the professional possesses substantial power, and the client who is being diagnosed brings significant vulnerability to the diagnostic event. The emphasis in AA is on self-diagnosis. In addiction treatment the "experts" credentials are measured in the degrees, licenses, and certifications awarded by governmental and private authorities. It is assumed that the professional possesses special knowledge and skill that the client lacks. In AA, the experts are measured by the credentials of personal experience and the experience is based on one's sobriety today, one's sobriety date, and one's degree of actualization of the values of AA. When participating in AA, members with professional credentials must take off their professional "hats." Because credentialing is nonexistent in AA, this reduces disparities in power and helps to

create a foundation of universal vulnerability.

Additionally, significant amounts of money are paid for professional treatment services, thus, treatment involves an exchange of money for services. These fees paid by the addict or someone else help to reinforce the non-reciprocal character of the client-therapist relationship and the inequality of power within the relationship. AA involvement calls for voluntary financial contributions, in small amounts, to help support the group. These contributions are optional for membership. Addiction treatment involves addiction-specific intervention technologies that target the cravings and compulsions that drive addictive behavior, to include the consequences of addiction. Treatment focuses on the core of addiction to include its antecedents, consequences, co-morbidities and obstacles to recovery. AA has one focus, the achievement of sobriety one day at a time through a spiritual program of daily living. With respect to the ethical and legal guidelines associated with treatment, relationships are guided by professional codes of ethics to which each individual practitioner is bound, as well as licensing and accreditation standards to which treatment institutions are bound. These legal standards were conceived and exist in order to govern the delivery of addiction treatment services, because harm to the public might result from the delivery of fraudulent or incompetently delivered services. Disclosures in treatment are confidential as well as legally protected. There are no legal regulations governing AA because the public perceives no similar threat resulting from involvement in mutual-aid activity, and disclosures in AA are

sacred and spiritually protected. Finally, White states that it is the practice of institutions and treatment programs to maintain extensive records on those who seek their services. There are no individual records in AA.

White (1988) explains that when AA is compared to professional treatment, the comparison is not being made between two types of treatment; the comparison is between professional treatment and something else. AA is not a treatment for alcoholism. AA is a spiritual community of individuals that share similar experiences. AA is a "way of living and being." The primary functional linkage between AA and alcoholism treatment is that both claim to have one driving mission, and that is to help alcoholics, and how and why these missions are achieved could not be further apart. White states that putting AA and alcoholism treatment in the same basket misunderstands them both. This is not an error of mistaking "apples for oranges", two objects from the same family; it is similar to comparing "apples and automobiles."

Seeking clarification in the differences between AA and alcoholism treatment is not a meaningless exercise and failure to recognize the distinctions or the loss of these distinctions has significant implications for the individuals seeking help for their addiction. Personal safety of individuals requires an understanding of, and adherence to the code of ethics, and the principles and boundaries that govern professional and personal relationships. If alcoholism treatment becomes nothing but an undeclared AA meeting, it stops being treatment; to call twelve-step work alcoholism counseling violates the AA traditions and the

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discipline of addiction counseling. Reflections about the differences between AA and professional treatment are offered as opening observations in what will be a continuing discussion of the historical depictions of AA and professional addiction treatment (White, 1998).

Philosophy of Alcoholics Anonymous

Lemanski (2000) posits that today one can join a twelve-step program for probably any self-defeating or compulsive behavior, and some popular twelve-step programs include: Narcotics Anonymous, Cocaine Anonymous; Debtors Anonymous, Gamblers Anonymous, Nicotine Anonymous, Overeaters Anonymous, Sex and Love Addicts Anonymous, Survivors of Incest Anonymous, Workaholics Anonymous, just to name a few. The AA model of recovery describes addiction as a progressive, chronic, and ultimately fatal disease. The addict is left “powerless,” experiencing a “loss of control” in the ability to refrain from the drug of choice. The AA model requires a commitment to abstinence, the embrace of spirituality, and life-long participation in AA or another twelve-step program, because addiction is defined as being treatable but never curable. Lemanski stated that for decades there has been strong resistance to developing alternative programs because large numbers of treatment providers themselves have been recovering twelve-step addicts and those who have opposed the one-size-fits-all dogma have been virtually viewed as heretics.

Alcoholics Anonymous was born in the spring of 1935 when two middle-aged, middle-class men met in Akron, Ohio

and formed an alliance to obtain and maintain sobriety. Both men, known now to AA as Bill W. and Dr. Bob, had been through years of compulsive, heavy drinking, and had tried to stay sober with the aid of the Oxford Group, an evangelical non-denominational Christian organization. From those beginnings, AA has grown into a world-distributed social organization consisting of autonomous local groups. An unusual institution, the only membership requirement is a desire to stop drinking. AA charges no dues or fees from members and keeps no membership lists. AA exists in and through local meetings and the interpersonal relationships between members. AA in the United States and Canada has a formal organizational structure based in New York City, but that structure has a minimal relationship with AA at large (Swora, 2004).

Kurtz (1979) describes AA as both a fellowship of alcoholics and a program of recovery from alcoholism, and AA participation and its principles are considered an effective treatment for alcoholism; however, AA itself is not therapy. AA’s program for recovery as outlined in the Twelve Steps is a set of spiritual concepts and practices that have the purpose not of curing alcoholism, but of transforming the alcoholic, and the key term here is spiritual. The AA model of recovery explains alcoholism as an incurable and progressive disease of the body, mind and spirit, with the fellowship and program focusing on the spiritual aspect. The cornerstone of the AA model of recovery is the paradoxical belief that to gain control of one’s life, the individual must give up control to a Higher Power. Although God is spoken about in AA, members believe that one’s

Higher Power can be many things or beings. AA does distinguish between spirituality and religion and believes that addiction is a spiritual disease as well as a physical one, and by embracing spirituality, and not a specific religious dogma, AA allows all individuals to embrace a Higher Power of their own choosing. AA is a “spiritual program of living.”

Marion and Coleman (1991) emphasize the belief that abstinence from substance use is not enough is fundamental in the 12-step philosophy, and individuals must be willing to make fundamental changes in their lifestyle with respect to attitudes and behaviors. The model is designed to allow individuals to address every aspect of their lives to include the physical, emotional, social and spiritual aspects, and to make positive changes in each of these areas. Once these changes are implemented by an individual, the individual will then reach out to others in an effort to offer assistance to others who are recovering from a substance using lifestyle. The Twelve Traditions are also an important component of AA; they govern the operation of AA.

AA currently consists of an estimated 1,800,000 members in 134 countries and more than 87,000 local groups (Alcoholics Anonymous World Services, 1990). It has become a major force in shaping our view of addiction (Le, Ingvarson, & Page, 1995). The treatment philosophy of AA has changed how many people view themselves, their substance use and abuse, and the roles played by the people around them. The influence of AA is not only seen in alcoholism treatment, but in the range of support groups for varying concerns of eating disorders, drug addiction, and

gambling. (Browne, 1991; Gifford 1989; Yeary, 1987).

AA provides the individual with an environment where experiences can be shared and trust can be established. In the AA environment, members can exchange stories and encourage and support each other (Flores, 1988). Feelings of isolation can be reduced through the AA group process (Talbot, 1990). A particular strength of AA is the ability of AA to help members in times of crisis. This idea of assisting others originated with AA’s founding members Bill W. and Bob S. Out of their friendship and mutual support came the philosophy of AA that one member can be of aid to another during periods of stress (Kurtz, 1988).

AA has been instrumental in bringing about the acceptance of the disease model of alcoholism (Kurtz, 1988). The model supports the idea that some people may be “allergic” to alcohol and unable to use it in any form (Alcoholics Anonymous World Services, 1976a), and presents alcoholism as a progressive illness that can be arrested but not cured (Alcoholics Anonymous World Services, 1984). Although the explanation of alcoholism as a disease is supported by the American Medical Association (AMA), its validity continues to be debated in the literature (Erickson, 1992; Miller, 1991; Peele, 1990, 1992). For many individuals, AA’s views have reduced feelings of guilt and shame. The views of AA have clarified the cause of the desire to drink, and has helped to remove much of the stigma associated with treatment. Although AA believes in a medical cause for alcoholism, their treatment program is a non-medical one that includes both

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social and emotional elements (Le, Ingvarson, & Page, 1995).

A majority of professional substance abuse programs in the United States use the 12 steps. These programs use the 12 steps either as a basis of their treatment program or by introducing them to clients as a means of recovery (Bradley, 1988). Professionals who espouse the use of AA philosophy usually perceive the philosophy as being of benefit to clients (Hulbert, 1992; Irwin & Stoner, 1991; Miller & Mahler, 1991). The benefits of AA to newcomers are emphasized and the newcomers are told that sobriety can be achieved if they will “just work the program” and are assured that “there is no reason in the world why it should not work for you” (Alcoholics Anonymous World Services, 1984, p. 19).

Research, Alcoholics Anonymous and Counseling Treatment

Kurtz, (1997) explains that the research on self-help and support groups has evolved over the past 20 years from anecdotal descriptions to ethnographic analyses and outcome studies. In the 1980s most self-help research focused on how professionals related to self-help associations, describing and classifying helping processes in the groups, and then evaluating the effect of such groups on members (Kurtz, 1992). Current research has continued to focus on the helping processes and outcomes, but has increasingly recognized that self-help is not treatment, and that clinical trials and outcome evaluations may be a misuse of research resources (Borkman & Schubert, 1995; Kennedy & Humphries 1995; Kurtz, 1992; Rappaport, 1993). According to Kurtz (1997), research has

focused more intensely on the factors that contribute to affiliation and participation in self-help and support groups, while recognizing that groups cannot remain in existence without new members, and that members cannot benefit without attending. Additional problems involved in the scientific research of AA, for example, include member anonymity, lack of control groups, and the confounding effects of other treatment programs. These difficulties have led researchers to conclude that the effectiveness of AA has yet to be proven (Bebbington, 1976; Bufe, 1991; Glaser & Ogborne, 1982; Vaillant, 1995).

As research has failed to assess the effectiveness of AA, counseling theory may be a more appropriate standard of measurement. Le, Ingvarson and Page (1995) suggest that through a comparison of AA and counseling philosophy it is clear that the principles of the AA program contrast with our interpretation of counseling theory. AA's steps revolve around themes of powerlessness, dependency, and humility. AA members are encouraged to relinquish self-direction and self-responsibility and to turn their lives over the care of a power outside of themselves. The steps emphasize removing character defects and personal shortcomings, rather than developing strengths and abilities. Unlike the AA program, most professionals in the counseling field value helping clients develop their responsibility for self and use their strengths. Individuals are usually encouraged to choose their own direction and personal differences are supported. These philosophical differences may be the reason why AA has been questioned, doubted, and

encouraged to change by many working with the counseling field. Ellis and Schoenfield (1990) questioned the use of religion by AA; questions related to AAs self-absorption and irrationality were raised by Bufe (1991) , and Trimpey (1989) was particularly concerned about those who specifically objected to AA philosophies. The temptation to encourage AA to change its program to fit counseling values is great. However, urging an organization to change its values because they are not similar to one's own beliefs is dogmatic and undesirable. AA is a vital community resource that has made a significant contribution to the growth of self-help groups. It has grown to offer several types of groups to help meet differing needs. The AA group atmosphere provides support, feedback, socialization, and encouragement, and in times of crisis AA help is available 24 hours a day through their sponsorship program.

Even though AA's philosophies may differ from those of counseling, AA can still continue to grow and be helpful to many. Nevertheless, AA is not the right program for everyone. According to Le, Ingvarson and Page (1995), it is not with AA that changes need to occur, but with the relationship of the counseling profession has formed with AA. Numerous treatment centers use the 12 step program without considering whether the principles of AA are consistent with their counseling values and acceptable for their clients. A full 80% of AA members are directed to AA through professional treatment and counseling programs (Alcoholics Anonymous World Services, 1990). It is clear that counseling theory and AA principles have become enmeshed and

roles have grown confused. If a healthy relationship between the two is to be achieved, then a clarification of boundaries is needed. These boundaries must be solid enough that both clients and counselors are aware of the important differences between AA philosophy and non-AA treatment programs, but flexible enough that clients can be referred to AA, if desirable. Le, Ingvarson and Page emphasize that for appropriate referrals, it is important that counselors are not only familiar with the differences between AA and general counseling philosophy, but also with the variations that can exist between AA groups. In the end, counselors can have the opportunity to decide for themselves if the AA program is consistent with their counseling values and potentially helpful for their clients. This decision is similar to the numerous choices that counselors must make concerning the use of different treatment methods, models, techniques, and schools of thought such as the existential approach to counseling, for instance. Becoming well acquainted with the AA program will help to make this choice easier, and will allow counselors to be clearer on the extent to which they wish to integrate AA into their work.

An Existential Approach to Substance Abuse Therapy

Counselors who approach psychotherapy from an existential perspective regard it as a series of functions resulting in helping clients clarify the ways in which they construct meaning (Corey, 1991). It can best be described as a philosophical approach that affects the therapeutic practice of a counselor (Corey, 2001). This approach is not

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specific and does not provide a new set of rules for therapy. Existential therapy seeks to answer deep, philosophical questions about the nature of human beings, and the nature of anxiety, despair, grief, loneliness and isolation (Corsini & Wedding, 2000). According to May and Yalom (1995), “the main goal of the founders of existential therapy was to integrate the key concepts and themes of existential therapy into all therapeutic schools rather than have existential therapy being a separate school. The existential philosophy provides a solid foundation for approaches to therapy that concentrate on the alienated and fragmented individual who finds no meaning in the family or in social institutions. Existential therapy addresses themes in modern-day living such as isolation, alienation and meaninglessness while addressing itself to people who are experiencing difficulty in finding significance in their lives and failing to recognize their purpose in life and in maintaining their identity.”

One basic premise of existential therapy is that we are not victims of circumstance, because to a large degree, we are what we choose to be, and a specific aim of therapy is to inspire in clients confidence to reflect on life, to recognize their range of alternatives, and then to decide among those alternatives. Once clients begin to recognize the ways in which they have submitted themselves into accepting circumstances and surrendering their control, they can then begin on a new path of awareness and begin shaping their own lives (Corey, 2001). Existential counseling was never conceived as a “cure” for people as in the medical model tradition, but views clients as being sick of life and clumsy at

living. Clients need help in deciding on the best road to take, so they can eventually find their own way. This therapy involves a process of searching for meaning and value in life, and the basic task of the therapist is to encourage clients to seek out options for creating a meaningful existence. We begin with a recognition that we do not have to be passive victims of our circumstances, but that we instead become the architects of our lives (van Deurzen-Smith, 1988, 1997).

Because psychological problems such as alcohol abuse disorders are viewed as a result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live, the conceptualization process and intervention strategies for alcohol abusers are aimed at increasing client self-awareness and self-understanding (National Institute on Drug Abuse (NIDA), 2005). The existential therapist is more interested in helping the client find philosophical meaning in the face of anxiety by choosing to think and act authentically and responsibly. Humans are in a constant state of transition, emerging, evolving, and becoming. To be a person implies that we are trying to make sense of our existence, and as persons we continually question ourselves, question others, and the world. Although our questions vary according to our developmental stage in life, the fundamental themes do not vary. Corey (2001) explains that a distinct human characteristic is the struggle for a sense of significance in life. He argues that the fundamental conflicts that bring people into counseling and therapy are centered in these existential questions: “Why am I here?” “What do I want from life?” “What gives my life

purpose?” “Where is the source of meaning for me in life?” According to Corey, therapy can provide the conceptual framework for helping clients challenge the meaning in their lives with questions a therapist can ask such as, “Do you like the direction of your life?” “Are you pleased with what you are now and what you are becoming?” “What do you want for yourself and what are you doing to get some clarity?”

Yalom (1981) identifies four ultimate concerns we all share and they are death, isolation, freedom and emptiness, and these concerns have considerable relevance for therapy. The individual’s confrontation with each of these concerns constitutes the context of the inner conflict of the individual from the existential perspective. The existential therapist is more interested in helping the client find philosophical meaning in the face of anxiety by choosing to think and act authentically and responsible.

Existential therapists are primarily concerned with understanding the subjective world of clients, focusing on the clients’ current life situations (May & Yalom, 1995). According to the existential therapist, the central problems people face are embedded in anxiety over loneliness, isolation, despair, and ultimately, death. Creativity, love, authenticity, and free will are recognized as potential avenues toward transformation, thus, enabling people to live meaningful lives in the face of uncertainty and suffering. Everyone suffers losses in life, parents die, friends die and relationships end, and these losses cause anxiety because they are reminders of our limitations and inevitable death.

The existential therapist also understands that humans are shaped by biology, culture, and luck. (National Institute on Drug Abuse 2005). Existential therapy assumes the belief that the problems of people come from not exercising choice and judgment enough to forge meaning in their lives, and that each individual is responsible for making meaning out of life. Existential therapy recognizes, however, that outside forces may contribute to the individual’s limited ability to exercise choice and live a meaningful life.

Existential Brief Therapy

There has been a tendency among existential therapists to be somewhat wary of brief therapy approaches in which a specific number of sessions, usually between 6 and 20, are agreed at the beginning of therapy. Existential therapists tend to believe that there are no quick and easy answers to life’s challenges (van Deurzen-Smith, 1988). However, existential therapists tend to have a preference for flexibility over rigid boundaries.

Brief therapy demands the rapid formation of a therapeutic alliance compared with the long-term treatment modalities, and this therapy penetrates at a deeper level to issues related to substance-related disorders, often serving as a catalyst for seeking alternatives to substances to fill the void of the client’s experience. The empathy and acceptance by the counselor, as well as the insight gained by the client contribute to the recovery of the client by providing opportunities to make new existential choices, beginning with an informed decision to use or abstain from

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substances (National Institute on Drug Abuse, 2005).

Existential therapy approaches are particularly appropriate for short-term alcoholism treatment because they tend to enhance counselor-client rapport, increases self-awareness of the client, stresses tapping into the inner resources of the client, and it maintains that the client is responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential. The role of the therapist is to help the client focus on personal responsibility for making decisions, and the therapist may integrate some humanistic approaches and techniques. The therapist, in turn, is perceived as a “fellow traveler” through life, and he uses empathy and support to elicit insight and choices. In the context of treating substance abuse disorders, the existential therapist often serves as a coach helping the client confront the anxiety that tempts him to abuse alcohol or other substances. Because this approach attempts to address the underlying factors of substance abuse disorders, it may not always directly confront the abuse itself. Typically, existential therapists show wide latitude in the methods they employ, varying not only from client to client but also with the same client at different phases of the therapeutic process. On one hand, they may make use of techniques that grow from diverse theoretical orientations, yet no set of techniques is considered essential. And yet, some existential therapists abhor techniques seeing them as rigid, routine, and manipulative and, instead, focus on the unique struggle of

each client (National Institute on Drug Abuse, 2005).

Existential therapists assist individuals in discovering the reason for their “stuckness” and they are especially concerned with clients avoiding responsibility and invite clients to accept personal responsibility. When clients complain about the predicaments they are encountering such as addiction and blaming others, the therapist is likely to ask them how they contributed to the situation (Vontress, Johnson, & Epp, 1999). Therapists with an existential orientation usually deal with people who have what could be called a “restricted existence.” These clients have a limited awareness of who they are, and are often vague about the nature of their problems. They may see few, if any, options in dealing with life situations, and they tend to express feelings of being trapped or helpless. A central task of the therapist is to confront these clients with the ways they are living a “restricted existence”, or how they are “stuck”, and to help them become aware of their own part in creating this condition. Once clients are aware of factors in their past and of stifling modes of their present existence, they can begin to accept responsibility for changing their future (Corey , 2001).

In a discussion of therapeutic techniques, van Deurzen-Smith (1990) points out that the existential approach is well known for its de-emphasis of techniques. She stresses the importance of therapists reaching sufficient depth and openness in their own lives to allow them to venture into “client’s murky waters” and not get lost. Existential therapy is a collaborative adventure in which both the client and the therapist will be

transformed if they allow themselves to be touched by life. Baldwin (1987) states that the use of the therapist's self is the core of therapy. It is in the *I/Thou* encounter, when the deepest self of the therapist meets the deepest part of the client, that the counseling process is at its best. Perhaps the most important concept for describing the patient-therapist relationship is the term *presence* (May & Yalom, 1995). The therapist must to be fully present as he or she strives for an authentic encounter with the client. Therapy is a creative, evolving process of discovery that can be conceptualized in three phases.

The Case of Sarah

Sarah is a 46-year old African American who has been married to her first and only husband for 21 years and she presents herself voluntarily for therapy because she recognizes that her pressurized life is no longer manageable for her. She appears nervous and shaky and states that she has been experiencing anxiety and worry. She relates that she has been drinking alcohol in excessive amounts during the past several months. Sarah and her husband have two teenage female children, ages 15 and 17. She has a master's degree in nursing and she works as a nurse practitioner at a local hospital. Her husband is a healthcare administrator and he works at another hospital in town. Sarah has no significant medical history and she is on no medication. Sarah admits that she is drinking at least every other day and her supervisor at work expressed some concern about her fitness for duty on at least two occasions; her supervisor has noticed alcohol on Sarah's breath. Her supervisor strongly encouraged Sarah to seek professional help for any problems

she is encountering. She is not sleeping well and she traces the onset of her symptoms to her home being vandalized about three months ago while the family was away at work and at school. Sarah states that she has always been a social drinker, but she has been drinking excessively in the last few months especially since the incident occurred in her home and admits she now relies more on alcohol to get her through some "tough" days. She reports that her husband and her daughters are most affected by the symptoms because they worry about her. Sarah reports that the alcohol seems to quell her anxiety and worry. She reports that she is used to taking charge of situations, but now feels a sense of having a loss of control of her life. Her work has been affected. Sarah is very successful as a nurse practitioner in primary care. Recently because of the nursing shortage at the hospital, she is putting in more hours at her work and her duties at home are being neglected more than she likes. She gets along well with her boss, also a woman. Socially, she and her husband have a few close friends. She reports that her marriage and family life are good, but much of the household responsibilities fall on her and she feels overwhelmed most of the time. She became extremely upset with her husband when he implied that the break in of the home was her fault for failing to set the alarm system when she left home to go to work that particular morning. She feels guilty for leaving it off; her home may not have been vandalized had she been more alert. Her husband works long hours and he does not contribute as much to running the daily affairs of the home as she believes he should. Sarah feels he is insensitive to the fact that she is now working longer hours too, and her responsibilities

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at home have not changed. Additionally, she is feeling apprehensive about what effect their work schedules are having on their daughters. She feels guilty about neglecting them so much and the quality time she has spent with him in the past has been significantly diminished.

Sarah states that she needs to stop drinking alcohol to quell her anxiety and worry because she is drinking more and more. Drinking is impeding her ability to be a good wife, mother and employee. She is unsure why she is so anxious, why she worries so much, as well as why she is drinking so much, but feels it is related to the pressures in her life and her home being vandalized, as well as her husband's unsympathetic stance towards the pressure she is experiencing. Sarah feels people expect so much from her; she feels she needs to be perfect.

Existential Therapy Applied to the Case of Sarah

Existential counselors construct the counseling process around two major themes, anxiety and authenticity. Existential anxiety basically reflects deep feelings of unease that accompanies awareness that one's existence is frail, and that one is ultimately responsible for the purpose of direction of one's own existence. Authenticity refers to the kind of existence people have when they accept responsibility for choosing the ideas and thoughts that direct their actions and these concepts are interrelated. The goal of existential therapy is to help clients like Sarah become aware of what she is doing and to prod her out of the stance of victim (Corey, 2001). Sarah appears to be a good candidate for existential therapy. She is courageous enough to

question the meaning of life and to challenge some of her comfortable but sometimes erratic patterns. Sarah is facing a number of developmental crises, such as wondering what life is about now that her children are getting older and are at that critical stage of preparing for their future, and as Sarah begins to expand her vision of the choices open to her, her anxiety is increasing. She is grappling with what she wants for herself, apart from her long-standing definition of herself as wife, mother and nurse practitioner; she is feeling guilty about not being present for her family. A major theme here can be posed by the question "How well is Sarah living her life?"

During the initial phase, the therapist assists their clients in identifying and clarifying their assumptions about the world (Corey, 2001). In this case, Sarah is invited to define and question the ways in which she perceives and makes sense of her existence as wife, mother and nurse in her professional world. The counselor asks Sarah to examine her values, beliefs, and assumptions to determine their validity. Sarah has a limited awareness of who she is and she is vague about the nature of her problem. She sees few options in dealing with life situations; she feels trapped, helpless and uses alcohol excessively to quell anxiety and worry. Sarah is drinking and blaming others, her husband, her teenagers, her supervisor at work, for her predicaments and feelings of inadequacy. The counselor's role is to ask her how she contributes to her situation and helps her become aware of her own part in creating this condition. Once she becomes aware of factors in her past and present existence, she can begin to accept responsibility for

changing her future. The counselor will assist Sarah in discovering the reasons for her “stuckness” and invite her to accept personal responsibility. Clients are asked to define and question the ways in which they perceive and make sense of their existence. This is a difficult task for many clients because they may present their problems as resulting almost entirely from external causes and focus on what other people “make them feel” or on how others are largely responsible for their actions or inaction (Corey, 2001). Sarah’s substance abuse is viewed by the counselor as a result of her inhibited ability to make authentic, meaningful and self-directed choices about how to live; therefore, interventions with substance abuse are aimed at increasing self-awareness and self-understanding. Because this approach attempts to address the underlying factors of substance abuse disorders and not directly confront substance abuse itself, existential therapy is best considered as an invitation to clients to recognize the ways in which they are not living fully authentic lives and to make choices, such as in the case of Sarah, that will lead to her becoming what she is capable of being. The counselor’s role is to teach Sara how to reflect on her own existence and to examine her role in creating her problems.

In the middle phase of existential counseling, Sarah is encouraged to more fully examine the source and authority of her present value system and this self-exploration will typically lead to new insights and some restructuring of her values and attitudes. Sarah’s experience in therapy stresses the basic premise that there are no absolute answers outside of her. Sarah learns that therapy is a

process of opening up doors little by little giving her room for more choices. Sarah and the counselor will have open discussion and talk about how they are experiencing each other, and this process happens because of the relationship between the counselor and Sarah. Sarah will learn that she is constantly creating herself by the choices she is making, as well as by the choices she is not making. The goal for the counselor is to show Sarah the connection between the choices she is making or not making and the anxiety and worry she is experiencing.

According to Corey (2001) the final phase of existential counseling focuses on helping clients take what they are learning about themselves and put it into action. Awareness of responsibility alone does not make change take place, nor does one’s awareness of thoughts, feelings and behaviors. This is only the first step in the process of change. When Sarah is aware of her actions, takes responsibility for them and genuinely desires to change, the counselor will see the client’s readiness to accept responsibility and to change. Sarah has then begun the journey of moving from awareness to action. Counseling can lead to personality change only as it guides the client to embrace a new mode of behavior. A real change that happens without action on the part of the client is a practically and theoretically impossible (Yalom, 1980).

Conclusion

The value and vitality of a psychotherapy approach depends on its ability to assist clients in dealing with the sources of pain and dissatisfaction in their lives. The existential orientation is

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particularly suited to individuals who are experiencing a lack of sense of identity that occurs in the cases of substance abuse and alcoholic addiction. The aim of existential therapy is that its key concepts and themes will become integrated into all therapeutic schools rather than existential therapy being a separate school. Existential therapists suggest that this form of therapy is best suited for clients who are committed to dealing with their problems about living and has particular relevance for people who feel alienated from the current expectation of society or for those who are searching for meaning in their lives.

The existential view provides the framework for understanding universal human concerns. These themes that come up in counseling sessions include wrestling with the problem of personal freedom, dealing with the self-alienation and estrangement from others, facing the fear of death and nonbeing, finding the courage to live from within one's center, searching for a meaningful life, discovering a personal set of values, being able to deal constructively with anxiety and guilt, and making choices that lead to a fullness of personal expression. In short, this perspective provides a sound philosophical base on which the therapist can build a personal and unique therapeutic style because it addresses itself to the core struggles of the contemporary person ♦

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