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Empowering Your Sober Self: The LifeRing Approach to Addiction Recovery

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Addicted persons are torn between the urge to consume addictive substances and the drive to break with the substances and get free of them. The LifeRing approach anchors itself in the addicted person’s drive to get free of the substances and works to empower that urge and to enthrone it permanently in the addicted person’s character. Positive peer support focusing on small decisions made in everyday life is the primary psychodynamic engine for recovery in the LifeRing context. Working through nine principal domains, each participant constructs a personal recovery program founded on complete abstinence from all drugs of addiction.

KEYWORDS addiction, recovery, mutual aid, LifeRing, secular

ORIGINS AND HISTORICAL DEVELOPMENT

Mutual support groups in the field of addiction recovery have a long history and have come in many flavors. William White’s monumental Slaying the Dragon (1998) describes a broad panorama of styles and philosophies and suggests that the existence of a diversity of approaches is a positive attribute, given the diversity of personalities, cultures, experiences, and needs among the addicted. One of the new mutual aid groups that have sprung up in this century, adding to the available diversity of approaches, is LifeRing Secular Recovery (LifeRing).

LifeRing held its foundational congress as a national organization in April 2001. Meeting at a retreat center in Florida, two dozen delegates from 15 U.S. states adopted a set of bylaws (LifeRing, 2001) that established a member-run, financially independent, abstinence-based network of peer-led mutual support groups under the name LifeRing Secular Recovery. A number of the organizers had previously participated in Secular Organizations for...
Sobriety; some had spent time in 12-step groups. As a broad generalization, the founding members believed that the traditional paradigm was valid in its emphasis on abstinence, its use of peer-based social support, and in many of its organizational/structural features, but that its therapeutic protocol (the 12 steps) was unacceptable due to its reliance on a “higher power” and its emotional negativity, particularly the emphasis on “powerlessness” and all that goes along with it. Members also felt that a recovery organization should encompass all addictive substances instead of segregating people into different groups by “drug of choice.”

Early LifeRing group meetings sometimes were little more than sounding boards for members who felt unserved, and in some cases “traumatized,” by their 12-step exposure. But within a short time, the group evolved a therapeutically positive meeting format and developed a workbook, *Recovery by Choice* (Nicolaus, 2011),¹ that provides a structured pathway for individuals to build personal recovery programs (PRPs).

LifeRing’s leadership at all levels is nonprofessional, as is also the case with the 12-step groups. Meeting facilitators, termed convenors, are “ordinary” persons in recovery and relate to other meeting participants as peers. A convenor’s handbook (Nicolaus, 2003) focuses on basic philosophy and on connectivity skills. Treatment professionals occasionally serve as initial convenors to get meetings started, and in a few instances, where client turnover is rapid, they have served as convenors for a longer term. Despite, or perhaps because of its peer-leadership basis, LifeRing’s growth owes much to leading addiction treatment professionals who have seen in the organization a useful service for the ever-present portion of their clients who seek an alternative to the 12-step paradigm. The majority of LifeRing meetings convene on the premises of treatment centers, and referrals from treatment professionals formed the leading source of LifeRing membership in the 2005 survey (LifeRing, 2005). A growing number of treatment professionals have opened the door to LifeRing groups because LifeRing groups are abstinence-based and have coexisted peacefully with 12-step groups in the same treatment settings for more than a decade.² LifeRing is also an obvious choice in settings involving state coercion over the client; federal court decisions have made it clear that forced referral to 12-step programs violates the Establishment Clause of the Constitution and that secular options must be offered (Nicolaus, 2009a).

**MEMBERSHIP**

The most recent membership sample survey (*n* = 401) conducted in 2005 yielded the following highlights (LifeRing, 2005):

- The typical member had been clean and sober for an average of 2.74 years.
• Men (58%) outnumbered women. The average age was 47.8 years.
• More than 80% of participants had attended some college, and 44% had an undergraduate degree or higher. Slightly more than half (54%) held professional, technical, or managerial occupations. About 80% were White.
• More than three out of four were raised in a religion. In the past year, nearly 40% (39%) had attended a religious service.
• Participants’ “drugs of choice” covered the spectrum, with alcohol, tobacco, marijuana, cocaine powder, prescription drugs, meth derivatives, club drugs, crack cocaine, and heroin each reported by at least 10% of the respondents.
• Nearly half (47%) had participated in some type of professional substance abuse treatment within the past year. Almost that many (45%) had received a diagnosis for a co-occurring mental health disorder, with depression (33%) being the leading item.
• Participants were enthusiastic about LifeRing, with 98% saying they would recommend it to their friends. The parts of the LifeRing experience that gave them the most satisfaction were the absence of religious content and the positive, empowering atmosphere (56%), the encouragement to build a PRP (53%), the encouragement of crosstalk (52%), and the small group setting (51%).
• Close to half used only LifeRing for mutual support; more than one third currently also participated in 12-step groups.
• Asked what improvements they would like to see in LifeRing, participants’ leading response by far was “more meetings!”

Initially, the group counted barely a dozen meetings, with most of these in the San Francisco Bay area. Currently (end of 2011), the organization shows more than 140 face-to-face meetings in the United States, Canada, Ireland, and Sweden and continues to grow steadily.

LifeRing has an extensive Internet presence centered on the www.lifering.org Web site. The LifeRing online social network has more than 1,000 members, and there are numerous online meetings in chat rooms. There are also e-mail lists, online forums, and linked LifeRing Web sites, such as www.liferingcanada.org and www.liferingcork.com (Ireland). LifeRing encourages participants to maintain connections outside the meeting hours. Participants exchange phone numbers and e-mail addresses, and social occasions are organized wherever feasible.

LifeRing continues to be financed entirely by member contributions and literature sales. All directors, officers, and meeting convenors are volunteers.

THEORETICAL BASIS

The almost-universal psychological experience of addicted persons is a Jekyll-and-Hyde struggle between the urge to consume the drug heedless
Empowering Your Sober Self

Addicts simultaneously want—more than anything—both to maintain an uninterrupted relationship with their drug of choice and to break free of the drug. Behaviorally, this paradox is evidenced both in the incredible lengths to which the addict will go to sustain a relationship with the drug and in his or her repeated efforts to exert control over the drug and sever his or her relationship with it. (White, 1998 p. 335)

Numerous other students of addiction (cited in Nicolaus, 2009b) have remarked on this fierce tug of war lying at the core of the addiction experience. The addicted person is a person in conflict between two antagonistic drives. It is useful to conceptualize these drives as if they stemmed from two parts of a divided self, or in effect, from two antagonistic selves within the same personality: an Addict Self (“A”) and a Sober Self (“S”). To be sure, the picture in any given individual displays numerous complexities and subtleties, many of which are mapped in the 300 pages of the Recovery by Choice workbook (Nicolaus, 2011), but the general dichotomy between the “A” and the “S” serves as a useful and easily grasped analytical tool that has numerous reference points in both individual and collective experience.

The LifeRing approach to the addicted person centers strategically on empowerment of the Sober Self. In contradistinction to the 12-step paradigm, LifeRing posits that the psychological map of the addicted person contains not only areas of illness, decay, degeneration, and morbidity in various forms, but also resources of health, vigor, strength, and vitality. The general aim of helping such a person is to facilitate the growth and expansion of these positive assets within the person and to enable their ascension to a stable dominance within the personality structure and behavior. In the loftier idiom of the Rev. Adler Temple, speaking in 1886, the aim of the group toward the addicted is, “by its living spirit of love and fraternity, [to] unlock the wards of their heart and reach the elements of humanness which lay buried there and rehabilitate and re-enthrone them” (quoted in White, 1998, p. 15).

LifeRing’s philosophical and therapeutic foundation is abstinence from alcohol and all other medically uncalled-for addictive substances. The organization’s hardcore insistence on abstinence is based in part on the personal experience of many members who experimented with moderation and found it a failure. It is based in another part on observation of other groups where moderation led to personal and organizational disaster. This experience suggests that far from enhancing a group’s popularity, an effort to bring moderators and abstainers under the same umbrella drives both sides away. Even among recovering persons who reject the 12-step paradigm, abstinence is overwhelmingly the popular choice (Fletcher 2002; Granfield & Cloud, 1999). To be sure, individuals who are undecided on the issue
and wish to see whether LifeRing groups are a fit for them are welcome to visit and talk out their concerns, but those who opt for moderation as their recovery goal are firmly invited to seek support elsewhere.

While committed to a comprehensive abstinence, LifeRing maintains a positive attitude toward physician-prescribed pharmaceuticals that address co-occurring disorders. If a participant has been honest with the physician and the physician is knowledgeable in addiction medicine, then the prescription is considered a sobriety tool, and participants are encouraged to take it as prescribed (Nicolaus, 2003, p. 125)

THE RECOVERY PROCESS

In very general terms, the process of empowering the Sober Self has three major components: recognition, activation, and mastery. These elements inspire the LifeRing meeting process and literature.

Recognition

The addicted person not uncommonly suffers from depression and negative self-esteem. These paralyzing states of mind, which emanate from the “A,” may become entrenched by repeated exposure to treatment paradigms that teach powerlessness, helplessness, and related attitudes. The first task, then, is to hold up a true mirror and to assist the addicted person to recognize, or rediscover, a spark of inner strength. LifeRing teaches that the mere fact of still being alive is evidence of the addicted person’s drive to survive, which is the core of the Sober Self. The act of coming to a meeting is proof positive that the Sober Self is stirring within the person. Your Sober Self brought you here! The LifeRing meeting process, which encourages all participants to speak from Day 1, underlines the message that each person brings something valuable and important to the gathering. Participants frequently come to recognize the Sober Self within themselves by its reflection in the regard of others. The positive atmosphere of the meeting process gradually erodes negative and self-abusive postures and endows individuals with a sense of their own value and power as sober persons.

Activation

Empowerment of inner resources can come about only by their activation. The most common LifeRing meeting format begins, after a very brief opening statement, with the question, “How was your week?” This format, which evolved from the process groups found in many treatment programs, asks
each participant to speak about the issues they encountered in their recovery since the last meeting and also to look ahead to the challenges they anticipate in the coming days. Positive cross-talk is encouraged and is a central feature of a successful meeting. Participation by speaking is a form of activating the inner recovery reserves, the Sober Self. As a rule of thumb, speaking engages the speaker in self-discovery and in change more forcefully than listening does. Because the topic is not book-based but life-based, literacy is not required for meeting participation. It is rare for a person to “pass” on this topic, and it is common for people to speak at their first LifeRing meeting. The topic focuses on the here and now and elicits individuals’ reporting on the decisions they made in everyday life—the “small” decisions. Participants’ explication of their actions both after and before the moment of decision fosters activation of sober emotive-cognitive resources in the decision-making process. Individual participants often say that as they go about their daily life, the awareness that they will report their decisions to the meeting is active in their minds, and it shapes what they do.

Mastery

A comprehensive study of relapse in chemical dependency concluded that the most successful client in resisting relapse is the one who “confidently acts as his or her own therapist” (Dimeff & Marlatt, 1995, p. 177). The largest longitudinal study of alcoholics in the United States concluded, similarly, that “alcoholics recover not because we treat them but because they heal themselves” (Vaillant, 1995, p. 384). It follows that a mutual aid organization for addicted persons needs to have as a strategic goal the empowerment of each of its members to be the “author and arbiter of their own recovery” (Herman, 1997, p. 133). The notion that there exists a universal cure, a silver bullet, a program that works for everyone is a case of magical thinking that has no basis in evidence. Self-treatment, the same as institutional treatment, must be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006; additional citations in Nicolaus, 2009b, Ch. 4).

PERSONAL RECOVERY PROGRAMS

LifeRing honors these basic findings of modern addiction research by facilitating each participant’s development of an abstinence-based PRP.

People develop their PRPs by two principal methods, or a combination thereof: random access and structured progression.
Random Access

At each meeting, and sometimes at encounters outside the meeting context, something happens that holds special significance for the participant and finds a place in long-term memory. This meaningful item is like a mosaic stone. Over time, additional pieces enter and gradually form a picture, which constitutes the person’s remade sober identity, their PRP. This method is effective because each of its elements is deeply meaningful to the individual. But the assembly of pieces depends on random events, and the individual has little control over the timing, structure, or coverage of the whole.

Structured Progression

Using the *Recovery by Choice* workbook (Nicolaus, 2011), participants engage, pencil in hand, with a comprehensive and searching series of recovery questions. They may proceed in an organized manner, choosing the whole sequence and content of their recovery planning. Where literacy is an obstacle, persons may choose to partner up with a reader. When done, they have a written product that they can carry, revise, and share. Working the workbook gives them the advantage of permanence, organization, and control—in a word, structure.

NINE DOMAINS

The *Recovery by Choice* workbook (Nicolaus, 2011) organizes the process of building a PRP into nine domains or work areas.

First Domain: The Body

Give yourself a medical checkup. Make a checklist of concerns and plan to see a health care professional as appropriate.

Second Domain: The Immediate Environment

Map the triggers and slippery places in everyday life, create a safe space, and learn daily exercises to solidify your commitment to sobriety.

Third Domain: Time and Activities

Assess how you spend your time and evaluate which activities are safe and which should be avoided for now. Learn how to do an activity clean and sober.
Fourth Domain: People
Some people in your life support your freedom from substances, some do not know that it’s an issue for you, and some try to drag you back. Learn to identify these three kinds of people and develop strategies for dealing with them.

Fifth Domain: Feelings
Learn to recapture old sober sources of pleasure and develop new ones that do not involve substance use. Learn to recognize your feelings, cultivate a more vibrant emotional life, and handle emotional crises while staying clean and sober.

Sixth Domain: Lifestyle
Assess the impact of substance use on your work, housing, living situation, social life, housekeeping, personal appearance, sex life, finances, legal situation, and other lifestyle aspects, and make a plan for positive change.

Seventh Domain: History
Review the origins of your substance use, understand the neurobiological dimension of addiction, and let go emotionally of this chapter of life.

Eighth Domain: Culture
Learn to read the messages about drinking and using that come from the culture and decide how you fit into the culture as a sober person.

Ninth Domain: Treatment and Support Groups
Decide what you need in the way of professional help and mutual aid groups to advance your recovery.

The Recovery by Choice workbook (Nicolaus, 2011) also contains a big chapter on relapse, but that is not a separate domain; rather, it is a synopsis and review of all the others. A provocative section of the relapse chapter is the “Relapse Planning Worksheet,” where participants contemplating relapse can plan it out in all its details—and have a hard look at the probable consequences.
It will be seen that the LifeRing approach arose pragmatically and eclectically out of the experience of recovering persons and is essentially a homespun, rather than an academic, product. However, it draws inspiration from and has affinities with a number of trends in the universities and in the healing professions. It navigates, of course, within the broad stream of cognitive-behavioral science. The LifeRing approach takes many lessons from the client-centered psychology of Carl Rogers (Cain, 2010; Rogers, 1980). It strongly resonates with much of the teaching of Albert Bandura about self-efficacy (Bandura, 1997). It shares many themes with modern strength-based movements in psychology, education, and social work (Maton, Schellenbach, Leadbeater, and Solarz, 2004; Powell, Batsche, Ferro, Fox, and Dunlap, 1997). It is independent of but highly congruent with the motivational interviewing movement in addiction recovery (Miller, 1995) and has much in common with other modern recovery approaches, including William Glasser’s choice theory, Ronald Warner’s solution-focused therapy, and Marsha Linehan’s dialectical behavior therapy. It is informed by the most solid findings on addiction and recovery emanating from public and private research institutions. In essence, LifeRing forms an instance of the New Recovery Movement described by William L. White (2000).

EVIDENCE FOR EFFECTIVENESS

The current evidence for LifeRing’s effectiveness is of the same nature as the evidence for the traditional paradigm a decade or more after its foundation—anecdotal. Thousands of clean and sober individuals are living evidence that LifeRing participation is associated with long-term, stable abstinence. It remains an open question whether LifeRing contains an active ingredient that causes individuals to recover when they would not have done so otherwise, or whether LifeRing is merely a congenial environment for individuals who bring the active ingredient of their recoveries with them, or whether both are true to some extent, varying with the individual. Basically, LifeRing operates by generating social support for living life free of alcohol and other addictive drugs, and this combination of factors—social support and abstinence—is widely appreciated as the secret of effective recovery approaches.

RESEARCH OPPORTUNITIES

Two senior researchers at the Alcohol Research Group in Emeryville, CA, have applied repeatedly for a federal grant to assess the efficacy of LifeRing as an adjunct to treatment programs, to date without obtaining funding. LifeRing presents a number of facets that may fit within the research interest of qualified professionals; for example:
• What are the pluses and minuses of combining users of different addictive substances in the same recovery group, as distinct from segregating users by “drug of choice”?
• What personality types (or other factors) might be a better fit for an approach where the posited agency of change is internal (the Sober Self) as distinct from external (the higher power)?
• What is the evidence for the efficacy of individualized approaches in related fields (e.g., medicine, occupational training, special education, etc.), as compared with the application of a standardized one-size-fits-all approach?
• What difference is there in outcomes for LifeRing participants who develop their PRPs by the random access method as distinct from the structured approach embodied in the *Recovery by Choice* workbook (Nicolaus, 2011)?
• What features of current chemical dependency treatment programs could be tweaked to encourage clients to recognize, activate, and empower their Sober Self?

Any research effort must, of course, comply with appropriate ethical standards and confidentiality guidelines.

**SUMMARY, CONCLUSIONS, AND FUTURE DIRECTIONS**

LifeRing is one of the recovery approaches that emerged since the founding of Women for Sobriety in 1975 cracked the hegemony of the 12-step paradigm. Its future depends fundamentally on the continuation of cultural trends that have, since the 1970s, favored a less religiously tinted and a more psychologically positive approach in addiction healing. It depends, secondly, on the continuing good faith of treatment professionals in serving, rather than excluding or punishing, the portion of the clientele that seeks a recovery paradigm other than 12-step. In this regard, although LifeRing has mapped a structured pathway to self-healing with the *Recovery by Choice* workbook (Nicolaus, 2011), LifeRing still faces the challenge of developing a treatment protocol for use by professionals in an institutional setting. LifeRing also needs to solve the problem of developing ever more meeting facilitators to fill the growing demand for new meetings. Finally, although LifeRing has achieved small miracles of growth and publicity with an all-volunteer leadership and a five-figure shoestring budget, a quantum leap to primetime public awareness with a fully staffed back office awaits the involvement of financially capable sustainers.

**NOTES**

1. The workbook, *Recovery by Choice* (Nicolaus, 2011), was originally published in 2001; it is currently in its fourth edition.
2. Among published professional references are these:

LifeRing meetings have always been well attended but the Saturday group has been so popular that at times we have had to open a second meeting room to accommodate all the people who wish to attend. I am happy to state that LifeRing has always been able to coexist harmoniously with other support meetings. Patients report being satisfied with the format and some say they attend LifeRing and 12-step support meetings. I am happy to recommend LifeRing to any drug treatment program” (day treatment co-coordinator, Kaiser Permanente Chemical Dependency Recovery Program, Oakland, CA)

LifeRing has been extremely popular with our clients, and we offer it every Wednesday evening. MPI would recommend LifeRing with enthusiasm and full support to any other drug treatment program (manager, Merritt-Peralta Institute [MPI], Summit Medical Center, Oakland, CA)

Both letters are published in Nicolaus (2003), where facsimiles of the original letters may be found. Additional professional references appear in the advance readers’ comments to Nicolaus, 2009b.

3. The reader will recognize here a debt to the Transtheoretical Model of Stages of Change; for a brief introduction, see Prochaska & DiClemente (1992).

4. Nicolaus (2009b) contains extensive citations. Among the findings of note since its publication is the working definition of recovery published in May 2011 by SAMHSA: Recovery “is an individualized process whereby each person’s journey of recovery is unique and whereby each person in recovery chooses supports, ranging from clinical treatment to peer services that facilitate recovery” (SAMHSA, 2011). Also noteworthy is one of the first neurological explorations of innate recovery resources, “Discovery of Brain’s Natural Resistance to Drugs May Offer Clues to Treating Addiction” (National Association of Alcoholism and Drug Abuse Counselors, 2012). Neurological research has concentrated almost exclusively on the addictive pathways, practically ignoring the vital mechanisms of recovery.

REFERENCES


Substance Abuse and Mental Health Services Administration. (2006). *Overarching principles to address the needs of persons with co-occurring disorders.* Washington, D.C.


