

Natural Allies: Twelve-Step Recovery and the Person-Centered Approach?

David P. Westwood

Abstract

Core underlying principles and concepts that are shared by the group process in twelve-step recovery meetings and the person-centered approach to therapy are examined. Although developed independently, both twelve-step recovery and person-centered therapy encourage change in adults and promote psychological development. Sharing from direct, personal experience is important in both practices, as is developing an awareness of feelings and needs.

As an example of sharing in a twelve-step meeting, an extended share on the topic of recovering sexual intimacy is included in an appendix. This example is intended to illustrate how sharing personal feelings and experiences with others, in a nonjudgmental and empathic setting, fosters self-acceptance and change.

Although the person-centered approach and twelve-step recovery have distinct features, both benefit from a felt quality of non-judgmental acceptance that is achieved by sharing feelings and personal experiences. Acceptance, which is the common ground in both models, helps individuals grow and differentiate while developing stronger connections with others.

Keywords: person-centered, group therapy, twelve-step recovery, empathy, acceptance, change

Author Notes:

This research was conducted by David P. Westwood.

David is now at The Center for Somatic Therapy in Santa Rosa, CA. Correspondence for this paper should be addressed to David P. Westwood at

davidandelise@earthlink.net

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When attending twelve-step meetings, I notice how each person's *share* (comparable to *sharing* in person-centered groups) adds to a sense of participation, and that the variety of personal expression contributes to a general feeling of well-being. How is it that listening to other people talk about their problems helps me feel better about mine? What produces this healing experience? I think it is a combination of acceptance and empathy, promoted by the common agreement that successive speakers do not comment on previous shares. Because I accept what other people say as being true for themselves, I trust that what I share will be accepted, as well.

For readers unacquainted with twelve-step recovery, most meetings offer participants the opportunity to speak for three or four minutes without interruption, feedback, or suggestions. The concepts of share and sharing in recovery meetings are similar to individual sharing in person-centered therapy groups: a spontaneous expression of current feelings and authentic experience.

As far as I know, no historical association exists between the person-centered approach and the group process in twelve-step meetings. Twelve-step recovery began in the mid 1930s with Alcoholics Anonymous (AA), which incorporated key principles from the Oxford Group, an international Christian movement of social and spiritual renewal (Alcoholics Anonymous, 1939). Both the Oxford Group and AA advocate turning one's life over to the care of God, making restitution for harm done, sharing in meetings, and tempering individual enthusiasm through open-minded discussion.

Carl Rogers began developing his approach to therapy during the 1940s. Rogers discussed effective treatment for hospitalized alcoholics in *On Becoming a Person* (Rogers, 1961). He cited contemporary research indicating that client-centered groups were more effective in treating hospitalized alcoholics than were groups using an impersonal learning theory approach (Ends & Page, 1957). Rogers concluded that an empathic connection between client and counselor, together with authentic responses by the therapist, contributes to effective treatment for alcoholics.

My recent experience as a postdoctoral intern at a community mental health clinic in California suggested that current therapies

attempt to combine both person-centered and behavioral methods. For example, *Seeking Safety*, which is a group therapy manual for treating co-occurring trauma and substance abuse, combines directive learning theory (cognitive behavioral rehearsal and didactics) with empathic interactions (Najavits, 2002). *Seeking Safety* focuses on enhancing coping skills in the present rather than healing past traumas, and consists of discussion points, such as developing compassionate self-talk. At a training session, Martha Schmitz (personal communication, February 5, 2008) summed up this model as “empathy with accountability.”

Underlying Principles

In this article, I examine some underlying principles of the person-centered approach and twelve-step recovery. In the first chapter of *On Becoming a Person*, Rogers (1961) succinctly presented several of his key therapeutic and philosophical principles under the heading “Some Significant Learnings” (pp. 15–27). Let us compare some of them with my observations in twelve-step meetings. Primarily, Rogers sought to be authentic in relationships, rather than behave contrary to his feelings. Similarly, I find that authentic shares in meetings are most engaging, and I find myself feeling dissatisfied if what I say becomes repetitive or incongruent with my current feelings. Newcomers at meetings often share most directly and personally, innocent of recovery jargon and driven by pent-up frustration and pain. I am often astonished by their unrehearsed eloquence.

Rogers (1961) also appreciated the value of moments when he relaxed judgment and evaluation and, as he said, “I can permit myself to comprehend another person” (p. 18). Rogers stated that by being open to the unique feelings, attitudes, and beliefs of others, and trusting his own experience—his present reality—he was led to accept rather than attempt to “fix things” in himself or others (p. 21). For me, being willing and able to hear what other people say in meetings, and to accept their charms and oddities, requires that I suspend my personal concerns and become temporarily absorbed by theirs. Witnessing others overcome fear and shame and talk about their struggles helps me to feel greater empathy for my own insecurities and shortcomings. The courageous example of others momentarily relieves me of shame, so I feel freer to share about who I am and explore who I

can become. Working on accepting others is good practice for self-acceptance, and vice versa.

Two Approaches to Transformation

Rogers (1961) described the positive value of developing an “internal locus of evaluation,” which he explained as the movement toward making conscious assessments, choices, and decisions for ourselves, and growing toward a way of life that is both creative and fulfilling (p. 119). As a person in recovery, I wish to cultivate my own internal locus of evaluation. However, many twelve-steppers might find this incompatible with the third step of Alcoholics Anonymous and other twelve-step programs, which stated, “[We] made a decision to turn our will and our lives over to the care of God *as we understood Him*” (Alcoholics Anonymous, 1976, p. 59).

I resolve this paradox by distinguishing between what is properly my work and what is not. Twelve-step recovery has a saying: “Do the footwork and turn over the results.” For me, this means reaching out to others and expressing my needs, then relinquishing control, thus freeing others to respond as they choose. This simple formula requires a major shift for many in recovery who have struggled to get their needs met by learning to trust and “accept life completely on life’s terms” (Alcoholics Anonymous, 1976, p. 449). This is what twelve-step programs encourage, using an approach that mirrors Rogers’ (1961) premise that unconstrained human nature is fundamentally “constructive and trustworthy” (p. 194).

Relying on a *Higher Power*, or guiding spiritual principle, can be helpful to people in recovery for two reasons. First, it is an antidote to self-centeredness, a common problem among people in recovery. This trait is vividly described as “self will run riot” (Alcoholics Anonymous, 1976, p. 62); pithy AA aphorisms I have heard that evoke this trait include “My best thinking got me here” and “My ego is not my amigo.” The second reason for relying on a Higher Power is to help achieve sobriety. An axiom of twelve-step recovery is that willpower alone is insufficient to overcome addictions. To assist in recovery when willpower has failed, an important task during early recovery is to begin to develop a spiritual basis in life and conscious contact with a Higher Power of one’s own understanding. The most rudimentary conceptions suffice: other members in the AA group are

colloquially known by the acronym G.O.D. (group of drunks), for example. In talking with others in recovery, I have learned that people's conceptions of a Higher Power often evolve over time.

However, being in recovery is not a passive process; it includes conscientiously working the steps, guided by a *sponsor* who has done this already. Working the steps is a rigorous process of self-examination that is followed by declaring responsibility for harm done, making restitution to those one has harmed, and amending actions from then on. This process assuages long-held guilt and shame, and results in a renewed sense of self-acceptance and reconnection with others. No longer secretly feeling inadequate or inferior, people come out of isolation and begin to feel a sense of acceptance by others. An awareness of the needs of self and others dawns, and with a greater awareness of boundaries, the complex interpersonal world becomes easier to navigate by "staying on my own side of the street," as the recovery aphorism suggests. In early recovery, attending meetings and socializing afterwards is a way to practice acceptance of self and others, and to learn to live a life of service rather than self-seeking. The transformation that many in recovery experience can be understood as resulting from Rogers' (1961) principle that change is precipitated by acceptance, rather than a desire for change: "The curious paradox is that when I accept myself as I am, then I change" (p. 17).

Alcoholics Anonymous (1976) described two kinds of "spiritual experience" (i.e., a sudden shift or a gradual change) as being equally valid (pp. 569, 570). Individual change is often registered in retrospect. A common request made of newcomers by their sponsors is to make a list of all they would like to achieve in their first year of recovery. When rereading the list a year later, it is often clear that much more has been achieved than the newcomer dared hope.

I understand being in recovery as a re-socialization process that compensates for relinquishing addictions and obsessions by offering positive feelings of belonging. Kurtz (1988) discussed socialization in AA as resulting in a "joyous pluralism" among members (p. 151). The concepts of Higher Power and spirituality are rather abstract, and each person in recovery is free to interpret them as he or she wishes. People in recovery seldom discuss their conception of a Higher Power in public because they do not wish to impose their views on others or

cause rifts with those whose views may differ from their own. As stated in the big book of AA (Alcoholics Anonymous, 1976), “Love and tolerance of others is our code” (p. 84).

Therapeutic Conditions in Recovery

Rogers (1961) identified three therapeutic qualities in his relationships with clients: extending “unconditional positive regard” by being openly accepting of the client, being “genuine” or authentically “congruent” with his own feelings as he related with clients, and showed “empathic understanding” of how the client felt (pp. 61–62). How might these conditions also affect change in twelve-step recovery?

First, I will examine Rogers’ concept of unconditional positive regard with respect to my experience of recovery. I felt welcomed and accepted at my first AA meeting, rather than feeling judged by other AA members. Although no feedback is given during meetings, newcomers’ shares are invariably followed by a group response: “Keep coming back, you’re in the right place!” Although unsure if I qualified as an alcoholic, I felt less concerned after hearing that “the only requirement for AA membership is a desire to stop drinking” (Alcoholics Anonymous, 1953, p. 139). I later learned that no one has a diagnosis imposed on him or her in AA, just as in person-centered therapy, and that members decide for themselves if they are alcoholic or not. The door is always open to those who return after a relapse; as the saying goes, everyone is sober “one day at a time.”

Rogers’ concept of congruence was also apparent. In early recovery I noticed that participants shared about their own experiences, without pretence and apparently at ease with their personal histories. I certainly felt ill at ease, but I kept coming back and worked the steps with a sponsor, who was authentic without appearing inflated or overly modest. Although he was uncritical, he frequently responded to my overly optimistic plans with a considered “Well, more will be revealed,” indicating that I might moderate my expectations. I felt that he sincerely practiced the principle of the program, “Life on life’s terms,” and I learned from his example to moderate my flights of fancy and to become more grounded.

I experienced Rogers’ concept of empathy with my sponsor and others at meetings I attended. In early recovery, I was gratified to

be among people who apparently understood and accepted me as I was, with all my faults. My AA sponsor emphasized similarities in our feelings of social disconnection, rather than differences in our drinking histories. Feeling accepted was a unique experience for me at that time, and I found it very attractive.

Recovery in Relationship

My life has changed, and I continue to grow as a person in recovery. It is a given in twelve-step recovery programs that participants are in the process of recovering, rather than being perfectly recovered. “We claim spiritual progress rather than spiritual perfection” is the frequently cited principle (Alcoholics Anonymous, 1976, p. 60). After several years in AA, I sought recovery in other programs to address relational difficulties. Now in Recovering Couples Anonymous (RCA), I continue on the path of recovery in company with my wife, Elise. RCA is a twelve-step program for people who are recovering from addicted and destructive relationships, rather than from alcohol or other addictions and compulsions. Individual members of RCA often attend other twelve-step fellowships to address their own problems, in addition to attending RCA with their partners.

In conclusion, I discuss how I and my wife felt sharing our stories in a couples’ recovery meeting. Rogers’ principles are included as they seem applicable. Speaker meetings are a particular form of twelve-step meeting at which guest speakers volunteer to tell their recovery stories. This is followed by general sharing during which the floor is open for other participants to share more briefly about their own experiences. Ten minutes is usually set aside for the main speaker, whose share traditionally takes a tripartite form: what it was like, what happened, and what it is like now. “What it was like” describes former difficulties and the progression of addiction. “What happened” describes the circumstances that precipitated recovery. “What it is like now” describes the speaker’s current state of recovery. Telling one’s story, or “carrying the message,” is an important aspect of twelve-step recovery and offers hope to others who still suffer.

In the first part of our share, Elise and I talked about the feelings of distress, hopelessness, and shame we experienced as children. Rogers (1961) observed, “Life is guided by a changing

understanding of and interpretation of my experience. It is always in the process of becoming” (p. 27). Uniquely among twelve-step programs, RCA (2011) places particular importance on reexamining formative experiences in one’s family of origin in order to understand how our present relationships are imprinted with the relational qualities with which we grew up. Reexamining my personal history helps me become more aware of how my expectations in relationships came about, and how I might improve my intimacy with others.

After concluding our share, Elise and I were relieved to hear how ready others were to share their own experiences on the topic of sexual intimacy, and how candid some were in sharing intimate difficulties. As others shared their difficulties, I felt empathy for them and greater self-acceptance, too. Hearing others reflect on their difficulties helps Elise and me appreciate that we are not alone or inadequate; others also experience painful feelings and work on accepting and changing them. Through our participation, we experience an expanded awareness of our progress in recovery and a shared appreciation for our relationship.

The interest generated by our share can be viewed as a verification of Rogers’ (1961) principle “What is most personal is most general” (p. 26). Frequently cited maxims in twelve-step recovery include “Look for the similarities not the differences” and “Take what you like and leave the rest.” I am also attracted to Rogers’ trust in direct experiencing. I can readily identify with people when they share directly from their own experience. The details may be unique to them, but I empathize with their feelings, and it is our common feelings that bridge the differences between us.

In moments of participation, I often feel a greater sense of clarity. I felt present to myself while sharing my part of our story, and as I received what other participants said afterwards, I felt I was hearing what they said clearly, rather than covering their words with my own private, reactive thoughts. Paradoxically, I felt both freer of negative judgments of myself and others, and also a heightened ability to appreciate each share as a perfect approximation—an authentic, in-the-moment expression of being. As people share in meetings, I have found that I become attuned to both positive and negative affects. My shame-sensitive internal monologue is soothed as I develop trust in the group; then I become aware of positive feelings and participate more

fully, momentarily achieving a sense of belonging, rather than separation and isolation.

Elise described her own observations of the meeting as follows:

One of the many sayings, or slogans, that have appeared over the years in twelve-step recovery is “we are only as sick as our secrets.” I have found this to be personally true, and when I have shared about things that were painful and shameful for me, I felt a sense of acceptance and relief; I could now own my experience, rather than it owning me. After this particular share, other attendees shared their own sense of relief that the box of cultural and personal shame was being further opened in a safe atmosphere. This mirroring and validating of my own experience never fails to move me deeply and to inspire me to keep going, keep working, and “keep coming back.”

A transcript of our share is included in the appendix. We were invited to speak on the topic of “Recovering Sexual Intimacy” at an annual RCA International Convention (Westwood & Westwood, 2013). Approximately 50 couples attended this session, and some shared on the topic after Elise and I spoke. I am unable to present shares by other people because anonymity protects what is said in meetings from being repeated. However, with my wife’s permission, I relate our story as an example of a recovering couple sharing their experience, strength, and hope.

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Appendix

A Twelve-step Share: Recovering Sexual Intimacy (Westwood & Westwood, 2013)

Elise: Hi, my name is Elise and I am in recovery with David.

Participants: Hi, Elise.

Elise: We weren't expecting this many people! (Laughter) This is my current statement of my view of myself: healthy sexuality is a core issue for me. It is interwoven with my sense of my personal power, self-image, autonomy, and self-expression; it is linked with, affected by, and affects those aspects of myself.

When I was born one of my eyes turned in, and as I grew and developed I didn't have good eye contact with my caregivers. It wasn't that I couldn't see them: rather, they were unable to determine if I was looking at them (because my eyes couldn't focus together). Through learning about infant bonding, and observing the visual connection between babies and their caregivers, I have come to think that my caregivers, my peers, and everybody I was around, couldn't really bond or connect with me. Not knowing where I was looking may have been confusing or disturbing for others, so I think I didn't get that reflective experience as a baby or later on.

As I got older I felt shame and panic because I was sure I was defective. I felt disengaged and insecure with others; I had difficulty forming healthy attachments. I was anxious, and I hungered deeply for touch, warmth, soothing and acceptance. Both of my parents valued having a family, but they didn't have good modeling from their families of origin to give me the affection and acceptance that I needed and wanted. My mother, my maternal grandmother, and my paternal grandfather were orphaned at young ages. My other two grandparents were psychologically disabled.

Our family moved every few years. It was hard for me to make friends and I felt isolated growing up, so I learned to comfort myself through sexual self-pleasure and romantic and adventurous fantasies. At age six or seven I learned from my church that "touching myself in an impure way" was wrong, and that if I died I would be burned, punished, and separated from everyone forever in the unending fires of hell. As hard as I tried, and as terrified as I was of this prospect, my

need for self-soothing and pleasure would eventually win out. I also feared anyone finding out and ostracizing me in this world. This affected my social skills and my ability to form friendships and romantic attachments as I grew up. My feelings of deep shame, worthlessness, hopelessness, and isolation seemed reinforced everywhere I went.

My mother died when I was 18, and my father was grief-stricken and trying to rebuild his life. He wanted to be close to me because I was the last child at home (the youngest of three). He did his best to help me make it in the world in the next few years, but I was unable to recognize and appreciate that at the time. I dropped out of university after my first year. I then went to theatre school, which had been a long standing ambition, dropped out of that after a couple of years, and dropped into hippy culture.

I became a topless dancer, a waitress, and a "B" girl (someone who encourages customers to buy overpriced, watered down drinks). (Faint laughter) It's okay to laugh! (Louder laughter) Some of this stuff is deep seated, painful and shameful; the more I talk about it the lighter it gets. I share my story because it really helps me. In 1970 I met my qualifier, lived 23 increasingly painful years with him, and got into SLAA (Sex and Love Addicts Anonymous) recovery in 1993 at the recommendation of my therapist. Separation from my qualifier (relationship that got me into the program) was a long, painful experience for me, but I kept working and I grew.

David: My name is David, and I'm in recovery with Elise.

Participants: Hello David.

David: I'm going to say a bit about "what it was like" for me. I grew up in England, and I was not shamed about sex as a child. My parents were teachers and were antagonistic toward each other most of the time, although they occasionally showed affection for each other. They are still alive, and they still have this ambivalent antagonism, sniping at each other for control and power, but they also share a lot of underlying interests and values.

When I was a baby my parents followed a book on child-care that advised beginning a rigid feeding and sleeping schedule at six months. Perhaps this might be suitable for a two-year-old toddler, but not for an infant, and certainly not for me. I have vague memories of protracted misery from early on, and my mother responding only

occasionally to my cries, which I found incomprehensible and very distressing.

As a teenager, growing up, I felt depressed and alone most of the time, and felt very separate from my family and others. As an adult I sought meaning through sexual and emotional relationships with women, girls when I was a teenager. On my own I felt dreadfully inadequate and without support, and the partners I chose had problems, too. My relationships usually lasted a year, maybe 18 months, or two years at the outside. Sometimes I left partners, and sometimes they left me. I couldn't attach securely to them.

I finally got into sobriety in my early forties. I qualified as an alcoholic, but barely. I didn't ride the elevator all the way down to the basement, but I was certainly miserable and shared a lot of negative feelings that alcoholics have. In sobriety I sought a more stable and intimate relationship. In early sobriety I started to come to terms with myself. I learned a different way of life in AA, including the principles of self-acceptance, acceptance of others, and trust that things will work out. I began to develop a concept of a Higher Power that really was working in my favor, rather than having to cope in a hostile world with no trust at all.

And so in sobriety I met Elise ... (time signal) so I'll turn it over to her. (Laughter)

Elise: I met David for the first time in 1996. Two years later we re-connected and began a relationship. We became domestic partners in 1999, were married in 2002, and we joined RCA (Recovering Couples Anonymous) six months after that. We have worked the RCA program all along, and, slowly, in my relationship with David I am learning to trust, healing from my physical and emotional losses, and receiving the warmth and acceptance that I always wanted and needed. I soak it up like a sponge.

In working the RCA steps with David again in 2011, I realized that I wanted to have a healthy and fulfilling sexual relationship with my partner, which I had never really had in life. I had given up hope of having one a long time ago. I didn't know such a thing was possible even after all my years in SLAA. I had made attempts in recovery to reach out and get help with this, and I found none where I looked. In working step six our Higher Power sent me a message to re-ignite my search, and I became committed to do that.

Very shortly after I got that realization in our step work, I received a cancer diagnosis that involved my pelvic area. The chemotherapy and radiation did great damage to my body and created great challenges to our sex life, which we are now actively working to restore and heal.

There are two hurdles for me: the physical challenge from radiation and my long time emotional and psychological challenge; though they occurred at separate times, they are very connected. Paradoxically, my cancer and my recovery from treatment set me on a path to reach out for help with both issues, which led me to these resources: therapy, body work, medical consultation, and using the principles of the program. One of the actions that we are taking is a spiritual, sexual, and meditative practice that we do together as much as we can (we try to do it daily). Calming my mind is difficult for me, but as a practice that is spiritual, practical, and paradoxical, it really works to deepen our connection and our intimacy.

I also do sexological bodywork for physical and emotional therapy. I see my body worker every couple of weeks and we're working on restoring my physical abilities. [In my case, sexological bodywork includes physical therapy to restore awareness, responses, and functioning to tissues and organs in and around the pelvic floor area, which were damaged by radiation treatment.] I've also worked with a gynecologist who specializes in this area and with a psychotherapist. Speaking here on Healthy Sexuality is part of our focus on our sexual intimacy.

We keep coming back. We don't know what will happen and we know that's not up to us. As individuals we are growing and learning, and I feel our intimacy is growing and deepening, too, and that our relationship is flourishing. We just do what we can, and practice the principles of the program.

David: Thank you. So I'll give you a quick "what happened," and "what it is like now." Elise and I have been together for 15 years, married and in RCA for 11 years. In my opinion, our relationship has been positive, close, and sexually intimate.

Our present difficulties, as Elise said, were brought to light by the damage done by cancer treatment. My response has been to try not to expect sex with Elise, but to wait for her to show signs of being willing, and to focus on other, shared forms of intimacy, as best I could. It's been a very difficult two years but I have learned that

hanging in there is a virtue that I can practice. Also, with our record of successfully working together, I thought we could learn to cope with our dilemmas and difficulties, and the damage that was done as a result of cancer treatment. I am grateful that Elise survived. In fact this was her second cancer. Her previous cancer, unrelated breast cancer, was treated with radiation but without chemotherapy.

I felt disappointed that Elise had great difficulty having sex for the last couple of years, but I wanted to continue to be a loving partner. Although sex is important it is not quite as urgently needed, from my point of view, as it was when I was younger, one of the dubious benefits of getting older. So, Elise has initiated the healing practices that she outlined. Knowing that Elise is working on these issues, rather than giving up, has been a tremendous inspiration to me. She has also demonstrated how committed she is to recovering who she really is, and to participating in our relationship by being intimate in new ways.

One of the things we have learned to do in RCA is to reach out for help. Elise mentioned the meditation practice we do, which is called “Orgasmic Meditation,” or “OMing.” This originated in the San Francisco Bay Area, where we live. To learn how to do it we worked with a trainer for a while. Elise lies down, and I stimulate her clitoris very gently for 15 minutes. The people who developed this practice recently did a live on-line demonstration, and established a world record, with more than a thousand people watching! (Laughter) So this is new territory! (Laughter) We find that Oming creates a hypnotic state in both of us, and in that state our minds go where they go, but our bodies get in-tune. The result is that when we are through we feel close, calm, and very relaxed.

As Elise mentioned, she has been doing sexological bodywork for more than a year now, and I was recently invited to a couple of sessions to learn how to do it. Elise’s physiotherapist feels that she needs more practice between therapies, so I’m learning how to do hands-on treatment. This is supposed to stimulate the tissue that has been damaged by radiation in order for her to regain functioning, and for the muscles that are contracted to learn to relax again. So, I have been invited into this women’s world. This is women’s work and, as a man, to be invited into that world to help feels like a tremendous privilege.

To sum up, this is the area of recovery that we’re working on. We’re not a perfect couple, we’re not a completely recovered couple,

and this has been a tremendous challenge, but we're in recovery so we're up for it. We find intimacy where it's offered; recovering sexual intimacy is what is being offered, so this is our current work. As a result of this work, I feel close and involved with my partner rather than feeling isolated, as I did growing up.

We have learned that RCA is a program of action, and here is the list of actions we have taken to work on our difficulties:

- We talked to our sponsors, and they responded by offering us a "Healthy Sexuality Inventory" questionnaire, which we handed out so you can do your own. This originates from a precursor program to RCA called We Came To Believe, which was an intensive workshop for couples.
- We worked on our sexual inventory in our step study. (We go to a step study once a month, which is connected with our regular RCA group.) It took us a couple of months to complete our sexual inventory, which we then shared with our sponsors.
- We shared about our experiences and our difficulties in RCA meetings and received a lot of support.

By working on our difficulties together we feel closer to each other, and we feel hopeful rather than hopeless.

Thank you very much. (Applause)

Although developed independently, both twelve-step recovery and person-centered therapy encourage change in adults and promote psychological development. Sharing from direct, personal experience is important in both practices, as is developing an awareness of feelings and needs. As an example of sharing in a twelve-step meeting, an extended share on the topic of recovering sexual intimacy is included in an appendix. Although the person-centered approach and twelve-step recovery have distinct features, both benefit from a felt quality of non-judgmental acceptance that is achieved by sharing feelings and personal experiences. Acceptance, which is the common ground in both models, helps individuals grow and differentiate while developing stronger connections with others.