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“First Things First”: What is the First Thing?

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Abstract

This OP-ED piece comments on the down-side of an otherwise useful 12-step slogan, “First Things First,” which generally refers to staying sober (not drinking or using no matter what). While important, there are environmental, micro-social, psychiatric, and neurobiological considerations that may place other needs at an equal or higher priority than sobriety *per se*. That is, other changes may be needed to set the stage for, or enhance efforts at sobriety, prior to or concurrent with attempting to quit one's drug of choice. Perhaps slogans should be considered in a broader context and not be taken too literally.

Keywords

“First things First”; slogans; treatment needs

First Things First: What is the First Thing?

One central element of achieving lasting sobriety in recovery¹ movement (12-step) programs--along with working the steps, following the traditions, taking on a sponsor, and participating in the fellowship, among other features--is taking guidance from slogans (Kelly & McCrady, 2008). Slogans are brief phrases that can provide direction or assist with coping. One of the key slogans in the recovery movement is “First Things First” (e.g., White, 2002), although its origin is unknown. This slogan reminds the participant to remember one's priorities; to maintain a concentrated focus on prioritizing recovery so that the chances of success are not diminished; to do the next right thing; or more simply to just not drink or use (Herbert, 2012; Kelly & McCrady, 2008; Sifers & Peltz, 2013). Straussner and Byrne (2009) propose that future research would benefit from identifying the mechanisms of change that occurs through twelve step program participation and suggest that perhaps the Alcoholics Anonymous (AA) slogan “First Things First,” is helpful for

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¹Although there is no consensualized definition by a range of involved deliverers of care and services for its targeted populations recent definitions include: (1) In the U.S., *recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. Sobriety refers to abstinence from alcohol and all other non-prescribed drugs.* The Betty Ford Institute Consensus Panel, *Journal of Substance Abuse Treatment* 33 (2007) 221–228; and (2) the UK Drug Policy Commission: “Recovery is a process, characterized by *voluntarily maintained control over substance use*, leading towards health and well-being and participation in the responsibilities and benefits of society” The UK Drug Policy Commission, *Recovery Consensus Group Policy Report*, July 2008; www.ukpc.org.uk. “Recovery” is most often associated with abstinence. Its dimensions, and the necessary internal and external, micro- and macro-level conditions for its achievement and sustainment, and the person's necessary enabling resources, as well as interfering flaws and limitations, have yet to be delineated in treatment ideologies such as harm reduction, quality-of-life, and conflict resolution. Editor's note.

members because they may have poor multitasking skills or low tolerance to stress (either as a consequence of prolonged alcoholism or as a contributing factor to their alcohol misuse). Slogans are meant to be helpful, act as a heuristic, and serve as a source of direction and comfort when a member feels anxious or distressed. However, slogans assume a subjective meaning and at times different interpretations may become a source of confusion and distress for individuals very early in their recovery.

“First Things First” generally emphasizes the importance of not drinking or using no matter what.² Thus, when an AA member experiences a “slip” the implication is that the member has allowed some other problem to assume a greater priority (Rayburn and Wright (2009). Certainly, focusing on a sustained effort not to drink or use is imperative; however, to achieve and maintain sobriety sometimes the “first” thing may not actually be putting down the drink or the drug. Some researchers and practitioners have cautioned against employing such a slogan too literally; that there are a variety of issues that may need to be addressed immediately in early recovery, possibly before or concurrently with quitting use of alcohol or another drug. These other issues pertain to environmental, microsocial, psychiatric, and underlying neurobiological issues.

Environmental Issues

Physical environmental issues may take precedence at times. If an alcoholic or addict, who represents heterogeneous persons, not a homogenized group or category, whatever his or her choice of psychotropic substance, manner and patterns of use, and imputed meaning(s) of use/functions, does not have enough to eat, or a place to live, quitting use may seem secondary when compared to survival. As Rayburn & Wright note (2009), individuals living in homeless shelters can have multiple needs that vie for precedence. Many shelters have strict length-of-stay limitations. When one's time in the shelter is about to expire, finding alternative shelter may become more pressing than “working the program.” Although shelters are necessary and intended to promote stability, they are constrained by limited resources and policies that can, at times, work against an individual's desire to remain sober. Likewise, a person who has not had a decent meal in several days may place greater emphasis on finding a soup kitchen or other means of securing food than admitting his or her powerlessness over alcohol.

While alcoholics or addicts find themselves in a condition under which their long-term survival (and in some cases even short term) depends upon getting sober, their immediate environmental needs can become a barrier to prioritizing sobriety and engaging in the activities that would help them achieve this. Thus, for example, Graves (2007) provides a new approach for the treatment of homeless persons with serious addiction problems, “housing first.” The idea is to provide apartments without requiring addicts to get sober, as a first step. Such ideas are not new. In fact, Maslow (1943) expressed a similar idea in a paper on human motivation in which he described what is popularly known as the “hierarchy of needs.” While some criticism of the exact ranking scale is noteworthy, clinicians and

²Almost all (not all) persons with serious substance use problems as adults are unable to become “controlled” drinkers or users (Sussman & Ames, 2008).

researchers can take guidance from Maslow's hierarchy in addressing domains of a person's life that make it difficult to focus solely on sobriety.

In summary, getting sober, and sustaining the effort to maintain sobriety, typically requires enormous effort as reevaluating and then restructuring multiple aspects of one's day-to-day life concurrently taxes cognitive, affective, and physical capacities; . Unstable physical environments or conditions (chaotic living situations) can cause extreme survival anxiety, which in turn can undermine or derail efforts at quitting using one's drug of choice. The “first” thing may be to permit one to obtain a more stable environment (food and shelter).

Microsocial Issues

If an alcoholic or addict is surrounded by others that tend to be violent or actively using, it may be necessary to leave that social milieu at least temporarily in order to improve one's chances of achieving physical safety and gain a hopeful perspective regarding a new life situation. One may consider this perspective “safe social climate first.” That is, if one is being physically or mentally abused by significant others, avoiding such abuse likely would take precedence over quitting using a substance. The substance, pharmacologically and/or its “drug experience”, may actually assist the person in coping with the abuse.

In addition, if one is pressured to drink or use by significant others or peers, it might be difficult to avoid using even if one is initially motivated not to. Social context (e.g., peer pressure from other users) is one of the strongest predictors of alcohol or drug use experimentation (Reed & Rountree, 1997; Bahr, Hoffman, & Yang, 2005), is a major impediment to stopping drinking or using, and facilitates relapse (Lorman, 2013; Sussman & Ames, 2008). Leaving a risky social milieu before making a firm decision to try to quit drinking or using may be essential—and potentially helpful if the new milieu involves nonusers.

Perhaps more importantly, alcoholism and other drug addiction often isolates an individual from healthier friends and colleagues, who may have severed ties with the addict, such that the addict/alcoholic seeks and finds comfort in the companionship of other alcoholics/addicts. This creates a conundrum; a desire to be sober would demand distancing oneself from the drinking and using social network; yet this loss of friendship (even those built on negative behaviors) can exacerbate fears of impending loneliness that for the alcoholic/addict have been assuaged by drinking or using. Going to 12-step meetings may be helpful, but motivation tends to fluctuate among persons during early sobriety, and initial concerns for physical safety and social connectedness may compete with, or even be more important than, becoming and remaining sober. Perhaps the “first” thing would be to assist the person in relocating to a new social milieu even before making a decision to quit.

Psychiatric Issues

Wallace (1986) notes, with enthusiasm, that alcoholism counseling became a specialty based on a “naïve disease concept” built around the critically important issues of the patient's recognition of the problem, identification of self as an alcoholic, acceptance of alcoholism, learning how to live a comfortable, productive and fulfilling life without consuming alcohol

and, for many, continuing to self-identify, and to be identified by others, as an (former, recovering, or recovered) *alcoholic*. However, he also noted that a related separatism from other professions has had costs as well as benefits. An alcoholic or addict may manifest a variety of psychiatric issues that demand immediate attention, simultaneously or even before stopping drinking or using. This needs to be seriously considered. In fact, drugs and alcohol, their actions and their associated “experiences” (Zinberg, 1984) may have served as a home-remedy for symptom management of acute or chronic diseases, including mental health difficulties. If addressed very early in recovery, treatment staff can provide an individual with a better understanding of how to navigate and sustain efforts that balance mental health and addiction needs. By disengaging with the legitimized mental health professional community, immediate assistance may have been delayed or derailed to some extent.

For example, a substantial percentage of individuals who are chemically dependent also suffer from posttraumatic stress disorder, and/or survivor syndromes related to childhood abuse (Sullivan & Evans, 1994), or other mental health diagnoses (e.g., anxiety, depression, bipolar disorder; Sussman & Ames, 2008). Sullivan and Evans (1994) discuss a model that applies a principle of “safety first” to direct integrated substance abuse and mental health treatment programming.

Underlying Neurobiological Issues: Multiple Addictions

Finally, focusing on a single addiction may ignore underlying neurobiological issues. As such, if one addiction is halted, another one that serves similar functions may take its place. Other addictions—even those that don't involve substances—may not be any healthier than the previous one (Sussman, Lisha, & Griffiths, 2011).

Of course, substitute chemical addictions often do not occur. Blanco and colleagues (2014) investigated the occurrence of one substance use disorder (SUD) taking the place of another SUD that remitted (stopped, at least when queried again after a 3-year duration), versus a new SUD occurring on top of one that had not remitted, in a two-group analysis. Approximately 13% of those who remitted developed a new SUD, whereas 27% of those who did not remit developed a new SUD. This paper did not address the issue of substitute addiction as described by Sussman & Black (2008), which pertains to many different types of addictions (e.g. food, gambling, and sex). Blanco and colleagues did find that people who have a problem with one substance (drug) may develop a concurrent problem with a second substance; and that they are more likely to do so than persons who have been able to quit using a substance. This makes sense in that personal application of principals of substance use cessation may generalize to other substances.

One arena, however, in which “first things first” has generated considerable debate and attention is smoking cessation among individuals new in recovery (e.g., Bobo & Huston, 2000; Garner & Ratschen, 2013; Sussman, 2002). This discussion is not about substitute addiction (though some persons new in recovery may even begin smoking after beginning treatment for alcohol or other substances; Sussman, 2002), but rather the appropriateness of engaging in cessation of concurrent addictions. Cigarette smoking is the leading behavioral cause of premature death among adults (Sussman, 2002). Bobo and Huston (2000) assert

that often 12-step group members are advised to avoid tackling new challenges, like quitting smoking, until they are confident about their ability to remain sober even when under additional stress. They note material on page 135 of the Big Book which warns against attempting to stop someone from smoking and drinking coffee right away; that they might relapse (Alcoholics Anonymous, 1976).

Currently, nonsmoking AA meetings are available and enforced by city ordinance in many communities, though they were rare until the mid-1980s. Karam-Hage, and colleagues (2005) found that among those persons in treatment for alcohol dependence, persons who quit smoking (18 of 144 patients) were much more likely to report last 28-day abstinence from alcohol at a 6-month follow-up than those who continued smoking (93% versus 62%). Such data suggests that focusing on “multiple behaviors first” may lead to better overall outcomes.

The consideration of providing smoking cessation services during early recovery is only one type of behavior that may need to be treated early on. There are many other types of dual addictions. In the early phases of recovery behavioral addictions can take the place of a substance as people in early recovery may have difficulty feeling excitement, stimulation, or joy by engaging in non-addictive behaviors (e.g., Leventhal et al., 2010). The scant research literature on substitute addictions suggests a proportion of persons in recovery do indeed take on other addictions (Sussman & Black, 2008). One school of thought assumes that treating an addiction to the “drug of choice” is preferable. However, another potentially beneficial approach may be to address the underlying addiction process immediately and discuss dangers of substitute addictions or concurrent addictions (e.g., Horvath, 1999).

Sussman, Lisha, & Griffiths (2011) engaged in an extensive review of the literature on 11 (behavioral and substance) addictions. They found that 47% of the adult U.S. population exhibit one or more addictions in a 12-month period and that 23% demonstrate co-occurrence of two or more addictions (i. e., to cigarettes, alcohol, other drugs, food, gambling, sex, love, internet, work, shopping, and/or exercise). Subsequently, Sussman and colleagues (2014) used latent class analysis to examine the discriminability of these 11 different addictions among former alternative high school youth. However, they ended up finding only two classes: an addiction group and a non-addiction group. In fact, this same study indicated that 38% of youth reported two or more concurrent addictions in the last 30 days. Together, these studies suggest that persons entering recovery from alcohol or other drugs are likely to be experiencing multiple addictions reflecting an underlying addictive process. This process involves engaging in a behavior to achieve an appetitive effect followed by brief periods of satiation, preoccupation with the addiction, loss of control, and experience of negative or undesired consequences (Sussman & Sussman, 2011). Possibly, treatment programs should consider this underlying process in addition to, or rather than, addressing the “drug of choice” to minimize manifestations of multiple concurrent addictions or in substitute addictions.

Conclusions

“First Things First” is a great slogan to focus the person in their recovery efforts and processes from using alcohol or other drugs, to put effort into not using his or her drug of choice. However, this slogan is not adequate for treatment planning. Assessment of concurrent environmental conditions, micro-social context, cognitive function, and neurobiological features could be of great assistance to individuals and facilitate obtaining long-lasting and meaningful recovery. It is important to remember that there are many recovery program slogans. Others such as “One Day at a Time”, may be used along with “First Things First”, to encourage one to accept that one has limitations; and that perhaps focusing on only doing one thing at a time when trying to get sober is necessary but at times may not be sufficient (Kurtz, 2008; Sifers & Peltz, 2013). The field would benefit from an assessment of how these slogans are employed as an integrated set and their subjective interpretations by members of recovery programs, social service institutions, and the treatment community. Treatment agents, whatever their treatment ideologies and disciplines, professionals or not, are uniquely placed to address these issues and could benefit from careful and thoughtful application of slogans that can help clients navigate what might appear to be, and at times can be, competing goals.

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Biographies

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