

Guidelines for Helping the Alcoholic

Based on Father Joseph Martin's Principles

From Love to Action — The Recovery Files

Father Martin's Six Principles

- 1. Change Your Attitude** — Understand addiction as a disease, not a moral failing
- 2. Recognize the Addiction** — Acknowledge that loss of control is real and clinical
- 3. Stop Enabling** — Let consequences land; stop subsidizing the disease
- 4. Confront with Love** — Speak truth firmly, specifically, and compassionately
- 5. Utilize Resources** — Get professional help for the person AND for yourself
- 6. Never Give Up** — Maintain hope with boundaries; recovery is always possible

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Changing Your Attitude: Addiction as a Disease

Father Joseph Martin began with the most fundamental principle of all: before you can help the alcoholic, you must first change your own attitude. You must come to understand, not merely intellectually but in the deepest chambers of your heart, that alcoholism — and by extension all substance use disorders — is a disease. It is not a moral failing. It is not a character defect. It is not a lack of willpower, discipline, or love for you. It is a chronic, progressive, and potentially fatal disease that hijacks the brain's reward system, decision-making capacity, and survival instincts.

This is where every helper must begin, because without this foundation, everything else you do will be contaminated by judgment, resentment, and misunderstanding. If you believe, even unconsciously, that the addicted person "chooses" to drink or use, then every time they pick up a substance you will interpret it as a deliberate act of betrayal — a conscious decision to hurt you, abandon responsibility, or throw away everything good in their life.

Father Martin understood that this attitude kills more alcoholics than the disease itself. When the people around the addicted person operate from a framework of moral judgment, they inadvertently create the exact conditions that perpetuate addiction. Shame drives addiction underground. Contempt destroys the trust necessary for honest conversation. Angry ultimatums trigger the defiance that active addiction feeds on.

The disease model does not excuse behavior. Understanding that addiction is a disease does not mean the addicted person bears no responsibility for their actions. They broke trust. They lied. They stole. They drove drunk. They neglected their children. They said terrible things. All of that happened, and all of it matters. But here is the critical distinction: the disease drove the behavior. The person, underneath the disease, is not the behavior.

The same compassion — the same clarity — must be extended to the person suffering from addiction. Not because they deserve it (though they do), but because it is the only framework that actually works. Judgment has never sobered anyone up. Understanding opens the door.

For the clinician, this principle means examining your own biases constantly. Do you believe, deep down, that your patient "wants" to be sober "enough"? Do you interpret missed appointments, positive screens, and ambivalent motivation as personal affronts or treatment failures? The disease model requires that we treat addiction with the same clinical objectivity we bring to any other chronic illness — not with sentimentality, not with enabling, but with the rigorous compassion that evidence-based medicine demands.

Father Martin would say it simply: "Change your attitude first. Everything else follows from there."

Reflection Questions

1. When you think about the addicted person in your life (or your patients), do you genuinely believe addiction is a disease, or do you still carry some belief that it is a choice? Be completely honest.

2. How has moral judgment — yours or others' — affected the addicted person's willingness to seek help or be honest about their struggles?

3. Can you separate the person from the disease? When you recall specific hurtful behaviors, can you see the disease driving those actions without excusing them?

4. What attitudes or beliefs about addiction did you grow up with? How have those shaped your current response to the addicted person?

5. If you fully embraced the disease model today, what would change about how you interact with the addicted person or your patients?

Recognizing the Addiction: Understanding Loss of Control

The second of Father Martin's principles is recognition: the helper must acknowledge, clearly and without reservation, that the alcoholic has lost control over their drinking. This is not a metaphor. It is not an exaggeration. It is not something the addicted person is "using as an excuse." Loss of control is the defining clinical feature of addiction.

Loss of control in addiction operates on multiple levels. At the neurological level, chronic substance use has fundamentally altered the brain's reward circuitry. The prefrontal cortex — the brain region responsible for judgment, impulse control, and long-term planning — has been progressively weakened, while the limbic system — the primitive brain region that drives survival instincts — has been hijacked to classify the substance as essential for survival.

The addicted brain does not process the substance as a pleasure or a luxury; it processes it as a necessity, as urgent as food, water, or air. This is why the addicted person will sacrifice everything — relationships, career, health, freedom, self-respect — for a substance that appears, from the outside, to be destroying them. They are not making a rational calculation. Their brain has reclassified the substance as essential to staying alive.

For helpers, recognizing loss of control means abandoning several deeply comforting illusions. The first is the illusion of controlled use: "If they could just drink less..." These are not viable strategies for someone with the disease of addiction. They are the equivalent of telling someone with a peanut allergy to "just eat fewer peanuts."

The second illusion is the illusion of willpower: "If they loved me enough, they would stop." Willpower is a function of the prefrontal cortex — the very region that addiction compromises. Asking an addicted person to use willpower to overcome addiction is like asking someone with a broken leg to walk it off.

The third illusion is the illusion of insight: "They know what they're doing to themselves." Actually, one of the most insidious features of addiction is its ability to distort self-perception. The defense mechanism of denial — not conscious lying, but genuine neurological inability to perceive the severity of one's own condition — is a hallmark of the disease.

For the family member, recognizing loss of control means letting go of the fantasy that you can manage, monitor, or moderate the person's use on their behalf. You cannot pour out enough bottles. You cannot hide enough car keys. The disease is bigger than your surveillance. Recognition means accepting this truth, painful as it is, and redirecting your energy toward the things you actually can influence: your own behavior, your own boundaries, your own recovery.

Reflection Questions

1. Have you been holding onto the belief that the addicted person could control their use "if they really tried"? What evidence supports or contradicts this belief?

2. Which illusion has been hardest for you to release — the illusion of controlled use, the illusion of willpower, or the illusion of insight? Why?

3. How has the person's loss of control manifested specifically? Can you identify moments when they clearly intended one thing but the disease drove them to another?

4. If you truly accept that loss of control is a clinical reality rather than an excuse, how does that change the way you interpret the person's past behavior?

5. What monitoring or controlling behaviors have you engaged in that you now recognize as attempts to manage what cannot be managed? What would it look like to redirect that energy?

Breaking the Enabling Cycle: Forcing Responsibility

Of all Father Martin's principles, this one cuts the deepest: stop enabling. Stop protecting the addicted person from the consequences of their own behavior. Let them feel the full weight of what the disease is doing. Do not stand between the alcoholic and the natural consequences of their drinking. This is the hardest thing any helper will ever do, because enabling feels like love.

When you call the boss and say your spouse is sick instead of admitting they are hungover, you are protecting your family's income. When you bail your child out of jail at three in the morning, you are protecting them from a terrifying experience. Every individual act of enabling, examined in isolation, looks like compassion, kindness, and responsibility. That is precisely why enabling is so dangerous — it disguises itself as love.

But here is the truth that Father Martin saw so clearly: every time you shield the addicted person from consequences, you remove one more reason for them to change. You are, in effect, making it comfortable to stay sick. You are padding the prison cell of addiction with cushions so the person inside doesn't feel the walls. And as long as the walls don't hurt — why would they seek treatment?

Father Martin called this "killing with kindness." The helper, driven by genuine love and terror of what might happen if they stop intervening, becomes an unwitting partner in the disease. The enabler and the addiction form a team — not intentionally, not consciously, but functionally. The addiction creates chaos, and the enabler restores order. The addiction generates consequences, and the enabler absorbs them.

Breaking the enabling cycle requires a fundamental shift from protecting the person from the disease to allowing the disease to reveal itself. This does not mean cruelty. It does not mean abandonment. It does not mean withholding love. It means that when the addicted person misses work because they were using, they face their employer. When they spend the rent money, they deal with the landlord.

For the helper, stopping enabling requires its own form of recovery. You must examine why you enable. Is it fear? Fear that without your protection, the person will die? Is it guilt? Guilt that somehow you caused the addiction, and therefore you must fix it? Is it identity? Has your role as the fixer, the rescuer become so central to who you are that you cannot imagine yourself without it?

Father Martin would say: "The most loving thing you can do is the thing that feels the most cruel — step aside and let reality do its work." This does not mean you stop loving. It means you start loving differently. You love them enough to let them hurt. You love them enough to say, "I will be here when you are ready for help, but I will not help you stay sick."

Reflection Questions

1. List three specific ways you have enabled the addicted person's behavior. For each one, identify what consequence you were protecting them from and what you were afraid would happen if you didn't intervene.

2. How has your enabling affected your own physical health, emotional wellbeing, finances, or relationships? What has it cost you personally?

3. What do you believe would happen if you stopped enabling today? What is the worst-case scenario you fear? How realistic is that fear?

4. Can you identify the primary motivation behind your enabling — fear, guilt, identity, or control? How did this pattern develop?

5. Write a specific boundary you are willing to set this week that stops one enabling behavior. What will you do instead when the urge to enable arises?

The Art of Loving Confrontation

Father Martin was clear that confrontation is not optional. It is not something you do only when things get bad enough. It is not a last resort. Confrontation is a responsibility that comes with loving someone who has a disease that depends on secrecy, denial, and avoidance for its survival. If the people closest to the addicted person will not speak the truth, the disease will continue to speak its lies unchallenged.

But Father Martin was equally clear about what confrontation is and what it is not. Confrontation is not screaming. It is not shaming. It is not attacking. It is not delivering an ultimatum in the heat of fury. Confrontation, in the tradition Father Martin taught, is an act of love delivered with firmness, clarity, and compassion. It says: "I see what is happening. I love you. And I can no longer pretend."

The key to effective confrontation is specificity. Father Martin emphasized that helpers must speak to behaviors, not to character. "You missed your daughter's recital on Saturday because you were drinking" is confrontation. "You're a terrible parent" is an attack. The distinction matters enormously, because the addicted person's shame-saturated brain will seize on any character attack as confirmation of what the disease has been telling them all along: "You are worthless. You are hopeless. You might as well use."

Effective confrontation follows a structure. First, choose the right time. Not when the person is intoxicated. Not in the middle of a crisis. Not when you are consumed with anger. Second, lead with care. "I love you. I need to talk to you about something important because I love you and I am scared." Third, present specific, observed behaviors. Use dates, times, incidents. Fourth, describe the impact. Fifth, state what you need. Sixth, state the consequences.

Father Martin warned against several common confrontation mistakes. The first is confrontation without love — using the truth as a blunt instrument to inflict pain. The second mistake is confrontation without consequences — saying "this needs to change" without being willing to follow through. Empty confrontation teaches the addicted person that your words don't mean anything. The third mistake is confrontation as a one-time event — doing it once, getting no result, and concluding "I tried." Confrontation is not a magic bullet. It is a consistent practice of truth-telling that, over time, erodes the wall of denial that the disease has built.

Recovery from addiction often begins with a moment when the truth can no longer be avoided. Confrontation accelerates that moment.

Reflection Questions

1. Have your past attempts at confrontation been more like attacks or like loving truth-telling? What was the result of each approach?

2. Can you identify specific, observable behaviors you need to address? Practice converting any character judgments ("you're irresponsible") into behavior-specific observations ("you missed work three times last month").

3. What prevents you from confronting the addicted person? Fear of their reaction? Fear of making things worse? Fear of losing the relationship? Name the specific fear.

4. If you were to plan a confrontation using Father Martin's structure (care, behaviors, impact, need, consequences), what would each element look like?

5. For clinicians: How comfortable are you with therapeutic confrontation? Do you tend to avoid it? What clinical situations most need your willingness to speak difficult truths?

Resources & Resilience: The Long Road of Recovery Support

Father Martin's final two principles — utilize resources and never give up — are deeply connected, and they form the sustaining framework that keeps the helper going when the journey gets long and the results feel invisible.

Utilize resources means recognizing that you cannot do this alone. The disease of addiction is larger than any one person's love, knowledge, or determination. It requires professional help — addiction counselors, therapists, physicians, psychiatrists, interventionists — people who understand the disease process and know how to treat it. It requires community help — mutual support groups like AA, NA, SMART Recovery, Celebrate Recovery, and dozens of other programs. And critically, it requires help for the helper.

Al-Anon, Nar-Anon, CODA, and family therapy programs exist because addiction is a family disease. The family members, friends, and colleagues who surround the addicted person have their own wounds, their own patterns, and their own recovery work to do. Father Martin was emphatic on this point: you cannot give what you do not have. If you are depleted, traumatized, resentful, and running on empty, your attempts to help will be contaminated by your own unprocessed pain. Getting help for yourself is not selfish — it is a prerequisite for being genuinely helpful to someone else.

For clinicians, utilizing resources means knowing your referral network cold. It means being able to tell a family member at their moment of crisis exactly where to go, who to call, and what to expect. Willingness in addiction is often fleeting. When a person says "I need help," the response must be immediate, prepared, and actionable. This is not the moment for "let me look into it." This is the moment for "I have a bed available tonight. Here is the address. I will drive you."

And then there is the final principle, the one that holds all the others together: never give up. Father Martin knew, from years of working with alcoholics and their families, that recovery is possible even when it seems impossible. Never giving up does not mean tolerating abuse. It does not mean continuing to enable. It means maintaining hope without maintaining dysfunction. It means keeping the door open while keeping your boundaries firm. It means saying, "I love you. I believe you can recover. I will be here when you are ready. But I will not participate in your disease while I wait."

Father Martin's message was ultimately one of hope. Addiction is a disease, but it is a treatable disease. People recover — not just from the substance use, but from the wreckage the disease created. Families heal. Trust rebuilds. Lives that seemed destroyed are reconstructed with a depth and meaning that would not have been possible without the crisis of addiction. Never give up. But take care of yourself while you don't.

Reflection Questions

1. What resources are you currently utilizing for yourself as a helper? What resources do you know about but haven't accessed? What is preventing you from reaching out?

2. Can you identify a specific moment when you were tempted to give up? What kept you going, or what would have helped you keep going?

3. How prepared are you to act quickly when a window of willingness opens? Do you have phone numbers, treatment options, and logistics ready?

4. What does "maintaining hope without maintaining dysfunction" look like in your specific situation? How do you hold both simultaneously?

5. Write a personal statement of resilience: "I will not give up because..." and "I will protect my own wellbeing by..."

Disease vs. Moral Failing

Examining Your Core Beliefs About Addiction

Why This Matters

Father Martin taught that everything begins with attitude. If you carry unconscious beliefs that addiction is a moral failing, those beliefs will contaminate every interaction with the addicted person. This exercise makes your beliefs visible so you can examine them honestly.

"They choose to drink/use — nobody forces them"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

The initial choice to use may have been voluntary, but addiction changes brain chemistry so that continued use becomes compulsive. The prefrontal cortex — the decision-making center — is compromised by the disease.

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

"If they had enough willpower, they could stop"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

Willpower is a function of the brain region most damaged by addiction. Asking an addicted person to use willpower alone is like asking someone with pneumonia to will their lungs clear.

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

"If they loved me/their kids enough, they would quit"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

Addiction hijacks the brain's survival circuitry. The addicted brain classifies the substance as necessary for survival — more urgent than relationships, responsibilities, or love. This is neurology, not a reflection of how much they care.

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

"They've seen what it does to them — they know better"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

Denial is a neurological symptom of addiction, not conscious deception. The addicted brain literally impairs the person's ability to accurately assess their own condition.

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

"Addiction only happens to weak people"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

Addiction affects people across all demographics, intelligence levels, and personality types. Genetic vulnerability, trauma exposure, and environmental factors are far more predictive than "strength of character."

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

"They brought this on themselves — they deserve what happens"

How strongly do you hold this belief? Rate 1 (don't believe this at all) to 5 (strongly believe this):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

THE CLINICAL REALITY

We do not deny treatment to people with heart disease caused by poor diet, or lung cancer caused by smoking. The origin of a disease does not determine whether the person deserves treatment and compassion.

Where did this belief come from? Who taught it to you, or what experience reinforced it?

How has holding this belief affected your behavior toward the addicted person? Has it helped or hindered?

Belief Examination Summary

1. Which belief scored highest (most strongly held)? What would need to happen for you to release or soften this belief?

2. How might your interactions with the addicted person change if you fully adopted the disease model? Be specific.

3. Is there grief involved in accepting the disease model? What are you grieving — the person you expected them to be, the life you expected to have, or something else?

4. Write a new belief statement that replaces your strongest moral judgment with a disease-informed understanding.

Personal Enabling Inventory

Mapping Your Patterns of Protecting the Disease

The Hard Truth

Enabling is not love — it is fear dressed up as love. Every time you protect the addicted person from a consequence, you remove one more reason for them to change. This inventory is not about blame; it is about awareness. You cannot change what you cannot see.

Covering Up

Making excuses, lying to employers/family, hiding evidence of use

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Financial Rescue

Paying bills, lending money, covering debts, funding their lifestyle

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Emotional Cushioning

Absorbing their anger, managing their mood, walking on eggshells

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Taking Over Responsibilities

Doing their chores, parenting their children, managing their obligations

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Minimizing & Rationalizing

Downplaying severity, making excuses ("they're just stressed"), normalizing use

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Avoiding Confrontation

Not bringing it up, changing the subject, pretending everything is fine

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Legal/Social Rescuing

Bailing out of jail, hiring lawyers, smoothing things over with authorities

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Blaming Yourself

Taking responsibility for their use ("if I had been a better spouse..."), feeling guilty

How frequently do you engage in this type of enabling? Rate 1 (never) to 5 (constantly):

Not at all ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 Very much

Give a specific recent example of when you did this. What happened, and what consequence did you prevent?

What were you afraid would happen if you didn't intervene? What was driving the enabling?

What would it look like to stop this specific enabling behavior? What would you do instead?

Enabling Inventory Summary

1. Which enabling pattern scored highest? How long have you been doing this, and how has it escalated over time?

2. What has your enabling cost you personally — emotionally, physically, financially, relationally?

3. If you stopped all enabling today, what do you honestly believe would happen? Separate realistic consequences from catastrophic fears.

4. Write a commitment statement: "I will stop enabling by [specific behavior change] starting [specific date] because [specific reason]."

Consequence Mapping

What Has the Disease Cost — and What Have You Absorbed?

The Purpose of This Exercise

Father Martin taught that consequences are recovery's greatest ally. This exercise maps two things: the consequences the addicted person has experienced AND the consequences you have absorbed on their behalf. When you see the full picture, the case for stopping enabling becomes undeniable.

Physical & Mental Health

Examples: Medical crises, injuries, mental health deterioration, overdose risk, malnutrition, sleep deprivation

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Relationships & Family

Examples: Broken trust, emotional abuse, neglected children, damaged friendships, isolation, divorce

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Employment & Career

Examples: Missed work, poor performance, job loss, professional reputation, lost opportunities

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Financial

Examples: Debt, unpaid bills, lost savings, legal costs, inability to provide, theft

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Legal

Examples: DUI/DWI, drug charges, custody issues, restraining orders, incarceration

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Spiritual & Emotional

Examples: Loss of purpose, moral injury, shame, spiritual disconnection, hopelessness, loss of identity

CONSEQUENCES THEY EXPERIENCED

CONSEQUENCES YOU ABSORBED FOR THEM

WHAT WOULD YOU STOP ABSORBING?

Consequence Mapping Summary

1. Looking at the full map, what is the total cost of this disease — to the addicted person, to you, and to your family?

2. In which domain have you absorbed the most consequences? What has that cost you personally?

3. Which specific consequence, if allowed to land fully on the addicted person, might be the catalyst for them to seek help?

4. Write a statement of release: "I am no longer willing to absorb consequences in the area of [domain] because [reason]. Going forward, I will [specific action]."

Confrontation Planning Workshop

Preparing to Speak Truth with Love

Father Martin's Framework

Effective confrontation follows a structure: Lead with love, present specific behaviors, describe the impact, state what you need, and outline consequences. This workshop walks you through building your own confrontation plan step by step.

Step 1: Lead with Care

Begin by expressing your love, care, and concern. This sets the tone and makes clear that what follows comes from a place of love, not punishment.

1. Write your opening statement. How will you communicate that this conversation comes from love?

Step 2: Present Specific Behaviors

List 3-5 specific, observable incidents with dates and details. No character attacks. Just facts.

1. Specific incident #1 (date, what happened, what you observed):

2. Specific incident #2 (date, what happened, what you observed):

3. Specific incident #3 (date, what happened, what you observed):

4. Specific incident #4 (date, what happened, what you observed):

5. Specific incident #5 (date, what happened, what you observed):

Step 3: Describe the Impact

Share how these behaviors have affected you and others. Use "I feel" and "I have noticed" statements. Focus on YOUR experience.

1. How have these behaviors affected you emotionally?

2. How have they affected your physical health or daily functioning?

3. How have they affected other family members (children, parents, siblings)?

4. How have they affected the relationship between you and the addicted person?

Step 4: State What You Need

1. What specific action are you asking the addicted person to take? Be clear and concrete.

2. What are you willing to do to support them if they take this step?

Step 5: State the Consequences

This is not a threat. This is a boundary. State clearly and calmly what will happen if the person does not seek help. Only state consequences you are willing and able to follow through on.

1. What specific consequence will you implement if the person refuses to get help?

2. Are you prepared to follow through on this consequence? What will make it difficult, and how will you stay committed?

Confrontation Plan Summary

1. Read through your full confrontation plan. Does it feel like love or like punishment? What adjustments would make it more compassionate without losing firmness?

2. Who else should be involved in this confrontation? Would a professional interventionist be appropriate?

3. What is the most likely response from the addicted person? How will you handle defensiveness, anger, tears, or promises to change?

4. When and where will you deliver this confrontation? Plan the logistics.

Resource Inventory & Action Plan

Building Your Recovery Resource Network

Be Ready Before the Moment Comes

When the window of willingness opens, you must be able to move immediately. Father Martin taught that willingness is often fleeting — the addicted person who says 'I need help' at 7 AM may have changed their mind by noon. Your resource inventory is your emergency kit. Have it ready.

Treatment Providers

List treatment centers, detox facilities, IOP programs, and outpatient providers you have identified or can contact:

What gaps exist? What resources do you still need to identify?

Individual Professionals

List counselors, therapists, psychiatrists, or addiction medicine physicians you know of or have been referred to:

What gaps exist? What resources do you still need to identify?

Mutual Support Programs

List AA meetings, NA meetings, SMART Recovery groups, or other recovery support meetings in your area with times and locations:

What gaps exist? What resources do you still need to identify?

Support for Helpers

List Al-Anon meetings, Nar-Anon meetings, family therapy providers, or support groups for family members you can attend:

What gaps exist? What resources do you still need to identify?

Crisis Resources

List emergency contacts, crisis hotlines, and immediate-response resources:

What gaps exist? What resources do you still need to identify?

Financial & Insurance Resources

List insurance information, financial assistance programs, sliding-scale providers, or scholarship treatment programs:

What gaps exist? What resources do you still need to identify?

Resource Action Plan

1. How quickly could you act if the addicted person said "I need help" right now? What would you need to do in the first hour?

2. Which resource gaps are most critical to fill? What specific steps will you take this week to fill them?

3. Have you accessed support for yourself as a helper? If not, what is stopping you, and what will you do about it?

4. Create a "Window of Willingness" action plan: Step 1, Step 2, Step 3 — what happens the moment the person says yes?

Hope & Resilience Journal

Because Father Martin Said: Never Give Up

Why Hope Matters

Hope is not optimism. Optimism says 'everything will work out.' Hope says 'I will keep going regardless of how it works out.' Father Martin's final principle — never give up — is sustained by active, practiced hope. This journal helps you cultivate it.

The Darkest Moment

Describe the lowest point of this journey. What happened, how did you feel, and what did you do?

A Glimmer of Light

Describe a moment — even a small one — when you saw hope. A moment of clarity, kindness, or progress, however brief.

Your Strength Source

What has kept you going? What internal resource, relationship, belief, or practice has sustained you through this?

Recovery Stories You Know

Write about someone you know or have heard of who recovered from addiction. What does their story teach you about possibility?

Letter to Your Future Self

Write a letter to yourself one year from now. Describe the life you hope to be living and the relationship you hope to have with the recovering person.

Letter to the Person Underneath the Disease

Write a letter to the person you love — not to the disease, not to the behavior, but to the human being underneath it all. What do you want them to know?

Hope Declaration

1. After completing this journal, write your personal declaration of hope and resilience. What do you believe, what will you do, and what will you never stop doing?

Boundaries & Self-Care Assessment

Protecting Yourself While Helping Others

You Cannot Give What You Don't Have

Father Martin was emphatic: the helper needs help too. If you are depleted, traumatized, and running on empty, your attempts to help will be contaminated by your own unprocessed pain. Boundaries are not selfish — they are the foundation of effective helping.

Physical Safety

Are you physically safe? Have you been harmed, threatened, or put in danger? What boundaries do you need around physical safety?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Emotional Protection

How has the addicted person's behavior affected your emotional health? What emotional boundaries do you need to set?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Financial Boundaries

How has the addiction affected your finances? What financial boundaries do you need to establish and maintain?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Children & Dependents

If children are involved, what boundaries must be in place to protect them? What are you willing to do to ensure their safety?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Social & Relational

How has the addiction isolated you or damaged your other relationships? What social boundaries do you need?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Personal Self-Care

What self-care practices have you abandoned while managing the addiction crisis? What will you recommit to?

What specific boundary will you set in this area? Write it as a clear statement.

What will make this boundary difficult to maintain? How will you hold firm?

Boundaries & Self-Care Summary

1. Which boundary feels most urgent to set? Why have you not set it yet?

2. List three self-care practices you will commit to this week, regardless of what is happening with the addicted person.

3. Who in your life will support you in maintaining these boundaries? Who might undermine them?

4. Write a self-care commitment: "I matter too. I will take care of myself by..."

Communication Skills Practice

From Attacks to Effective Confrontation

The Rewrite Principle

Father Martin distinguished between confrontation (love + truth) and attack (anger + judgment). In each scenario below, you'll see a common attack response. Your task is to rewrite it as an effective confrontation that maintains love, uses specific behaviors, and stays firm without cruelty.

You Discover Evidence of Use

SITUATION

You find empty bottles, drug paraphernalia, or other evidence that the person has been using.

COMMON ATTACK RESPONSE

"I found your bottles again. You're a liar and I can't believe anything you say. You'll never change."

Rewrite this using behavior-specific, impact-focused language:

What is different about your rewritten response? What does it accomplish that the attack does not?

They Break a Promise

SITUATION

The person promised to attend their meeting/appointment and didn't go.

COMMON ATTACK RESPONSE

"You promised you'd go and you didn't. You don't care about this family. You're so selfish."

Rewrite this using "I" statements that express your feelings and needs:

What is different about your rewritten response? What does it accomplish that the attack does not?

They Make Excuses

SITUATION

The person blames their use on stress, you, or circumstances and refuses to take responsibility.

COMMON ATTACK RESPONSE

"Stop making excuses! You always blame everyone else. Take some responsibility for once in your life."

Rewrite this in a way that redirects to accountability without attacking:

What is different about your rewritten response? What does it accomplish that the attack does not?

They Relapse After Treatment

SITUATION

The person returns to use after a period of sobriety or treatment.

COMMON ATTACK RESPONSE

"I can't believe you're using again after everything we went through. All that money and time was wasted. You're hopeless."

Rewrite this in a way that maintains hope while addressing the reality:

What is different about your rewritten response? What does it accomplish that the attack does not?

They Ask for Help (Again)

SITUATION

The person says they want help but has said this before without follow-through.

COMMON ATTACK RESPONSE

"You said that last time and the time before that. Why should I believe you now? I'm done falling for this."

Rewrite this in a way that tests willingness without dismissing the moment:

What is different about your rewritten response? What does it accomplish that the attack does not?

Communication Skills Summary

1. What was the hardest scenario to rewrite? Why? What does that reveal about your emotional triggers?

2. What common patterns do you notice in the attack responses? (Character attacks, absolutist language, hopelessness?) Which patterns show up in your own communication?

3. How would the addicted person likely respond differently to a confrontation versus an attack? What outcome are you actually trying to achieve?

4. Write a personal communication commitment: "When I feel triggered, I will [specific strategy] before I speak."

Support System Mapping

You Cannot Do This Alone

The Community Principle

Father Martin emphasized that helpers must utilize resources — and the most important resource is other people. Addiction thrives in isolation, and so does helper burnout. Map your support system to see where you are strong and where you need to build.

Inner Circle (Daily/Weekly Support)

People you talk to regularly who understand the situation and support you

List the people and resources in this circle. Include their name and how they support you:

How often do you actually reach out to these people? What prevents you from leaning on them more?

Middle Circle (Monthly/As-Needed Support)

People you can call when things get tough, trusted friends or professionals

List the people and resources in this circle. Include their name and how they support you:

How often do you actually reach out to these people? What prevents you from leaning on them more?

Outer Circle (Background Support)

Community resources, groups, online communities, faith communities

List the people and resources in this circle. Include their name and how they support you:

How often do you actually reach out to these people? What prevents you from leaning on them more?

Missing Support

Types of support you need but don't currently have

What types of support are missing from your life? What would help most?

Support System Action Plan

1. Looking at your map, is your support system adequate for what you are facing? What does it need?

2. What is one specific step you will take this week to strengthen your support system?

3. If the addicted person reaches a crisis point, who are the first three people you will call? Do they know their role?

4. Write a request for help — something you would actually say to someone this week to let them know you need support.

Recovery Partnership Action Plan

Putting Father Martin's Principles Into Practice

From Knowledge to Action

You have read the material, completed the assessment, and worked through the exercises. Now it is time to create a concrete, specific, actionable plan. Father Martin's principles only work when they are practiced — not just understood.

Principle 1: Change My Attitude

1. What specific belief about addiction do I need to change? What will I replace it with?

2. What will I do this week to deepen my understanding of addiction as a disease? (Read, attend a meeting, talk to a professional?)

Principle 2: Recognize the Addiction

1. What illusion (controlled use, willpower, or insight) am I still holding onto? How will I release it?

2. What does accepting 'loss of control' mean for my behavior going forward? What will I stop doing?

Principle 3: Stop Enabling

1. What is the single most important enabling behavior I will stop this week? Be specific.

2. What consequence will I allow to land on the addicted person that I have been absorbing? What will happen when I stop?

Principle 4: Confront with Love

1. When will I confront the addicted person? Set a specific date and time.

2. What specific behaviors will I address, and what specific outcome will I request?

Principle 5: Utilize Resources

1. What professional resource will I contact this week — for the addicted person OR for myself?

2. What mutual support meeting (Al-Anon, Nar-Anon, or other) will I attend this week? When and where?

Principle 6: Never Give Up

1. What does 'not giving up' look like for me in practical, daily terms? What will I do every day to maintain hope?

2. What is my self-care commitment? List three things I will do for myself this week, no matter what.

Final Commitment

Father Martin's Promise

'You cannot force an alcoholic to get sober. But you can change your own behavior to stop enabling them and encourage them toward recovery.' Your journey as a helper begins with your own transformation. The plan you have written above is your first step.

1. Write your personal commitment statement, incorporating all six of Father Martin's principles. Sign and date it.

2. Who will you share this action plan with for accountability? When will you review and update it?
