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*ARTICLE*

# Cognitive Restructuring and the 12-Step Program of Alcoholics Anonymous

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**Abstract –** *Alcohol addiction affects many clients that enter the offices of traditional mental health professionals. Their recovery is impacted by what goes on inside the office, in treatment, as well as by involvement outside the office, in 12-step programs as Alcoholics Anonymous (AA). This article examines alcoholism as a thought disorder and cognitive restructuring as an effective model of treatment. Cognitive restructuring occurs in therapy and in AA. It can, therefore, be the bridge that encourages understanding and cooperation between the two factors influencing recovery.* *© 1999 Elsevier Science Inc. All rights reserved.*

**Keywords –** alcoholism; Alcoholics Anonymous; cognitive restructuring; recovery.

## INTRODUCTION

ALCOHOL ADDICTION AFFECTS many of the clients that are seen in the day-to-day practice of mental health. It is estimated that 10 million men, women, and children suffer from alcoholism in the United States, and another 14 to 18 million adults are problem drinkers (National Council on Alcoholism, 1989). A federal survey by the National Center for Health Statistics (1991) found that 4 in 10 Americans have been exposed to alcoholism in their families. Miller and McCrady (1993) estimated that 1 in 10 Americans have attended an Alcoholics Anonymous (AA) meeting and 1 in 8 have attended a 12-step program.

Treatment and recovery for alcohol addiction involves multifaceted approaches, usually including both addiction treatment and participation in AA. Treatment of addictions, which involves a cognitive focus through restructuring ineffective thinking, has been used in the offices of many mental health practices (Brown, 1985; Haaga & Allison, 1994; Henman & Henman, 1990; Pecsok & Fremouw, 1988; Sylvain & Ladoucheur, 1992). Recovery of addictions also moves outside the office practice to include AA involvement. Brown, Peterson, and Cunningham (1988) surveyed inpatient alcohol treatment programs and found that 95% incorporated AA and Narcotics Anonymous (NA) into their programs of recovery. According to Johnson, Phelps, and McCuen (1990) programs such as AA serve as a resource to 15 to 20% of clients/patients in health-professional offices and 30% of general hospital patients. These stated percentages are based on clients who meet the criteria for addiction to alcohol and drugs. Further, Valliant (1983) found attendance at AA meetings to be a significant variable factor (28%) impacting positive clinical results, even over other important variables, such as employment and marital status.

Since effective alcohol addiction treatment is clearly multifaceted, counselors and other professionals in the field of mental health need to have a thorough understanding of what AA and other 12-step programs do for individuals caught in the throes of alcohol or drug addiction. Counselors' awareness and understanding of the local recovery support community as a valuable tool, im-

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pacts the recovery of the addicted as well as those in relationship with the addicted (Johnson & Chappel, 1994).

Participation in AA is far-reaching; but, Henman and Henman (1990) stated that there is often a “subtle and often overt mistrust” between traditional counselors and 12-step–program people. This mistrust often discourages counseling, inhibits recovery, and reflects the lack of counselor training in alcoholism addiction, as well as the lack of understanding of the principles of 12-step anonymous programs. Competent and supportive counselors need to understand the therapeutic interventions that occur both inside the counseling office and in the 12-step support groups, in order to maximize client recovery.

This article will explore the benefits derived from participation in AA as a therapeutic strategy of cognitive restructuring. This cognitive intervention will be defined and examined in terms of its effectiveness with various populations in general, and, specifically, with alcoholics. Therapeutic gains will be discussed considering areas of participation in the 12-step program such as, meetings, sponsorship, and working the 12 steps.

## COGNITIVE RESTRUCTURING

This section examines the history and development of cognitive restructuring, including definition, goal, and procedures, and concludes with populations and issues that have been impacted successfully by cognitive restructuring.

Traditional therapy utilizes cognitive approaches. Cognitive counseling regards thinking errors as the basis for emotional upsets and inappropriate behaviors, and focuses on internal dialogue as a foundation for a person’s reaction to a life event. Beck (1976) is often credited with first using cognitive therapy for treatment of depression in the early 1960s. Since then, cognitive treatment has been used with a wide variety of client problems and populations.

Ellis, Beck, Meichenbaum, and Burns all address cognitive restructuring. Ellis (1962) explained “rational and irrational thinking.” When thought, assumptions, and expectations are inaccurate, false, or irrational, clinical intervention into the thought process, rather than the responses to it, is appropriate. An individual learns some psychological distance in cognitive restructuring, in order to examine thoughts, see them as misconceptions in light of rational evidence, and change the perception. Cognitive restructuring helps a client control emotions and, ultimately, behaviors, by convincing the client that certain ideas are irrational and by teaching more rational, less defeating ideas. Beck (1976) described “automatic thoughts.” These are thoughts that spring up without deliberate reasoning, usually unaware to the client or uncritically accepted as true, and cause negative emotions. He identified four patterns: dichotomous thinking (things are either good or bad), overgeneralization (arriving at conclusions based on little data), magnification (catastrophizing), and arbitrary inference (arriving at conclusions without evidence). Meichenbaum (1977) discussed “self instructions.” His cognitive-behavioral modification is self-instructional therapy. The client is taught to focus on self-talk and to modify the instructions. Cognitive restructuring plays a central role in this theory by helping the client to reorganize aspects of thinking and to become in control, or his or her own “Executive Processor,” and direct the restructured thoughts. Burns (1980) outlined “distorted thinking.” His cognitive approach begins with understanding that a person feels the way one thinks. Once the connection is made between thought and feeling, the next step is to examine the illogical thoughts that contribute to the bad feelings. Burns put these distorted thoughts into 10 categories: all-or-nothing thinking, overgeneralization, mental filter, discounting the positives, jumping to conclusions (mind-reading and fortune-telling), magnification or minimization, emotional reasoning, should statements, labeling, and blame. In summary, cognitive therapists believe that a person needs to be taught to attend to shifts in affect, and that if a person is helped to effectively and positively think about life events, then negativity and behavior, which causes disruption, will lessen, allowing the client to have the goal of moving forward with a happier and more fulfilling life (Patterson & Welfel, 1994).

This goal is reiterated by Kaarsemaker, Jedding, and Lange (1986), with further clarification of how this is therapeutically achieved. They defined the goal of cognitive restructuring as a verbal intervention that challenges the client to find a new way of seeing his or her situation and to begin to effect positive change. They examined the verbal and behavioral interventions used by therapists in the cognitive restructuring process. They devised seven exclusive categories in this process: making comparisons, stressing consequences, giving assignments, providing information, reformulation, gathering information, and challenging the language of the client. Lange and Van Woudenberg (1994) further examined these categories in therapeutic settings, concluding that therapists used a particular intervention according to the therapy model they most practiced. Goldfried’s (1988) research stated that there was no empirical support for any one therapeutic restructuring procedure over another. However, he translated several general principles that underline the therapeutic procedure for cognitive restructuring into a four-step process: (a) helping the client to see that thoughts affect emotional responses, (b) helping the client to see unrealistic beliefs and to offer alternatives to those beliefs, (c) exploring deeper awareness into beliefs and developing a hierarchial structure, and (d) helping the client to reevaluate beliefs and provide guidelines and practice for change and mastery.

This cognitive restructuring goal and these procedures have been successful with many populations with diverse issues such as, anxiety, depression, suicidal ideation, obsessions, relationship issues, and addictions. These issues all correlate with issues endemic to the alcoholic population. Goldfried (1988) discussed the theoretical

application of using cognitive restructuring for symptom reduction in anxiety-based disorders. He considered it an appropriate intervention for a variety of forms of anxiety, especially "forms of social-evaluative anxiety" where there is "excessive concern" over other peoples' negative reactions (p. 66). Beck's (1976) cognitive restructuring approach in working with people who suffer from depression was that faulty thoughts were causal to the basic symptom of depression. Patsiokas and Clum (1985) studied the effects of cognitive restructuring on suicide attempters, often with accompanying depression, and noted significant improvements with this intervention. Suicide ideations are filled with distorted cognitions and faulty perceptions. Simos and Dimitriou (1994) used cognitive restructuring with obsessional rumination. Difficulty in realizing thoughts as irrational was also complicated by a culturally implied superstition. Cognitive restructuring involved realistic perceptions of responsibility, while attending to cultural beliefs. Huber and Milstein (1985) found the use of cognitive restructuring particularly beneficial in the couple's therapy and relationship difficulties. It helped to modify the underlying unrealistic beliefs couples held about their partners and their relationships and to restructure realistic goals and understandings.

Many addictive behaviors are also often treated successfully with cognitive restructuring. The Sylvain and Ladoucheur (1992) study showed some impact from the use of cognitive restructuring on the faulty thoughts and perceptions of gamblers in decreasing faulty verbalizations, increasing adequate verbalizations, thus decreasing frequency of gambling in controlled gambling situations. Haaga and Allison (1994) studied smokers' relapses in reference to cognitive coping tactics. They found that cognitive restructuring was used more consistently by abstainers then lapsers, and was associated with maintaining abstinence. Pecsok and Fremouw (1988) evaluated the effect of cognitive restructuring in binge-eating among restrained eaters and found the intervention beneficial in reducing the magnitude of the binges. Effective treatments for bulimia nervosa have included cognitive restructuring as a major component, based on the fact that dysfunctional thinking and irrational perceptions lie at the root of binge-eating and purging behaviors (Fairburn, 1981; Wilson, 1984).

## COGNITIVE RESTRUCTURING AND THE 12 STEPS OF AA

Alcoholic treatment utilizes cognitive restructuring. Henman and Henman (1990) discussed their model of counseling alcoholics, which encourages 12-step program participation with a therapy based on cognitive-behavioral modification and neuro-linguistic programming (NLP) called, Cognitive-Perceptual Reconstruction (CPR). This model helps the alcoholic work interactively with the counselor to "explore and reframe" (cognitive restructuring) the old faulty alcoholic "assumptions, beliefs, attitudes, perceptual filters, internal dialogue, and unconscious patterns of processing information" (p. 107). The client is taught awareness of internal thought and dialogue and the process that is needed to challenge and change dysfunctional thinking.

Brown (1985) stated that with the progression of alcohol addiction, certain changes in cognitions occur, which form what has been commonly referred to as "alcoholic thinking." These are ways of thinking and rationalizations that are also accompanied by characteristics of "grandiosity, omnipotence, and low frustration tolerance" (p. 97). Denial of these cognitive changes grows with the addiction and creates emotional immaturity, self-centeredness, and irresponsibility. Henman and Henman (1990) have also stated that alcohol addiction is a thought disorder and that these characteristic qualities contain the alcoholic's primary defenses.

These defenses are discussed by Bean-Bayog (1993) as three basic cognitive distortions that are held by active alcoholics: (a) they deny that they cannot control drinking; (b) they believe they drink abnormally because of pain and that drinking relieves pain, they do not see that drinking becomes the source of pain; and (c) they are ignorant and hopeless about solving this problem. Typical reactions to suggestions of recovery through AA are met most often by the alcoholic with furtive interest as well as fascination, and overtly with fear, shame, repression, revulsion, and rage. Abstinence from alcohol and changes in thinking along with actions that stabilize the commitment to change are necessary ingredients for recovery.

These necessary ingredients to recovery are best introduced at AA meetings, which provide an atmosphere in which cognitive restructuring can take place. Khantzian and Mack (1994) refer to AA meetings as a reprogramming process. The 12-step group encourages and supports alcoholics to explore and own selfish, self-seeking, and self-centered thinking, which brought them to AA in the first place. Members hear other members tell stories of their drunken thoughts, feelings, and behaviors. These narratives are familiar to all alcoholics in AA meetings and provide the drinkers with mounting external evidence that something was and is not right about their drinking and their cognitions, which underlie their substance abuse. Attendance at meetings provides alcoholics with "emotional arousal, hope, and dependence on others for relief" (George, 1990, p. 167). In the presence of fellow alcoholics for whom self-regulation has been an ongoing struggle, alcoholics learn that dependence on others is key to gaining strength for continued abstinence.

Attendance at AA meetings also allows members to learn the messages of cognitive restructuring. In AA, there are numerous and often-used slogans that have been gleaned from the AA literature. The slogans reflect some of the issues, like control, power, and distorted thinking, which alcoholics have struggled with while drinking. Repeatedly hearing these catch phrases assists recovering alcoholics to fight old ways of thinking. Robertson (1988)

suggested that alcoholics cannot think straight and that these slogans provide extra protection. These sayings include, but are not limited to: "Let go and let God"; "Live and let live"; "Easy does it"; "Keep it simple"; and "One day at a time." Drinking alcoholics are in a battle for control over their drinking behavior, denying that they cannot control the behavior, only to lose control when they do drink. This distorted thinking about self-control can be dismantled with the slogans, which teach about relinquishing control.

Sponsorship is an additional area that operates as a cognitive strategy for change. Sponsors play a pivotal role in members working a solid program of recovery. AA sponsors serve as mentors and teachers for newcomers and assist in the development of new cognitions. Sponsorship is of paramount importance. Chappel (1993) found that 85% of AA members have sponsors. Sponsorship also serves a dual purpose. Sheeren (1988) found that the most important predictor of stable sobriety was being a sponsor.

The 12 steps of AA formulate the basis for cognitive restructuring and abstinence. DiClemente (1993) examined the 12-step program and indicated that it addressed significant problems for alcoholics with faulty beliefs and maladaptive cognitions, which need to be identified and changed in recovery. AA phrases like "stinking thinking" are commonly used in program to identify thought patterns that lead to relapse and interfere with sobriety.

According to AA's *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous 1981), the 12 steps, "are a group of principles, spiritual in their nature, which is practiced as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole" (p. 15). *Alcoholics Anonymous* commonly referred to as *The Big Book* (Alcoholics Anonymous World Services, Inc., 1986), discussed the necessity for thoroughness and honesty in following the 12 steps, in order to change lives. The necessity to restructure thinking is addressed: "Some of us have tried to hold onto our old ideas and the result was nil until we let go absolutely" (p. 58). The letting go of old ideas and the turning of lives over to a higher power, a newly structured thought for most alcoholics, is fundamental to the 12-step recovery process. "This concept was the keystone of the new and triumphant arch through which we passed to freedom" (p. 62).

Fowler (1993) created an understanding of cognitive and affective recovery using a 12-step commitment, based on and expanding the work of Brown's (1985) phases of recovery, a progression from the drinking phase, through transition, early recovery, and ongoing recovery. The initial drinking phase cognitions are compartmentalized, with denial, defensiveness, manipulation, and selective screening operant. Object attachment is to alcohol. The therapeutic strategy is to try to break through the denial and faulty belief system. The transition phase is characterized by the admission of loss of control and alcoholism and is pivotal with the beginning of learning a new language (restructured cognitions) of recovery and relinquishing the old faulty thinking. The therapeutic strategies are concrete guidance, imitation, and reimaging, moving the object attachment from alcohol to AA meetings, slogans, and Steps 1 to 3. The early recovery phase starts with the beginning of an integration of new attitudes (restructured cognitions) resulting in new behaviors, moving from the isolated self-reliance based in old faulty thinking and ways of acting that perpetuated the addiction, to the ability to ask for help, rely upon a group, become teachable, and begin to reimage the self. The therapeutic strategies are 12-step self-exploration and therapy, grasping the paradox of freedom through dependence. Object attachment moves to include sponsorship, AA principles, and a higher power. The ongoing recovery phase begins with the realization that the 12 steps are a continuing life process. Identification of character defects and distorted life patterns using family of origin work and the 12 steps as tools for restructuring and reconstructing the past. Therapeutic strategies are based on critical reflection on beliefs and practices using the object attachment of sponsors, groups, friends, therapy, books, higher power, and meetings, to formulate a new recovering alcoholic identity that has an executive system that helps to activate and monitor integrated cognitions and continual ongoing practices. Henman and Henman (1990) create, in their CPR treatment, what they call, a "new program adult" utilizing the new recovering cognitions to monitor the old irresponsible alcoholic "2-year-old" personality.

George (1990) stated that in order to get and maintain sobriety, first, one does not go through these 12 steps in a simple linear process. A new member of AA may, in fact, take them initially one after the other, but soon learns that recovery is a continual cycling through the various steps, with ongoing work, study, and discussion within the AA program. Second, step work involves effort and a commitment to the AA program. "Effort simply means to be willing to think new thoughts, to try new behaviors, to make an effort to do those things which are necessary to 'working the program'" (p. 169).

The program is a unified process. The 12 steps cannot be taken individually. The first three steps together provide the basis for a cognitive restructuring that allows for the distorted alcoholic cognitions, emotions, and behaviors to change. Step 1 challenges the cognitive distortions of grandiosity, defiance, and isolation by admitting powerlessness together with other alcoholics, "we admitted we were powerless. . . . " Step 2 restructures this powerlessness into reliance and hope through belief in a higher power. Step 3 is the action step that cuts out self-will and begins dependence upon this higher power.

**Step 1. We admitted we were powerless over alcohol—that our lives had become unmanageable.**

Tiebout (1953), Bateson (1971), and Brown (1993) examined the beliefs about power and control with mainte-

nance of abstinence and life-long change. Distorted faulty beliefs concerning the power of self and control form the basis of addiction. Brown (1993) stated that the recovery process paradoxically is based in relinquishing that self-power to find true power and freedom. "Recovery involves relinquishing the core belief of power over self and accepting the reality of loss of control over one's drinking or use of substance. Drinking alcoholics often believe they are empowered by alcohol when in fact they are victimized by it. Recovering alcoholics acknowledge that they have no power over alcohol and are, in turn, empowered by the truth and their acceptance of it" (p. 138).

*Twelve Steps and Twelve Traditions* (Alcoholics Anonymous, 1981) elaborated:

> Who cares to admit complete defeat? Practically no one, of course. Every natural instinct cries out against this idea of personal powerlessness . . . Upon entering A.A. we soon take quite another view of this absolute humiliation. We perceive that only through utter defeat are we able to take our first steps toward liberation and strength. Our admission of personal powerlessness finally turn out to be firm bedrock upon which happy and purposeful lives may be built. . . . Our sponsors declared that we were victims of a mental obsession so subtly powerful that no amount of human willpower could break it. . . . We stand ready to do anything which will lift the merciless obsession from us. (pp. 21–24)

Brown (1993) stated that powerlessness alone does not lead to sobriety. However, powerlessness acknowledged within a "complementary schema" does. Recovering alcoholics do not recover in isolation.

**Step 2. Came to believe that a Power greater than ourselves could restore us to sanity.**

Brown (1993) reflected how the reliance on a higher power offers alcoholics a continual challenge to that "alcoholic thinking" of omnipotence, grandiosity, and defiance. Bateson (1971) stated:

> Implicit in the combination of these two steps is an extraordinary, and I believe correct idea: the experience of defeat not only serves to convince the alcoholic a change is necessary; it is the first spiritual experience. The myth of self-power is thereby broken by the demonstration of greater power. (p. 3)

He further elaborated that alcoholics are steeped in pride and in "symmetrical, competitive" relationships with themselves and others. This is based on distorted dichotomous thinking of winning and losing, which is permeated with control and power. Steps 1 and 2, admitting powerlessness and then reliance on a higher power, allow alcoholics to shift to complementary thinking and relationships, becoming of "service rather than dominance" (p. 16) and laying the foundations for the remaining steps.

**Step 3. Made a decision to turn our will and lives over to the care of God as we understand Him.**

The step is often referred to as the action step within the first three steps. It is directly linked to cognitive restructuring. Here, the concept of self-will is challenged and removed and dependency on a higher power is cultivated. Brown (1993) stated that the "first three steps are a direct assault on pathological egocentricity or narcissism, a condition that includes an inflated unrealistic belief in self-power" (p. 146), which needs to be changed for recovery to ensue.

The *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous, 1981) claims that the effectiveness of a recovery program depends upon how thoroughly this step is taken. The program alludes to a dissolving of egotism. The alcoholic challenges self-sufficiency and instead claims dependency. The difficulty and misunderstanding of this step with traditional psychology is discussed in AA literature. Dependency of any type is often viewed by mental health professionals as pathological. AA calls for a reexamination of the concept that all forms of dependency are wrong and suggests the need for an understanding of dependency in program as a process of bringing one's will in conformity with that of a higher power's will. "In times of emotional disturbance and indecision, we can pause, ask for quiet, and in the stillness simply say: 'God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference'"(pp. 40–41). The flexibility this step allows in using one's own understanding of a higher power, be it person, idea, or concept, helps make this step easier for many people who do have the traditional Judeo-Christian concepts of God, and thereby works to exclude no one from the recovery options offered (George, 1990).

**Step 4. Made a searching and moral inventory of ourselves.**
**Step 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.**
**Step 6. Were entirely ready to have God remove all these defects of character.**
**Step 7. Humbly asked Him to remove our shortcomings.**
**Step 8. Made a list of all persons we had harmed, and became willing to make amends to them all.**
**Step 9. Made direct amends to such people whenever possible, except when to do so would injure them or others.**

Steps 4 though 9 are often referred to as the "housecleaning" steps. These steps involve beginning with a personal moral inventory done with thoroughness and rigorous honesty, working with others to address interpersonal problems and increase awareness of personal defects. Most practicing alcoholics do not think to use introspection to focus on their defects. Introspection is integral both for recovery and as insurance against relapse by listing defects and persons that have been harmed with the destructive alcoholic behaviors and attitudes and making amends to them, while continuing to look for and resolve interpersonal problems (DiClemente, 1993).

Guilt from past actions or omissions are decreased by confession, atonement, and making amends, so there is less need for defenses, projections, and distorted cognitions (Bean-Bayog, 1993).

**Step 10. Continued to take personal inventory and when we were wrong promptly admitted it.**
**Step 11. Sought through prayer and meditation to improve our conscious contact with God, as we understand Him, praying only for knowledge of His will for us and the power to carry that out.**
**Step 12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.**

Steps 10, 11, and 12 are often referred to as the "maintenance" steps (Alcoholics Anonymous, 1981). Using a present time focus, these steps call for a restructured self, based on restructured cognitions, as the alcoholic moves through the stages of recovery. These steps require a continuing vigilance, spiritual development, a contact and reliance on a higher power, and attitudinal and characteristic trait changes that can help recovering alcoholics awaken to and maintain ego reduction, honesty, humility, gratitude, and responsibility, while being connected to something greater than themselves (Brown, 1993). In the 12th step, a recovering person moves toward altruism and uses his or her personal recovery to help others (Bean-Bayog, 1993).

## CONCLUSION

Alcoholism needs to be thought of as a thinking disorder, with participation in AA and professional treatment working together to provide effective establishment and maintenance of abstinence. It is necessary that this unified action between AA and therapy be encouraged to facilitate client recovery. Attendance at AA meetings, obtaining, using, and eventually becoming a sponsor, and working the 12 steps provide a mechanism through which alcoholics learn new cognitions of recovery that can then be supported in counseling.

Mental health professionals who work with addicted persons need to possess knowledge of AA's 12 steps to ensure sound, ethically competent treatment. Information on how to access clients' local AA recovery support systems, and how to maximize their impact on the recovery process is necessary for those working with persons seeking assistance with recovery from chemical dependency.

Additional empirical research needs to be undertaken that calls for verification of AA's 12-step program as cognitive restructuring and discusses correlation of recovery with sound collaborative working arrangements of counseling professionals and AA, specifically addressing and working to further understand those areas that claim to have been historically problematic, such as spirituality, powerlessness, dependency, and alcoholic identification.

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