

# Treatment of Alcohol Use Disorder: Integration of Alcoholics Anonymous and Cognitive Behavioral Therapy

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Alcohol use disorders (AUDs) are among the most common psychological disorders experienced by Americans. Only 10% of individuals with this disorder receive treatment, and the most popular treatment is some form of 12-Step involvement. Although there is evidence for the efficacy of 12-Step treatment, most AUD treatment providers are not well versed in 12-Step principles and practices. Recent work suggests that clinicians and training directors do not feel confident in their knowledge about and training in 12-Step programs. This concern is not new, and programs have struggled to find ways to help trainees bridge this knowledge gap in a way that would be beneficial to clients. Therefore, the current article seeks to address this by clarifying common misconceptions about Alcoholics Anonymous (AA), describing AA's conceptualization of alcoholism, and its goal. We also offer a number of ways in which the 12-Steps share principles and skills/techniques with cognitive behavioral therapies for AUD. Finally, we provide training recommendations for closing the training gap through increased trainee exposure to 12-Step programs and interprofessional training opportunities. It is our hope that once AUD treatment providers understand that the 12-Steps are meant to accomplish similar goals using similar techniques to Evidence Based Practices (EBPs) for AUDs, they will be able to provide more integrated, or at least less disparate, treatments to individuals with AUDs.

## Public Significance Statement

This article presents information for clinicians about how to work with alcohol use disorder clients who engage in both cognitive behavioral therapy and Alcoholics Anonymous. Recommendations for how to integrate the two approaches are offered.

**Keywords:** alcohol, treatment, 12-Steps, cognitive behavioral therapy

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Alcohol use disorders (AUDs) are among the most common psychological disorders experienced by Americans, with 13.9% of individuals diagnosed in a given year and a lifetime prevalence of 29.1% (Grant et al., 2015). However, only 10% of those individuals receive treatment (Jonas et al., 2014), and the most popular treatment is some form of 12-Step involvement (Laudet, 2008). Individuals can engage in 12-Step programs, such as Alcoholics Anonymous (AA), by attending mutual self-help groups, by meeting with a peer who is in recovery (the sponsor), and/or by engaging in a more formal outpatient or residential treatment program that uses 12-Step principles. Although there is a great deal of evidence for the efficacy of 12-Step approaches (see below), many AUD treatment providers are not well versed in 12-Step principles and practices (e.g., Bergman & DeLucia, 2014).

The American Psychological Association (APA) Standards of Accreditation (APA, 2015) do not specify competencies in particular treatment modalities, preferring instead to mandate that training programs deliver education and training experiences in evidence-based treatments. Historically, psychology and counseling programs have not uniformly trained students in issues related to AUDs, including evidence-based treatments (Chiert, Gold, & Taylor, 1994; Dimoff, Sayette, & Norcross, 2017; Madson, Bethea, Daniel, & Necaise, 2008). Although there is recognition of a need to develop providers with expertise in AUDs, for example, the APA recommends licensed psychologists who desire evidence proficiency secure credentialing as a Master Addiction Counselor through the National Association for Addiction Professionals (APA, 2018), there is still scant attention paid to didactic education on 12-Step programs, much less how to treat clients who engage in both cognitive behavioral theory (CBT)-based and 12-Step-based approaches simultaneously. However, despite clinicians feeling ill-prepared to treat AUD clients (Cardoso, Pruett, Chan, & Tansy, 2006; Cellucci & Vik, 2001), they report that they refer to 12-Step groups and use relapse-prevention coping skills training in their treatment of patients with substance use disorder (SUDs; Cardoso et al., 2006). This article presents some ways for clinicians to think about the overlap between CBT and 12-Step based approaches to AUDs in order to more effectively work with patients with these disorders who engage in both modalities. Because of the popularity and prevalence of 12-Step treatments, and because many clients who engage in AUD treatment with a licensed clinician supplement their formal treatment with 12-Step involvement, it is critical for AUD treatment providers to think about how to integrate these modalities.

### Evidence-Based Treatments for AUD and 12-Step Approaches

Psychosocial treatments for AUD with the most empirical support come from the CBT tradition, categorized as “behavioral therapies.” These treatments can be administered in individual, group, and family formats. Relapse prevention (RP; e.g., Kadden et al., 1995; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002) is a manualized CBT-based treatment approach in which clients are taught how to manage urges to use, how to challenge thoughts about their substance use, how to engage assertive communication skills, and how to use alternative behaviors instead of substance use to cope with stressors. New skills are taught didactically, then practiced in role-plays (Monti et al., 2002). Another Evidence

Based Treatment (EBT) for AUD, motivational enhancement therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1995), is based in the motivational interviewing (MI) model (Miller et al., 1995), and it aims to increase a client’s internal motivation to change by eliciting a commitment to reduce substance use via Socratic questioning that challenges a person’s reasons to continue using. A variant of the 12-Step approach, 12-Step Facilitation (Nowinski, Baker, & Carroll, 1995), is a manualized treatment that encourages and enhances a client’s participation in AA. Its outcomes are also positive and are even comparable to RP and MET (Project MATCH Research Group, 1997, 1998). Additional 12-Step approaches, including AA, involve attending mutual help groups, working with an individual successful in recovery, the sponsor, and navigating through the 12-Steps toward obtaining and maintaining abstinence (see Miller & Kurtz, 1994, for an excellent discussion of these approaches).

Much residential AUD treatment occurs in 28-day programs that encourage adjunctive 12-Step involvement, although attendance at 12-Step meetings often occurs at the end of the day, after “treatment” (i.e., group and individual psychotherapy) ends. Further, many of the individuals who provide residential AUD treatment (e.g., Licensed Chemical Dependency Counselors) primarily subscribe to a 12-Step model (Fuller & Hiller-Sturmhöfel, 1999). The APA’s Recovery to Practice program (APA & Jansen, 2014) describes the importance of working with paraprofessionals and individuals in recovery (“peer support specialists”) and provides training for clinicians to effectively integrate these peers in recovery into treatment to support clients seeking to obtain and maintain their own recovery.

When EBT-trained clinicians work from a CBT model, it can be difficult to reconcile treatment information for clients who also engage in 12-Step programming because of lack of familiarity with the AA model. More specifically, clinicians may not have a strong enough knowledge base to address client questions about how their 12-Step work fits with what they are doing in a CBT-focused session. Since satisfaction with SUD treatment predicts better service utilization and treatment outcomes (Kendra, Weingardt, Cucciare, & Timko, 2015), AUD treatment providers working with patients involved in 12-Step programs may increase patient satisfaction and strengthen the therapeutic alliance through a better understanding of the 12-Steps (Dennis, Roland, & Loney, 2013). Below, we compare and contrast overlapping CBT and 12-Step principles and techniques, provide considerations for integration of 12-Steps and CBT, and provide training recommendations for clinicians.

### Understanding AA

Over the past 25 years, the scientific literature, comprising various study designs and methodologies, including randomized control trials, propensity score matching, and rigorously controlled longitudinal, naturalistic designs, has consistently established the benefits and cost-effectiveness of 12-Step involvement (for a detailed and helpful review of this literature, see Kelly, 2017). Read, Kahler, and Stevenson (2001) provide an excellent overview of treatment mechanisms for a variety of evidence-based approaches, including CBT and 12-Step treatments, comparing them on a global level. This article offers a brief overview of AA and AA-related misconceptions, as well as more specific comparisons

between principles and techniques across CBT and 12-Step approaches, followed by a set of recommendations for working with AUD patients and for training AUD treatment providers.

### The 12-Step Conceptualization of Alcoholism

AA posits that the addiction cycle occurs on both a physical and cognitive level. The Big Book (BB), AA's recovery manual, notes that since physical craving follows alcohol consumption, the alcoholic's primary problem lies in the cognitive process that underlies a return to drinking despite the myriad of negative consequences. Ultimately, the BB concludes that the primary problem is the maladaptive pattern of thinking that causes the negative affect (i.e., restlessness, irritability, and discontentedness), which the alcoholic relieves with alcohol.

### Common Misconceptions

**The fellowship is synonymous with the program.** The fellowship consists of the community of AA members who attend AA meetings, while the program refers to working the 12-Steps. An individual may actively attend AA meetings but never engage in the program of recovery. This can confound research on AA, since many studies measure AA attendance but do not specify whether the individual has worked the 12-Steps. Importantly, the fellowship and the program can overlap when AA members attend meetings motivated by the 12th Step's suggestion to work with other alcoholics.

**It is a religious program requiring belief in God to work the steps.** Although a historic Christian influence exists at the level of broad principles (e.g., self-examination, confession, restitution, and service to others; Kurtz, 1979; McCrady, 1994), AA considers itself "a spiritual program of action" (AA, 2001, p. 85) that is "not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses or opposes any causes" (AA, 2013). The BB asks only whether one is "even willing to believe that there is a Power greater than myself" (AA, 2001, p. 47). No requirement to define this Power or state its existence with absolute certainty exists. One of AA's earliest members, Jim B., an atheist who inspired language changes in the BB from God to "Power greater than ourselves" and "God of our understanding," remained a sober and consistent member of AA for 30 years. For Jim and other atheist and agnostic members, the AA group can serve as Power greater than oneself. Other AA members turn God into the acronym G.O.D. (Good Orderly Direction). Atheist and agnostic drinkers can find a home in AA, despite the spirituality, by finding a Power greater than themselves as they understand it.

**Negates personal responsibility for sobriety.** Although the First Step asks individuals to admit "powerlessness" over alcohol, once alcoholics discover a "Power greater than [themselves]" (AA, 2001, p. 45) to rely upon, they are no longer powerless over alcohol. Rather than being driven by alcoholic compulsion, the BB suggests that this Power provides the individual with the actual freedom to choose whether to pick up the first drink.

**Membership requires motivation to stop drinking.** The Third Tradition states "the *only* requirement for membership is a desire to stop drinking" (AA, 2004, p. 139). An important distinction exists between desire and motivation. One can desire a par-

ticular outcome, but experience little motivation to achieve that end. Further, although the AA program aims to help alcoholics achieve complete abstinence from alcohol, AA does not require current abstinence from alcohol for membership. In fact, since AA posits that the alcoholic is "without defense against the first drink" (AA, 2001, p. 24), AA would expect many of its members to continue drinking until they complete the Steps and gain access to a Power greater than themselves that can serve as a defense against the first drink. AA does not even require working the Steps for membership, although they are "suggested as a program of recovery" (AA, 2001, p. 59).

### Goals of the 12-Steps

The goal of the 12-Steps is to facilitate a "spiritual awakening" (sometimes referred to as a "spiritual experience"). The BB defines a spiritual experience as of the "nature of huge emotional displacements and rearrangements. Ideas, emotions and attitudes which were once the guiding forces of the lives of these men are suddenly cast to one side and a completely new set of conceptions and motives begin to dominate them" (AA, 2001, p. 27). Simply, the goal of the 12-Steps is to identify the ideas, emotions, and attitudes that cause problems and replace them with new, more adaptive ones. In doing so, the 12-Steps seek to help the individual not only achieve and maintain total abstinence from alcohol but also engage in altruistic, prosocial behavior: "Our real purpose is to fit ourselves to be of maximum service to God and the people about us" (AA, 2001, p. 77).

### Similarities and Differences Between CBT and 12-Step Approaches

While AA processes may overlap with a number of different evidence-based treatment modalities, CBT for SUDs emerges as an obvious and natural partner with which to explore overlap given both approaches' common interest in identifying and changing maladaptive thoughts, feelings, and behaviors (see Magura, 2007, for an overview of the relationship between 12-Step involvement and treatment for SUDs). CBT for SUDs comprises various interventions, including motivational interventions, contingency management, and RP, as well as various clinical skills/elements (see McHugh, Hearon, & Otto, 2010, for an overview of CBT for SUDs). Despite real and perceived differences in approaches (Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001), CBT for SUDs and 12-Step approaches significantly overlap in both broad interventions and practical skills/techniques rooted in cognitive, behavioral, and social learning theories (McCrady, 1994; Morgenstern et al., 2001) and change models (Morgenstern & McCrady, 1992).

### Overlapping Interventions

**Motivational enhancement.** The practice and structure of AA overlap with motivational enhancement interventions that are often employed in AUD treatment (Miller et al., 1995). Practically, the BB (AA, 2001) suggests that motivation is best achieved by sharing one's personal story, letting potential members identify with the story, and then sharing the hope and gifts of recovery. Similar to MI's pedagogy, this format targets behavioral ambiva-

lence and creates disparity between individuals' current state and who/how they desire to be. Structurally, the BB's chapters correspond to Prochaska and DiClemente's (1982, 1983) stages of change. The first few chapters help individuals recognize that there may be a grave and hopeless problem (precontemplation) that some individuals have recovered from—a solution open to anyone (contemplation). The BB then details what the solution entails in order to prepare the individual for what is to come (preparation). The transition from preparation to action is signaled by the following line in the BB: "If you have decided you want what we have and are willing to go to any length to get it—then you are ready to take certain steps" (AA, 2001, p. 58). At this point, an individual begin the Steps. Interestingly, the chapter in the BB concerning Steps 4–11 is called "Into Action."

**Contingency management.** Contingency management has proven effective for fostering abstinence from alcohol (Petry, Martin, Cooney, & Kranzler, 2000). AA groups offer a number of nondrug reinforcers for abstinence aimed at countering drug-related rewards. Most AA groups award periods of sobriety with a chip or a coin indicating the length of abstinence. In the first year, sobriety is celebrated in 3-month increments. Social reinforcement in the form of applause from the group accompanies the presentation of the coin. Celebrations for years of sobriety are often larger and more elaborate. Frequently, members are also given responsibilities within the group and the AA organization as a whole as they progress in sobriety. The approval and trust of the group often functions as an enforcer.

**RP.** RP comprises the identification of situations and cues, which may increase the likelihood of an individual drinking (Larimer, Palmer, & Marlatt, 1999). A number of slogans permeate AA's culture, but relevant to RP, one prominent slogan says, "People, places, and things." This slogan aims to remind members to avoid old people, place, and things that serve as temptations, cues, or reminders of drinking.

## Overlapping Elements/Skills

**Cognitive restructuring.** CBT interventions for SUDs rely heavily upon cognitive restructuring of maladaptive alcohol-related beliefs, including beliefs that directly precipitate drinking behavior as well as beliefs that create mood states that precipitate drinking. The Fourth Step challenges AA members to create an inventory of fears, resentments, and sexual conduct that is intended to reveal the irrational/maladaptive beliefs about themselves, others, and the world and encourages them to replace them with more adaptive beliefs. Members share this inventory with their sponsor, who can assist in pointing out irrational/maladaptive beliefs. These maladaptive beliefs are called "stinking thinking" among AA members. AA is also permeated with slogans that are repeated as a means of altering faulty/maladaptive beliefs: "Think the drink through; Let go, and let God; This too shall pass; One day at a time."

**Prosocial behavioral activation/social engagement.** CBT encourages interpersonal interaction and prosocial behavior in order to foster positive self-schemas and increase the experience of personal value a client receives through service to others. The *fellowship* (i.e., meetings) of AA is intended to foster positive social peer engagement and social support for the recovering individual. Members are encouraged to reach out to their support

group, particularly when they are struggling with cravings or difficult life situations. However, the *program* (i.e., the Steps) of AA is also founded upon the importance of prosocial behavior. AA characterizes itself as an "altruistic movement," noting that the alcoholic works out his or her solution on a "spiritual as well as an altruistic plane" (AA, 2001, p. xxiv). AA states that the alcoholic's sobriety depends upon the "constant thought of others and how we may help meet their needs" (AA, 2001, p. 20). It also informs alcoholics that they should try to be of "maximum service to God and the people about us" (AA, 2001, p. 77). Finally, the 12th Step embodies the prosocial nature of the AA program, informing alcoholics that in order to safeguard their sobriety, they need to reach out to others and share the solution: "Nothing will so much insure immunity from drinking as intensive work with other alcoholics. . . . Carry this message to other alcoholics! You can help when no one else can" (AA, 2001, p. 89).

**Relaxation/imagery.** Many CBT interventions for SUD contain relaxation skills, mindfulness-based relaxation, and imagery exercises (Bowen, Chawla, & Marlatt, 2010; Temme, Fenster, & Ream, 2012) aimed at increasing positive coping, reducing stress, and increasing motivation toward an alcohol-free lifestyle. Similarly, the 12-Steps also have components related to relaxation/meditation and imagery. AA suggests in the Eleventh Step that individuals engage in a daily morning meditation. Individuals are invited to use their imagination to think about the day ahead and to consider which action/decisions they might make. Through this meditation and its daily effects, AA believes that an individual is in "less danger of excitement, fear, anger, worry, self-pit, or foolish decisions" (AA, 2001, p. 88). Greater relaxation and affective coping often accompany the day following this morning meditation. Furthermore, AA notes that alcoholics should remind themselves throughout the day, "Thy will be done" (AA, 2001, p. 88). When understood in conjunction with a line from a popular story in the BB that states, "Acceptance is the answer to all of my problems today" (AA, 2001, p. 417), these ideas invite alcoholics to practice a type of acceptance common to mindfulness-based meditations used for AUD (Bowen et al., 2010).

Table 1 provides some aspects of CBT conceptualization, goals, and treatment of alcoholism. In many cases, there is a 12-Step corollary. Clinicians may benefit from using this table by pairing a CBT intervention with a corresponding skill/practice of the 12-Steps. Table 1 may also help clinicians translate certain 12-Step practices into related CBT language. While the lists are not exhaustive, they provide a beginning for clinicians interested in integrating CBT and 12-Steps into their practice as well as a foundation from which to begin translating CBT into 12-Step language and vice versa (where appropriate).

AA is a culture, possessing its own language, values, beliefs, hierarchy, rules, and rituals. Clinicians interested in delivering culturally competent therapy should understand the program of AA so that they can provide culturally informed therapy to clients who attend AA, as well as make appropriate referrals to AA programming. Although AA is not a therapy per se, it can serve as an alternative or an adjunct to therapy. Therefore, while clinicians should not be trained in delivering AA, they should be sufficiently familiar with and educated in the principles, processes, and beliefs of AA so as to be confident and comfortable integrating CBT and AA when and where appropriate.

Table 1

*Common and Divergent Conceptualization, Goals, and Techniques of CBT and AA*

| Variable                                                                                                                                                                                                                                   | CBT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 12-Steps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Broad Conceptualization of Addiction (Epstein & McCrady, 2009 <sup>a,b,c</sup> ; Marlatt, 1996 <sup>a,b,c</sup> )                                                                                                                          | <ul style="list-style-type: none"> <li><sup>a</sup> Negative core beliefs combine with life stressors to produce excessive negative emotions, which then activate drug-related beliefs (that one can best relieve these feelings through alcohol).</li> <li><sup>b</sup> When unpleasant affect arises, the individual neutralizes it by drinking.</li> <li><sup>c</sup> The cycle persists when negative consequences and conflicting/dysfunctional beliefs about drinking lead to anxiety and negative affect.</li> </ul> | <ul style="list-style-type: none"> <li><sup>a</sup> Negative cognitive and psychological states (primarily anxiety, anger, and discontent) arise from thought errors and maladaptive core beliefs relating to needs for emotional/physical security, sex, and status.</li> <li><sup>b,c</sup> An individual drinks to alleviate these negative emotions, which usually increases negative consequences and causes more negative emotions, which continues the cycle of drinking.</li> </ul>                                                                                                                                                                       |
| Goals (Epstein & McCrady, 2009 <sup>a,b,c</sup> )                                                                                                                                                                                          | <ul style="list-style-type: none"> <li><sup>a</sup> Replace dysfunctional core beliefs, cognitive distortions, and their subsequent addictive beliefs with those that are adaptive/positive.</li> <li><sup>b</sup> Help client learn adaptive coping methods</li> <li><sup>c</sup> Sometimes encourage total abstinence, sometimes seek to reduce dependency</li> </ul>                                                                                                                                                     | <ul style="list-style-type: none"> <li><sup>a</sup> Ideas, emotions, and attitudes that were once the guiding forces in one's life are replaced with a completely new set of conceptions and motives that begin to dominate him or her.</li> <li><sup>b</sup> Teach new attitudes, ideas, and behaviors that help the individual handle difficult situations</li> <li><sup>d</sup> Total abstinence</li> </ul>                                                                                                                                                                                                                                                    |
| Cognitive Interventions (Beck, Wright, Newman, & Liese, 1993 <sup>a,b,d,f</sup> ; Kadden et al., 1995 <sup>f</sup> ; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002 <sup>f</sup> )                                                        | <ul style="list-style-type: none"> <li><sup>a</sup> Identifying/modifying drug-related beliefs (cognitive restructuring)</li> <li><sup>b</sup> Daily thought record of negative emotions</li> <li><sup>c</sup> Pros/cons analysis (matrix)</li> <li><sup>d</sup> Reattribution of responsibility</li> <li><sup>e</sup> Imagine healthy/productive life</li> <li><sup>f</sup> Learn problem-solving skills</li> </ul>                                                                                                        | <ul style="list-style-type: none"> <li><sup>a</sup> Fourth step: identifying automatic thoughts and attempting to identify the core beliefs to which they are related</li> <li><sup>a,b</sup> Tenth step: daily admittance of selfish, dishonest, self-seeking, or fearful thoughts or behaviors</li> <li><sup>a</sup> Use of slogans</li> <li><sup>c</sup> Writing the list of the harms drinking has caused (first step)</li> <li><sup>d</sup> Take responsibility for problems: "So our troubles we think are basically of our own making"</li> <li><sup>e</sup> Prayer and meditation</li> </ul>                                                              |
| Behavioral Interventions (Epstein & McCrady, 2009 <sup>a,b,c</sup> ; Hunt & Azrin, 1973 <sup>c</sup> ; Kladner, Hartman, & Sobell, 1984 <sup>d</sup> ; Larimer, Palmer, & Marlatt, 1999 <sup>a</sup> ; Meyers & Smith, 1995 <sup>c</sup> ) | <ul style="list-style-type: none"> <li><sup>a</sup> Stimulus control/identifying triggers</li> <li><sup>b</sup> Social support</li> <li><sup>c</sup> Behavioral activation of prosocial behavior</li> <li><sup>d</sup> Relaxation techniques/training</li> </ul>                                                                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li><sup>a</sup> Avoid old "people, places, &amp; things."</li> <li><sup>b</sup> Call a sponsor or member of a support group</li> <li><sup>c</sup> Working with others, being of maximum service to fellow man, and engaging in altruistic behaviors</li> <li><sup>d</sup> Through daily practicing of the principles of the steps, one will "intuitively know how to handle situations which used to baffle them."</li> <li><sup>d</sup> Prayer and meditation</li> </ul>                                                                                                                                                     |
| Coping/Communication Skills (Bowen, Chawla, & Marlatt, 2010 <sup>a,b,c</sup> ; Epstein & McCrady, 2009 <sup>a,b</sup> ; McHugh, Hearon, & Otto, 2010 <sup>a,b</sup> ; Meyers & Smith, 1995 <sup>a</sup> )                                  | <ul style="list-style-type: none"> <li><sup>a</sup> Interpersonal skills training</li> <li><sup>b</sup> Emotion regulation/distress tolerance</li> <li><sup>c</sup> Acceptance</li> </ul>                                                                                                                                                                                                                                                                                                                                   | <ul style="list-style-type: none"> <li><sup>a</sup> Engaging in the fellowship, having mature communication modeled by sober members of AA</li> <li><sup>a</sup> Practicing patience, tolerance, and love</li> <li><sup>a</sup> Practicing honesty, open-mindedness, and willingness</li> <li><sup>a</sup> Practice making amends when at fault</li> <li><sup>b</sup> Use support group and sponsor in times of distress and for problem solving</li> <li><sup>b</sup> Acknowledge and review inventory of character defects</li> <li><sup>b,c</sup> Prayer/meditation</li> <li><sup>c</sup> Slogans—"Thy Will Be Done" and the Acceptance pages (417)</li> </ul> |

*Note.* Bullet points with the same superscripts are similar or overlapping concepts. CBT superscripts match citations where relevant. CBT = cognitive behavioral therapy; AA = Alcoholics Anonymous.

## Principles and Considerations for Integrating AA and CBT

### Clinician Education and Familiarity

Clinicians should be mindful of their own biases and misconceptions about the AA program and AA members, and they would do well to educate themselves on the research concerning AA. Also, attendance at open AA meetings to better understand the

process and environment would be helpful in the integration of AA and CBT. Clinicians also may access AA's program materials, including the BB, to allow for increased familiarity with the history, principles, and language of AA. These suggestions will help clinicians to be prepared to explain the program of AA to a client and help them understand how it works and to dispel any myths/misinformation about the program. Donovan, Ingalsbe, Benbow, and Daley (2013) and Miller and Kurtz (1994) offer excellent reviews of these approaches as a starting point.

## Which Clients May Benefit From a Referral to AA

As a general principle, clients experiencing deficits in the areas in which AA affects change (see above; i.e., increased self-efficacy, motivation enhancement, and positive social network) should be considered as candidates for a referral. Primarily, for clients for whom the social network is disrupted or supports continued alcohol use, AA involvement can be an important adjunct (Kelly, Stout, Magill, & Tonigan, 2011). In particular, AA involvement may be more beneficial for female clients struggling with anger and anxiety and male clients who need increased social support and abstinence self-efficacy (Project MATCH Research Group, 1997). For religious or spiritual clients, AA may be a natural fit (Tonigan, Miller, & Connors, 2000). If a client is an atheist or agnostic, the clinician can discuss that even clients who do not believe in God can benefit from AA (Tonigan, Miller, & Schermer, 2002), as AA is not explicitly religious and only requires a desire to stop drinking. If a client desires total abstinence or would benefit from total abstinence, then a referral to AA in conjunction with therapy may be beneficial. Clients for whom harm reduction or reduced consumption is the goal would not likely benefit from AA. If a client is in the precontemplation stage of change, AA may help mobilize motivation to change by creating discrepancy between where the client is and seeing where others like him or her are after achieving sobriety. See Donovan et al. (2013) for a review of how special populations, including women, youth, ethnic minorities, and clients with co-occurring disorders, benefit from AA involvement.

## For Clients Engaged in AA and CBT Simultaneously

If a client is currently engaged in AA, when possible, encourage the client to engage in the AA corollary of whatever CBT intervention or skill is being practiced. This will further reinforce the concept. Clinicians should also translate CBT concepts into AA language for clients in AA, so that they can see the compatibility between concepts. Clients will likely be in AA longer than therapy; therefore, understanding CBT concepts in the language with which they will be engaged can be helpful (for excellent examples of the CBT elements within AA and how to translate spiritual concepts into CBT language, see Bristow-Braitman, 1995; Steigerwald & Stone, 1999). Clinicians also should seek to capitalize on cognitive, social, and emotional gains being made in AA in the therapy room.

It is our hope that once clinicians understand that the 12-Steps are meant to accomplish similar goals using similar techniques to EBP for SUDs, they will be able to provide more integrated, or at least less disparate, treatments to individuals with AUD. To that end, below we offer a variety of methods for increasing clinician exposure to 12-Step programs, for increasing interprofessional training opportunities. We also discuss the need for additional research on the overlap between CBT and 12-Step mechanisms of change, as well as how to integrate CBT and AA to enhance treatment outcomes.

## Recommendations for Training

Other authors, notably Miller and Kurtz (1994), have made recommendations for training of AUD treatment providers to work

with clients engaging in AA. We echo and amplify those recommendations here.

### 1. Didactic Training and Education

- a. Incorporate more explicit training in the 12-Step model in coursework and workshops on SUD treatments. Infuse SUD treatment coursework with research on 12-Step process and outcome research.

### 2. Experiential Training Opportunities

- a. Encourage trainees to attend 12-Step meetings as guests.
- b. Work with externship and internship training sites to offer trainees opportunities to observe or participate in 12-Step focused groups.

### 3. Interprofessional Training Opportunities

- a. Interprofessional training includes opportunities for both psychologists and AUD treatment providers to serve on treatment teams together, staffing the same patients.
- b. Offer clinicians more explicit training and education in how to work with peers in recovery. The APA Recovery to Practice training model (APA & Jansen, 2014) offers a guide.
- c. Offer workshops aimed at training peers in recovery in how CBT works for SUDs, and workshops given by 12-Step researchers and practitioners for CBT-focused providers can enhance treatment process and outcomes for both types of providers.

## Future Directions

We suggest further research on how AUD treatment providers learn, understand, and integrate 12-Step programs into their training and practice in AUDs. Where these recommendations are implemented, research on their acceptability and efficacy can further enhance training for effective interventions for AUD. In particular, future research could explore specific ways of integrating the compatible aspects of CBT and 12-Step skills. Research on the effectiveness of such programs may benefit the AUD literature. Also, efforts to “translate” 12-Step language into CBT language and vice versa would be a valuable endeavor that will aid clinical trainees who may work in clinical settings with paraprofessionals. Translational projects may also allow trainees to use 12-Step skills/language more confidently with a client who is in a 12-Step program, knowing that the 12-Steps have CBT corollaries. We suggest offering one or more of the training recommendations above and assessing clinician knowledge about AA pre- and post-training. Finally, research on a trainee’s confidence and competence with the 12-Steps and integration of 12-Steps with CBT approaches should be examined as they relate to outcomes for clients who are engaged in both types of treatment.

Although limited training in SUDs has left many feeling ill-prepared for work in the field, implementing some of the training suggestions above and familiarizing oneself with the 12-Steps and AA programs may help increase trainees’ competence and confi-

dence in their clinical abilities to treat those with AUD. We think interprofessional engagement, treatment integration, and focused training in this field could aid not only clinicians but also those clients whom they serve.

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