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SPIRITUALLY MODIFIED COGNITIVE BEHAVIORAL THERAPY IN THE TREATMENT OF SUBSTANCE ABUSE: A CASE CONCEPTUALIZATION

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A Case Conceptualization

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Abstract

Although approaches to substance abuse treatment have included spiritual aspects and cognitive behavioral aspects, no one treatment modality has included both. This paper reviews the extant literature and explores the theoretical possibility of applying Spiritually Modified Cognitive Behavioral Therapy in the treatment of substance abuse. The author illustrates the case conceptualization of a 25 year old White female with Christian beliefs who is in recovery from opiate dependence. Based on the cognitive case formulation and spiritual assessment that were conducted, implementation specifics include incorporating prayer, scripture, exploration of meaning, and religious visual imagery into standard cognitive behavioral therapy. The author suggests guidelines for practitioners who consider using spiritual interventions.

Spiritually Modified Cognitive Behavioral Therapy in the Treatment of Substance Abuse: A Case Conceptualization

It is no secret that substance dependence and abuse are rampant in the United States. In 2008, 22.2 million Americans were diagnosed with substance-related disorders and 4.0 million of them received treatment (Substance Abuse and Mental Health Services Administration, 2009). Given the increasing emphasis on evidence-based practices, those who work in the field of substance abuse treatment are constantly trying to find the best interventions for their clients. The exact factors that lead to variance in recovery outcomes remain essentially unknown (Ringwald, 2002). While we may not be able to discern what percentages of outcome variations are due to which factors, looking to the strengths model can give us principles essential to recovery. Charles A. Rapp (1998) proposed that there are six elements common to people who have recovered from severe mental illness; his model can be applied to substance abuse recovery as well (Van Wormer & Davis, 2003). According to the strengths model, the six elements common to people who have recovered are identity as a whole person, personal control or choice, hope, purpose, a sense of achievement, and the presence of at least one key person (Rapp). The purpose of this paper is to analyze two common interventions currently used in the treatment of substance abuse- Cognitive Behavioral Therapy (CBT) and spiritual interventions- through the lens of the Rapp's strengths model. Spiritually Modified Cognitive Therapy (SMCBT) will be introduced as an intervention for substance abuse which encompasses all six critical elements to recovery. A case conceptualization and specifics of implementation for one subpopulation will then be discussed.

The Cognitive Approach to Treating Substance Abuse

In 1985, G. Alan Marlatt introduced Relapse Prevention- a cognitive-behavioral treatment geared to manage relapse of addictive behaviors. His theory proposed three determinants of relapse:

self-efficacy, outcome expectancies, and motivation. The implementation of Relapse Prevention included identification of high-risk situations, skills training, and an educational component which included cognitive restructuring (Marlatt & Witkiewitz, 2005). Then in 1993, after seventeen years of research on the effectiveness of cognitive therapy for emotional disorders, "Cognitive Therapy of Substance Abuse" was published (Beck, Wright, Newman, & Liese, 1993). The logical, structured approach of original cognitive therapy was blended with addiction theory to make a combination that was both effective and experiential. The cognitive theory of substance abuse posited that "dysfunctional beliefs play a role in the generation of urges" (Beck et al., p. 32). Cognitive therapists work with clients to identify and modify beliefs that aggravate cravings, to lessen negative affect, and to teach skills for coping with urges and cravings. A course of treatment would look similar to standard cognitive therapy in that it would include the same structure during sessions, cognitive case conceptualization, client education, goal-setting, and some of the same techniques. The key goal is to help clients make their belief in their ability to control their cravings stronger than their addictive beliefs (Beck, et al.).

The main benefits of cognitive therapies for the treatment of substance abuse are that they have been well-researched and that they are compatible with other treatment modalities. In a 2009 meta-analysis of 53 randomized control trials of CBT for alcohol or drug use, Magill and Ray found that CBT produced statistically significant treatment effects over comparison conditions and they proclaimed CBT as an overall effective intervention for the treatment of drug or alcohol use. According to Chambless and Ollendick's (2001) review of empirically supported psychological interventions, several cognitive therapy treatments meet the criteria to be considered empirically supported. In addition to the vast research on its effectiveness, standard CBT can work in conjunction with other approaches. Cognitive therapy is complementary to Twelve-Step programs or

psychobiological models (Beck et al., 1993). Liese and Franz (1996) add that CBT can also be compatible with the harm reduction approach in that they both emphasize collaboration, empathy, respect, and individualized goal setting. Overall, CBT has many advantages in the treatment of substance abuse, but it has one outstanding disadvantage: It contains only four of the six factors considered critical to recovery in the strengths model. CBT incorporates the elements of the client's identity as a whole person, personal control and choice, achievement, and one key person into treatment. The two other factors included in Rapp's strengths model- hope and purpose- are still unaccounted for in standard CBT.

The Spiritual Approach to Treating Substance Abuse

Alcoholics Anonymous (AA) was started in 1935 as a spiritual solution to a spiritual problem. AA, together with its companion groups Narcotics Anonymous and Cocaine Anonymous, remain the most common spiritual solution to substance abuse (Ringwald, 2002). In the 1940's and 1950's, the Minnesota Model emphasized spirituality in a treatment model that included pastoral care, meditation, and prayer. Most outpatient treatments today still contain elements of the Minnesota Model (Ringwald). As of 2002, most of the 11,000 programs for substance abuse treatment in the U.S. incorporate some form of spirituality (Ringwald). There are a number of theories about why spiritual interventions are a good match for people with substance abuse disorders. Jampolsky (1999) viewed addiction as a misguided spiritual search in which a person tried to fill a void with substances. Van Wormer and Davis (2005) said that spirituality can help individuals in recovery gain the courage needed to take risks and initiate change. Langrod et al. (2005) reported positive results in recovery for people with religious motivations, implying that underlying motives may be to credit. Furthermore, spirituality helps clients find meaning and purpose (Van Wormer & Davis) and is connected to hope

and healing (Yahne & Miller, 1999). Thus, spirituality can be seen through the lens of Rapp's strengths model as adding the previously mentioned elements of hope and purpose.

In addition to conceptual theories about why spiritual interventions fit with substance abuse treatment, there are other reasons to consider spirituality in the treatment of substance abuse. First, there is a "consistent inverse relationship between spirituality/religiousness and addiction" (Johnson & Robinson, 2008, p.181). Spirituality- especially particular religious traditions- may be a protective factor against substance abuse (Miller, 2003). Spirituality has also been shown to be related to positive outcomes in treatment (Pardini, Plante, Sherman, & Stump, 2000) and to be negatively correlated with current substance abuse (Miller 1998). Client values and preferences are another reason to consider spirituality in the treatment of substance abuse. In a study of client attitudes about the inclusion of spirituality in recovery, Arnold, Avants, Margolin, and Marcotte (2002) found that a majority of participants supported spiritual interventions and thought they would be helpful. A third reason to consider spirituality in the treatment of substance abuse is professional competency. Using a bio-psycho-social-spiritual model can help mental health professionals gain an understanding of their clients in a more complete way (Van Wormer & Davis, 2003). Hodge (2003) goes one step further and states that spiritual assessments are necessary in order for practitioners to respect client self-determination and to fully utilize client strengths to address problems. Professional organizations encourage practitioners to consider client spirituality within the context of ethical behavior (American Counseling Association, 2005; International Federation of Social Workers, 2004; The Joint Commission, 2006), but they do not give specific guidelines for implementation.

Considering the breadth of real-world implementation, theories, client interest, and professional endorsement, there is a surprising paucity of empirical research on the connection between spirituality and substance abuse treatment. Numerous authors have mentioned this dearth of research (Arnold et al.

2002; Langrod et al. 2005; Miller 1998; Pardini et al. 2000; Van Wormer & Davis, 2003). In an age of emphasis on evidence-based practice, this discrepancy between practice and research is incongruous. The lack of research about the relationship between recovery and spirituality and corresponding interventions- other than 12-step approaches- may be due to the amorphous nature of spirituality. Several authors cite the lack of consensus on an operational definition of spirituality as one reason (Arnold et al.; Galanter 2008; Johnson & Robinson, 2008; Miller 1998; Pardini et al.). Miller (1998) adds that other contributing factors may include the limited measurement of spiritual variables or the discrepancy between the religious beliefs of mental health professionals and those of their clients. Although the reasons behind it are unclear, the gap in research is widely acknowledged. For the purposes of this case conceptualization, the problem of an all-inclusive definition of spirituality was avoided in that spirituality was viewed through the eyes of the specific client, consistent with Miller's (1998) appraisal that spirituality is defined at the level of the individual. The issue of measurement of spirituality was solved by utilizing Hodge's "Spiritual Assessment: A Handbook for Helping Professionals" (2003). Finally, the concern about the mismatch in spiritual beliefs between professionals and clients was considered. Propst, et al. (1992) demonstrated that in order for spiritual interventions to be effective, a similarity of values between a client and therapist was not needed.

Blending the Cognitive and Spiritual Approaches

The attitude of cognitive therapy practitioners toward spirituality has changed dramatically in the years since its commencement. Although professionals who practiced cognitive therapy were once "quite hostile to the religious beliefs of the patient," they now show "an appreciation of religion's influence on cognition, emotion, and, ultimately, behavior" (Propst, 1996, p. 393). Those who pioneered modifying CBT for spiritual or religious clients realized that the values of standard CBT may be in conflict with the values of some clients (Hodge, 2008; Propst et al., 1992). Hodge (2008) further

asserted that clients have better outcomes when their treatments matched their values. He concluded that if the present values of CBT, which reflect the Enlightenment-based worldviews of the world in which it was developed, could be switched with spiritual views, CBT would be more acceptable to religious clients. The quest for effective ways to spiritually modify CBT had begun.

Spiritually Modified Cognitive Behavioral Therapy

SMCBT is based on Beck's cognitive model. Therefore, the theories and concepts remain the same while the specific content is altered to be spiritually-based (Propst, 1980). Implementation of SMCBT involves constructing spiritually modified statements. This is achieved by examining standard CBT statements, removing incongruent values while keeping the basic therapeutic concepts, and presenting these concepts in more value-matching terms (Hodge, 2008). Some examples of ways to incorporate a client's spirituality into CBT include using scripture to examine beliefs and assumptions or to construct self-statements (Hodge 2008; Propst, 1996), using prayer to discover client schemas and to create cognitive change, (McCollough & Larson 1999), using religious themes to guide imagery modification (Propst, 1980), and using religious rationale to counter irrational thoughts (Propst et al., 1992). Regardless of the specific modifications made, it is absolutely imperative that mental health professionals include their clients both in the decision to use SMCBT and in the process of modification (Hodge, 2006).

There are many ideas on why spiritual approaches to standard CBT may be beneficial for some clients. Several authors theorize that spiritual change and cognitive change are similar in that they both transform the way a person thinks and acts (Propst, 1996; Ringwald, 2002). Hodge (2003) views spirituality in cognitive therapy terms as a set of cognitive schemas that work as client strengths. Additionally, religious clients may view cognitive therapy in spiritual terms, making CBT more acceptable to both them and their clergy (Propst, 1996). When CBT is more acceptable to the religious

community, clients experience increased motivation and receive more social support (Hodge, 2008). Another benefit of SMCBT is that it can increase trust between a therapist and client (Propst, 1980). Hodge (2009) hypothesizes that additional general benefits of SMCBT may include increased rates of recovery, increased treatment compliance, decreased client relapse, and reduced treatment disparities. The possible benefits of using SMCBT for clients with whom it is a good fit are abundant.

Although there has been some empirical research conducted using SMCBT, it has been limited. In 1980, Propst undertook the first outcome study of cognitive therapy tailored to an individual's value system and found that among mildly depressed religious individuals, those who received religious treatment showed significantly more treatment gains than those who received nonreligious treatment. In a study of clients with clinical depression, Propst et al. (1992) found that those who received CBT with religious content had lower depression scores post treatment than those who received standard CBT or were on a waitlist. In Hodge's 2006 SMCBT literature review, he located 14 studies which integrated spiritual beliefs into cognitive therapies and concluded that there is a gap regarding the effectiveness of these interventions. The results showed that SMCBT was an experimental intervention by APA standards for the treatment of anxiety disorders, Obsessive Compulsive Disorder, Schizophrenia, perfectionism, and stress. With Depression, however, SMCBT was at least as effective as the standard approach. It was a well-established intervention for the treatment of Depression among Christians and was a probably-efficacious intervention for the treatment of Depression among Muslims (Hodge, 2006). Hodge reasonably concluded that more research is needed. More research is needed in the fields already studied, and a wider variety of client issues needs to be addressed. Although SMCBT has been employed as a treatment modality with numerous different populations, there is one client issue that is conspicuously missing from the SMCBT research: substance abuse.

Applying SMCBT to the Treatment of Substance Abuse

When the elements found in spiritual interventions- hope and purpose- are added to the elements found in standard CBT- identity as a whole person, personal choice, a sense of achievement, and the presence of at least one key person- the combination forms a treatment approach that encompasses all six elements of Rapp's strengths model: SMCBT. Although SMCBT is not currently being employed as a treatment modality for substance abuse, Martin and Booth (1999) assert that looking to Alcoholics Anonymous can help mental health professionals find a model for blending cognitive restructuring and spiritual practices. Albers (1999), however, states that the spirituality presented in AA may be too vague for some clients because they view the higher powers other than God as fallible. The case conceptualization and specifics of implementation that follow are based on a client who falls into the latter viewpoint. SMCBT, like any other ethically sound treatment, should flow with a client's values. The goal of spiritual interventions is to help clients grow in their existing spirituality; the goal is not to convince clients to alter their spirituality in any way (Miller, 2003). In the spirit of starting where the client is, a full case formulation and spiritual assessment were completed before spiritual modifications to CBT were made in the implementation phase.

Case Conceptualization

The following cognitive case formulation is based on Beck et al.'s (1993) model of cognitive therapy with substance abuse. In accordance with this model, it includes the client's relevant childhood data, current life problems, core beliefs and schemas, conditional assumptions, compensatory strategies, vulnerable situations, automatic thoughts and beliefs, emotions, and behaviors. The client is a 25 year-old White female with a history of opiate dependence. She had been abstinent for one month at the time therapy began.

Cognitive Case Formulation

Beginning in childhood, the client received very little approval or praise from her mother and developed the core belief that she is inadequate and therefore helpless. This limited support contributed to her intermediate belief that actions can earn love and the conditional assumption that if she appears perfect, she will gain the approval of others. She experiences automatic thoughts such as, "My actions will never be good enough." The client has developed a number of compensatory strategies to cope with her beliefs of inadequacy, such as taking on many responsibilities. The client recognizes that being the caretaker of an elderly family member shortly after her first attempt at recovery was a vulnerable situation for her in that the stress led to a relapse. The client also experiences automatic thoughts about her feelings of helplessness related to drug use, such as, "I can't survive here," and "I'll always have intense cravings for drugs." Her compensatory strategy in this area is to wear a mask of confidence. In order to appear strong, she surrounds herself with people who are still in active addition to prove she can handle it, she avoids some aspects of self-care, and she rejects some services offered to her in the treatment program.

The client also has a core belief that she is unlovable, stemming from the rejection she felt at being left out from a triangulated relationship between her mother and her sister. Being teased by peers at school about her appearance added to this belief. The client has the conditional assumption that if she exposes her true feelings to others they will abandon her. The client sees herself as an outsider among family and peers and states that she is never able to keep friends. Some of the compensatory strategies the client has adopted to cope with these beliefs include internalizing her feelings, avoiding confrontation with others, and avoiding emotionally intimate relationships with peers. She verbalizes thoughts surrounding feelings of anxiety, frustration, and disappointment, but is disconnected from her emotions and unable to label her feelings. Her lack of peer relationships in the past led to vulnerable

situations of feeling lonely and being bored. She has used drugs in the past to cope with these feelings. She currently recognizes the need to balance her time, but is unsure how to do that.

Spiritual Assessment

A spiritual history was taken following Hodge's (2003) suggested Interpretive Anthropological Framework. Within the guidelines of this verbal spiritual history assessment, an emphasis was placed on the cognitive and behavioral aspects of spirituality. The goal was not to measure level of spirituality, but to assess the client's strengths in this area and to build rapport with the client. The Interpretive Anthropological Framework was chosen because of its non-leading, open-ended questions and its ease of administration.

When describing the religious tradition of her family of origin, the client stated that she was taught the basics of the Christian faith by her father, who is a member of the clergy. She stated that she views her spiritual connection as a strength. She saw herself as a follower of Jesus and a member of God's team and eschewed the word religious because religion is manmade. When asked about spiritual practices, she spoke about the power of prayer and the use of scripture. The client reported owning a copy of the Bible with special applications for people in recovery from substance abuse and reported being familiar with these scriptures and relying on them regularly. With regard to cognitive aspects of her faith, the client stated that she believes that God has always been there for her, even when she walked away from Him temporarily. She stated that she believes God has a purpose for her life and finds meaning by looking to Him and considering His plan. She reported that her faith in Jesus helps her in trials because she can look to Him for guidance because He was tempted in every way. She emphasized her spiritual connection with others in saying that her broken path may allow her to help others in the future. In addition, the client stated that the arts in Christianity are underestimated and that visual aspect can be very influential.

Implementation

The implementation of SMCBT for the treatment of this client in recovery from substance abuse started with Beck et al.'s (1993) basic cognitive approach. The spiritual modifications were made based on the client's existing Christian beliefs and her established spiritual practices of praying, applying scripture to her life, and finding meaning in her life through her spirituality. The client's interest in visual aspects of faith was also taken into consideration. The process of blending the cognitive approach with the client's spiritual strengths was a mutual process between the therapist and the client. Once the client was introduced to the cognitive theory of substance abuse and the process of spiritually modifying standard CBT, she was encouraged to add her own spiritual modifications. The therapist role at that point was to ensure that the therapeutic ingredients of standard CBT were still included.

The first spiritual modification incorporated into treatment was the addition of prayer. Beck et al. (1993) first mentioned prayer in the initial book on the subject of the cognitive therapy of substance abuse. They suggested that clients use a favorite prayer as a type of grounding for the purpose of distraction to reduce cravings. For this client, the use of the Lord's Prayer or recitation of a favorite Psalm was appropriate. Because these prayers were already in first person form, they did not require alteration to become the kind of self-statements that create cognitive change.

The next spiritual modification made was the inclusion of scripture into standard CBT. Scripture can be used to evaluate current self-statements or to create new ones. Propst (1996) and Hodge (2008) suggested using scripture as a way to examine a client's beliefs and assumptions and to create healthy self-statements. One way to incorporate scripture is to use verses that counteract specific maladaptive responses or enforce specific adaptive responses as enumerated by Beck et al. (1993). For example, unlovable beliefs could be countered with the verse, "How wide and long and high and deep

is the love of Christ" (Ephesians 3:18, New International Version). The verse could be altered to make a self-statement, such as, "Christ's love for me is so big that I am surrounded by it." Another example would be to use a verse to further an adaptive response such as self-efficacy, like, "I can do everything through him who gives me strength" (Philippians 4:13). This verse would not need to be altered to make a self-statement, but could be personalized to reflect mastery over substance use, such as, "I can resist cravings to use because God gives me the strength to do it." One final way to incorporate scripture is illustrated in Figure 1, an adaptation of a cognitive model of control created by Liese and Franz (1996). The original cognitive model of control would be implemented with clients after they have learned to recognize the specifics of their drug-related beliefs and would be used to teach them how to change their maladaptive responses into control responses. In this adaptation, standard control beliefs are replaced with spiritual control beliefs tailored to this client.

Another way that standard CBT was spiritually modified was by exploring and emphasizing the client's view of meaning. This client was able to view her trials as part of God's purpose for her life. When looking at her struggle with substance abuse, she stated that possible reasons for it could be that God wanted her to be able to help others in the future, or that God wanted to prepare her father for helping others within his congregation. When she viewed being on probation and participating in the treatment program as a hardship, she was able to find comfort in finding some possible purposes God might have for her. She was thankful that she had learned to communicate with other women in a more effective way and that she had the opportunity to see what many years of substance abuse and incarceration looked like for others. In these ways, the client was able to see things from a more positive perspective. This is what Beck et al. (1993) advise when they recommend reframing trials as "blessings in disguise" (p. 144) and could be used specifically to restructure automatic thoughts in a Daily Thought Record.

The final way that spirituality was incorporated into standard CBT for this client was through imagery modification. This was a good fit with the client in that she expressed her strength as a visual learner and her view that the artistic and visual aspects of Christianity are underappreciated. Imagery modification has been utilized as a spiritually modified cognitive restructuring technique with mildly depressed patients by walking them through their maladaptive images and guiding them through the process of imagery modification (Propst, 1980). Propst used the spiritual image of Jesus standing with clients as a way to help them cope with their trials. This client could benefit from the use of that specific image, or from imagining what it might look or feel like to be engulfed in God's love. Given the client's appreciation for art, she could envision herself as part of a work of spiritual art she admired. While looking at a painting of Jesus holding a lamb, for example, she might envision what it would feel like to be the lamb.

Discussion

Given the widespread proportions of the substance abuse problem in the U.S. and the mental health profession's emphasis on evidence-based practices, finding and using interventions to treat substance abuse that are backed by empirical research is crucial. Both standard CBT and spiritual interventions were analyzed within the context of Rapp's strengths model and according to their evidence base. Standard CBT was found to have an immense amount of empirical support, but contained only four of the six elements of the strengths model. Spiritual interventions contained the remaining two elements of the strengths model, but were found to be limited in empirical support outside of Twelve-Step programs. Although many different forms of spiritual interventions are employed to treat people with substance abuse disorders, the gap between practice and research remains. The incipient field of SMCBT was explored as an intervention that includes all six elements of the strengths model. Although SMCBT has some supporting empirical evidence with certain

populations, it has not yet been researched in the treatment of substance abuse. We explored SMCBT as one possible intervention that combines the concepts of standard CBT and spiritual content. We walked through the cognitive case formulation, spiritual assessment, and implementation specifics for one client.

Even though the door to using spiritual interventions has been opened, mental health professionals are still hesitant to walk through it. The general attitude of professionals who practice CBT has shifted to one that is more open to using spiritual approaches, yet these professionals may be unsure of how to proceed. Possible reasons include the lack of a universal definition of spirituality, limited resources for assessment, and concern about the discrepancy between practitioner and client beliefs. Many clients in recovery from substance abuse would like to have spirituality incorporated into their treatment and mental health professional organizations support this holistic view, but the research is limited and the guidelines are few. Although spiritual interventions have many potential benefits for some clients, they should be used by practitioners judiciously. The key is in knowing when these spiritual interventions are appropriate.

Spiritual interventions such as SMCBT are appropriate in a number of different circumstances. Spiritual interventions can be used regardless of whether the spiritual views of the client and therapist are similar. The pivotal factor is assessing and incorporating spirituality from the client's viewpoint. Using a spiritual assessment tool is crucial for this reason. Spiritual assessments can help practitioners gain a more complete view of their clients. When spirituality is a strength for a client, it can be a great resource in treatment. The case conceptualization and implementation detailed here give the specifics for a client who espouses Christian beliefs, but this approach could be used to incorporate any different form of spirituality. Spiritually modifying standard CBT for the treatment of substance abuse is especially apt when a client's spiritual beliefs and practices are specific. When spiritual interventions

are used appropriately, they can enhance a practitioner's cultural competency and impact clients in many positive ways.

It is equally important for practitioners to recognize when spiritual interventions are not appropriate. This is another instance in which using a spiritual assessment tool is valuable. Spiritual strengths can be utilized as resources in therapy for some clients, but not for all clients. Attempting to utilize spirituality for clients in whom it is not a strength may alienate these clients (Zemore, 2008) and therefore limit rapport and treatment outcomes. Another instance in which practitioners who consider using spiritual interventions should practice caution is when they have similar value systems to their clients. As with any practitioner who wants to avoid the pitfall of countertransference, the focus needs to remain on the client's target problems and goals. Spiritual interventions cannot be ethically used by social work practitioners as a means of spiritual direction (Hodge, 2003). Finally, practitioners are ethically mandated to practice within the scope of their individual competency (National Association of Social Workers, 2008). They should be aware of the limits of their competency and choose to practice only in areas in which they are properly trained.

It is our hope that this paper will serve to educate practitioners in one way to incorporate spirituality into the treatment of substance abuse. The concrete examples given could be used as ideas for how to spiritually modify CBT to benefit other clients with similar spiritual views. Additionally, the same approach could be used to spiritually modify CBT for the treatment of substance abuse for clients with other spiritual views. Finally, the case conceptualization and implementation detailed within could be a starting point for those who will conduct research in the future on SMCBT for the treatment of substance abuse.

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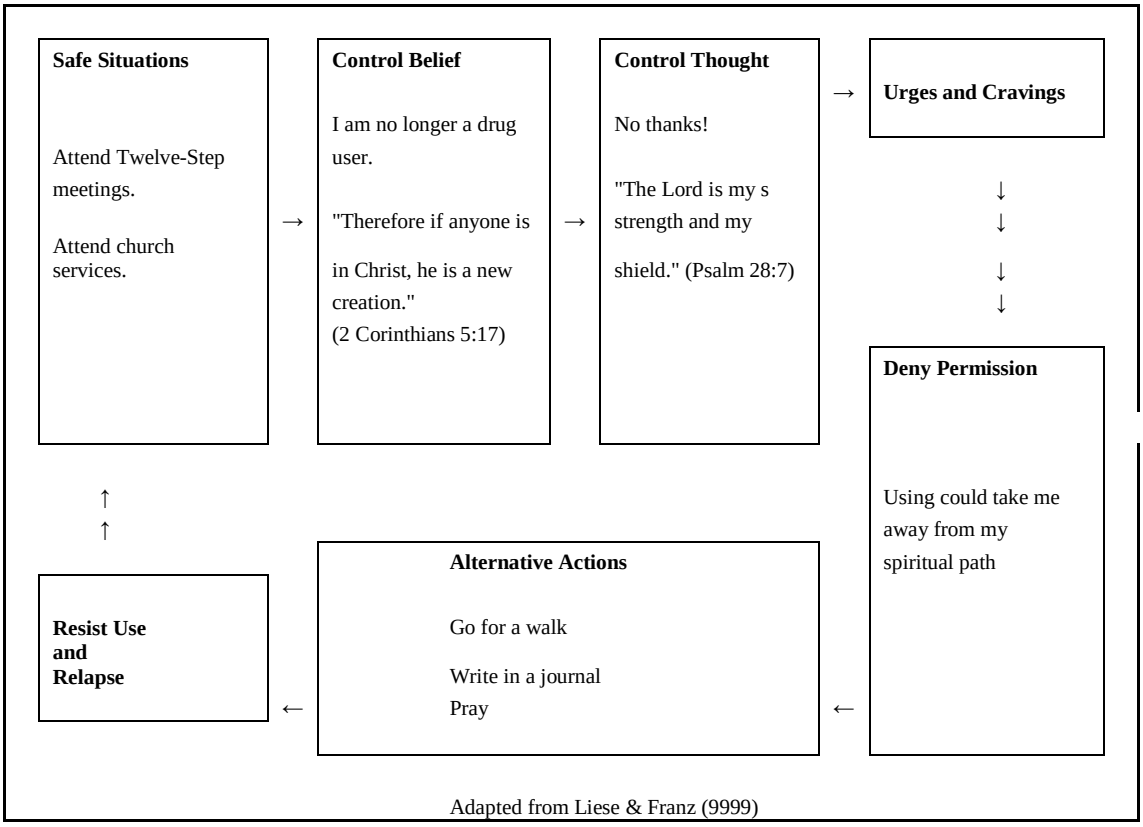
Figure 1- Spiritually Modified Adaptive Response Worksheet



Adapted from Liese & Franz (9999)