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Incorporating Clients' Underlying Religious and Spiritual Beliefs in Therapy May Improve Substance Abuse Treatment Practices, Especially for Persons of Color

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Incorporating Clients' Underlying Religious and Spiritual Beliefs in Therapy May Improve Substance Abuse Treatment Practices, Especially for Persons of Color

Abstract

ABSTRACT

INCORPORATING CLIENTS' UNDERLYING RELIGIOUS AND SPIRITUAL BELIEFS IN THERAPY MAY IMPROVE SUBSTANCE ABUSE TREATMENT PRACTICES, ESPECIALLY FOR PERSONS OF COLOR

Author: Marguerite E. Hendrickson

Dissertation Chair: Ram Cnaan, Ph.D.

Although pharmacological breakthroughs have improved treatment outcomes for alcohol and opioid dependence through decreased cravings and blocked reward effects, there are no FDA approved medications for the treatment of cocaine dependence. In addition, many routinely practiced psychotherapy models for addiction remain limited in their effects. As composite case studies will reveal, cravings and urges to use cocaine prevent clients from obtaining and sustaining abstinence. Multiple case studies will examine how clients use their underlying religious and spiritual beliefs to cope with cravings and urges. The first paper in this dissertation investigates how clients' religious problem-solving styles can both positively and negatively affect the recovery process when viewed through the lens of a scientifically validated instrument, *Religious Problem-Solving Scale*. The second paper examines how addressing religious/spiritual issues in therapy may strengthen the therapeutic alliance with African Americans in outpatient treatment for cocaine dependence. Given the research evidence that African Americans and Hispanics actively engage their religious/spiritual beliefs during recovery, this multi-paper dissertation suggests that clinicians adapt evidence-based therapies by incorporating religious/spiritual content to meet the needs of the growing population of color in the United States.

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**INCORPORATING CLIENTS UNDERLYING RELIGIOUS AND SPIRITUAL
BELIEFS IN THERAPY MAY IMPROVE SUBSTANCE ABUSE TREATMENT
PRACTICES, ESPECIALLY FOR PERSONS OF COLOR**

Marguerite E. Hendrickson

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

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Degree of Doctor of Social Work

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Dedication

This dissertation is dedicated to my dear sister and life-long friend

Anne Marie Schultz

ABSTRACT

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“It is sometimes much more important to know what sort of a patient has a disease than what sort of disease a patient has.”

-Sir William Osler, “Father of Modern Medicine”

INTRODUCTION

Heralded as the new “Fifth Force” in counseling and psychology, Stanard, Sandhu, and Painter (2000) recommend spiritual and religious assessment with clients to help with diagnosis and treatment. Many clients use their religious and/or spiritual beliefs in counseling to help problem solve and cope with stressful life events. Pargament (2007) warns that we deal with clients’ spirituality either implicitly or explicitly because “When people walk into the therapist’s office, they don’t leave their spirituality behind them in the waiting room” (p. 4).

Unlike some areas in mental health treatment, spirituality/religiousness is not a new force in addiction treatment and recovery, but a cornerstone of the addiction recovery movement. Twelve-Step programs are rooted in Alcoholics Anonymous (A.A.), and A.A. is rooted in Protestantism (Miller, 1998). Addiction counselors and recovering persons have observed and experienced exploration of spirituality and/or religiousness as an integral part of the recovery process. As co-founder of Alcoholics Anonymous, in 1939 Bill W. wrote that men and women with substance abuse problems “have been not only mentally and physically ill, (they) have been spiritually sick” (AA World Services, 2001, p. 64).

The two papers that follow seek to highlight the importance of opening up therapeutic space for clients’ religious and/or spiritual beliefs and practices in addictions’ counseling. Cervantes and Parham (2005) warn counselors that addressing the cognitive,

affective, and behavioral dimensions of personality without including the spiritual essence for people of color may cause harm. Social workers and psychologists are called upon by their professional organizations to provide culturally competent models of practice that include sensitivity to clients' religious and spiritual worldviews (Canda & Furman, 2010; NASW, 2008; Miller, 1999; Sue, 1999). Yet, social work and clinical psychology are rooted in secular values (Hodge, 2006; Galanter, 2006). Many social workers and counselors are uncomfortable delving into clients' religious or spiritual issues. Clinicians may feel ill-equipped in new, unfamiliar territory and for others, it may raise questions about their own unresolved religious/spiritual issues.

Clinical social workers provide 41% of outpatient mental health services in the United States (Simpson, Williams, & Segall, 2007). Social workers often work with vulnerable populations which frequently includes minorities. As the United States is projected to become a majority-minority nation for the first time in 2043 (Bernstein, 2012), social workers are in a position to take a leadership role to provide an ethnoculturally competent assessment and treatment that includes clients' religious identification and/or spiritual orientation. The papers included in this dissertation project represent a step in the social work literature to meet clients' psychospiritual needs in addictions treatment.

The first paper provides composite case examples of clients in treatment for cocaine dependence viewed through the lens of a scientifically validated instrument, *Religious Problem-Solving Scale (RPS)* (Pargament, 1988). The three cases presented reflect the three problem-solving styles found in the RPS; namely, Self-Directing, Deferring, and Collaborative. The composite case examples demonstrate the importance

of uncovering the spiritual and religious beliefs of clients that may help, delay, or stop the recovery process. Religious and spiritual assessment questions, appropriate for clients in treatment for substance abuse, are recommended.

The second paper examines the research on Evidence-Based Therapy Relationships to explore how clients use religious and/or spiritual beliefs during treatment for substance abuse. It investigates how religion/spirituality, judged as demonstrably effective when integrated into psychotherapy, may strengthen the therapeutic alliance for African Americans in outpatient treatment for cocaine dependence. Given the importance of the therapeutic alliance, therapists may negatively impact the therapeutic relationship by ignoring a proven coping mechanism for clients of color. The research evidence on the therapeutic alliance in psychotherapy and substance abuse treatment is explored. Additionally, a composite clinical case is presented as an example of how underlying religious/spiritual beliefs may benefit and/or hinder a client's substance abuse recovery.

Reflexivity Statement

In my experience with a predominantly African American male population seeking treatment for crack cocaine addiction, I have anecdotal evidence that most of the clients treated at an outpatient addictions' research facility bring spiritual/religious beliefs to the counseling experience. My experience is drawn from direct clinical practice with clients participating in drug and alcohol research trials during the past 13 years, and as clinical supervisor to social workers, psychologists, and student interns for the past eight years. Even though I was highly churched growing up in a Roman Catholic tradition, initially I was taken aback by how readily clients spoke about their

spiritual and religious beliefs. Although I remained open to religious/spiritual discussions initiated by clients, previous counseling positions and the social work education I received had not prepared me to address issues in any formal way. Some of my clients use spiritual and/or religious beliefs about God and church life to help their recovery; other clients hold spiritual and/or religious beliefs that delay or even stop the recovery process. As I considered a dissertation project, I knew it would inform my clinical practice and help social workers overall to further explore the phenomenon that I view in my office daily.

Religious Problem-Solving Styles: Helping or Hindering Addiction Recovery

Introduction

Given that 88% of the world's population follows some kind of theistic belief system (Frame, 2003) the importance of integrating a client's spiritual or religious worldview into the therapeutic experience is no longer up for debate (Cervantes & Parham, 2005; Koenig, King, & Carson, 2012; Pargament, 2007; Richards & Bergin, 1997; Shafranske, 1996). Gallup (2010) surveys in 114 countries showed that religion played an important part in people's lives worldwide (Crabtree, 2010). The global median percentage of adults who said religion was important in their daily lives was 84%. The poll established a correlation between the level of importance of religion in countries and per-capita GDP. The world's poorest countries reported a median percentage of 95% for people who said religion was important in their daily lives, and among the richest countries the median percentage was 47% (Crabtree, 2010). Interestingly enough, the United States, one of the richest countries, did not fall in line with the trend because 65% of Americans said religion is important in their daily lives. One explanation may be that the population in the United States reflects a more global community with people from every continent and country holding a myriad of spiritual and religious beliefs (Cervantes & Parham, 2005).

The importance given to spiritual and religious assessment can be seen in the revised standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2012). JCAHO, the largest health care accrediting body in the United States, requires the administration of spiritual assessments in a number of healthcare settings (Hodge, 2006a). In 2001, addiction services, long-term care facilities, home care

organizations, and hospitals were mandated to administer spiritual assessments.

JCAHO's spiritual assessment standards represent evidence for the growing interest in the interface of spirituality/religiousness (S/R) and healthcare (Bonelli & Koenig, 2013; Koenig, King, & Carson, 2012). Heralded as the new "Fifth Force" in counseling and psychology, Stanard, Sandhu, and Painter (2000) recommend spiritual and religious assessment of clients to help with diagnosis and treatment. Pargament (2007) warns that we will deal with clients' spirituality either implicitly or explicitly because "when people walk into the therapist's office, they don't leave their spirituality behind them in the waiting room." (p. 4).

This paper provides composite case examples of clients in treatment for cocaine dependence viewed through the lens of a scientifically validated instrument, *Religious Problem-Solving Scale* (RPS) (Pargament, 1988). The three cases presented reflect the three problem-solving styles found in the RPS; namely, Self-Directing, Deferring, and Collaborative. The composite case examples demonstrate the importance of uncovering the spiritual and religious beliefs of clients that may help, delay, or stop the recovery process. Religious and spiritual assessment questions, appropriate for clients in treatment for substance abuse, are recommended.

Role of Spirituality/Religiousness in Addiction Treatment and Research

Spirituality and Religiousness are not a new force in addiction treatment and recovery, but a cornerstone of the addiction recovery movement. Twelve-Step programs are rooted in Alcoholics Anonymous (A.A.), and A.A. is rooted in Protestantism (Miller, 1998). As co-founder of Alcoholics Anonymous, in 1939 Bill W. wrote that men and women with substance abuse problems "have been not only mentally and physically ill,

(they) have been spiritually sick” (AA World Services, 2001, p. 64). The recovery movement has been steeped in S/R through the influence of Twelve-Step programs arising from A.A. Recognizing the relationship between S/R and addiction recovery, empirical research studies have examined how S/R affects clients during and after treatment with little focus on how clients use their underlying religious and spiritual beliefs to make change (Longshore, Anglin, & Conner, 2008). Moreover, there is the dilemma of how to gather information about religious coping and problem-solving styles when S/R lives in the minds and hearts, and some would say souls, of individuals struggling with drug addiction.

Funded by the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the Fetzer Institute, the addiction field received a major contribution with the creation of a bibliography to facilitate research and scholarship on religion, spirituality and addiction (Geppert, Bogenschutz, & Miller, 2007). A total of 1353 papers on spirituality and addictions were divided into (10) categories. Reflective of recent research literature, the vast majority of studies in the bibliography reported an inverse relationship between S/R and substance use (Bonelli & Koenig, 2013; Koenig, King, & Carson, 2012; Pargament, 1997; Willis, Wallston, & Johnson, 2001). The majority of research found had focused on alcohol use and spirituality. The absence of research data in the bibliography informs researchers and draws attention to current gaps. For example, the majority of research focused on alcohol dependence and spirituality with scant longitudinal and prospective studies with drug-dependent clients. Only one empirical study compared spirituality in AA for differing ethnicities (Tonigan, Miller, Juarez, & Villanueva, 2002). The

bibliography highlights the need for research on the role S/R and ethnicity in substance abuse treatment.

Spirituality/Religiousness and Ethnicity in Addiction Treatment and Research

Bliss (2007) recognized the dearth of research related to spirituality and ethnicity in the substance abuse field. Bliss (2007) reviewed 44 articles between 1977 and 2004 and found only 11% of the studies reported ethnic differences in the results. Among the eight studies that examined differences in ethnicity and spirituality, only two studies examined and reported how African Americans compared to other ethnic groups.

Roland and Kaskutas (2002) examined spirituality and religiousness and involvement in A.A. among three ethnic groups, African Americans, Caucasians, and Hispanics. African Americans described themselves as more religious than Caucasians and Hispanics, and African Americans were less likely to substitute church attendance for participation in A.A. meetings. Wood and Hebert (2002) examined spiritual meaning and substance use among college students. The study found African American students had significantly higher spirituality scores compared to Caucasians.

More recently, Bliss' (2009) study examined African American, Caucasians, and Hispanics and found that African Americans scored significantly higher in spiritual well-being, religiousness, and cognitive orientation toward spirituality compared to Caucasians. Bliss (2009) suggests ethnic differences in spirituality between African Americans and Caucasians may have implications for African Americans as either protective factors or as resources to help the recovery process. McKay, Lynch, Pettinati, and Shepard (2003) findings suggest that African Americans may pursue a different path to recovery than Caucasians. McKay et al. (2003) call for further studies to improve

treatment outcomes for African Americans. Although limited in number and scope, the studies above may indicate that African Americans use religious or spiritual paths during the recovery process.

Current Trends in the Treatment of Substance Use Disorders

Coexistent throughout the twentieth century with the Twelve-Step movement, the science of addiction has made progress with medications and psychotherapeutic tools to help individuals manage their addictive behaviors. Although introduced 60 years ago, Disulfiram (Antabuse) continues to be recommended as an effective medication to deter alcohol use (Fuller & Gordis, 2004). Naltrexone helps reduce cravings and blocks the rewarding effects of alcohol for some patients, and Acamprosate has been shown to decrease alcohol use (Volpicelli, Alterman, Hayashida, & O'Brien, 1992; Vocci, Acri, & Elkashef, 2005). Methadone maintenance has been used since the 1960s to treat opioid addicted patients and has been shown to reduce mortality rates for patients (Vocci, Acri, & Elkashef, 2005). Suboxone is also used as a first-line treatment for opiate addiction as it blocks the effects of opioids, decreases cravings, and suppresses major withdrawal symptoms (Vocci, Acri, & Elkashef, 2005). Testing medications for cocaine dependence remains one of the National Institute of Drug Abuse's (NIDA) top research priorities (NIDA, 2012). After twenty years of active research, there are no FDA approved medications for treating cocaine addiction.

With no pharmacological breakthroughs to date, psychotherapy remains the most widely used treatment for cocaine addiction (Rotgers, Morgenstern, & Walters, 2003). Unfortunately, the most widely used models of therapy for the treatment of substance use disorders (SUDs) remain limited in their effects, including: Cognitive Behavioral

Therapy, Twelve-Step Facilitation Therapy, Motivational Enhancement Therapy, Family Therapy, Contingency Management Therapy, Psychodynamic and Psychoanalytic Therapies (Beck, Wright, Newman, & Liese, 1993; Carroll & Rounsaville, 2007; Carroll, Rounsaville, & Keller, 1991; Dowling, 1995; Miller & Rollnick, 2002; Prendergast, Podus, Finney, Greenwell, & Roll, 2006; Rotgers et al., 2003). However, there is much evidence to date from chemical dependency research findings that the model of therapy is not as significant as the therapeutic alliance developed between the client and therapist (Barber et al., 1999; Barber et al., 2001; Connors, Carroll, DiClemente Longabaugh & Donovan, 1997; Meier, Barrowclough, & Donmall, 2005; Muran & Barber, 2010; Ruglass et al., 2012). The question must be asked whether a therapist can build a therapeutic alliance if a client's underlying religious and spiritual beliefs are left out of the therapeutic dyad.

Challenges Related to Crack Cocaine Addiction

During the 1980s and 1990s, crack cocaine allowed for a cheaper high that devastated inner-city African American communities (Dunlap, Golub, & Johnson, 2006). The Treatment Episode Data Set for the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) shows a decline for cocaine admissions (as primary drug for treatment) in recent years. Cocaine admissions decreased considerably from 14% in 2000 to 8% in 2010. However, it should be noted that 71% of cocaine admissions were for the treatment of crack cocaine and 53% of those admitted were non-Hispanic Blacks. In substance abuse treatment, clients often enter facilities with dismal track records for sustained abstinence. Relapse rates are quite high, 50% by the six-month mark following

treatment completion (McLellan & Meyers, 2004). Research has uncovered biological evidence for the high relapse rates among crack cocaine users.

There is much evidence to date that crack cocaine addiction is one of the most difficult to treat because cocaine craving serves as a negative reinforcer for the addiction cycle (Dackis & O'Brien, 2001). Crack cocaine affects the same brain regions that generate hunger and sexual arousal. Individuals addicted to crack cocaine show reductions in neural density of frontal lobe regions on MRI examination (Childress et al., 1999). These reductions suggest two problems for crack cocaine users: (1) they could play a role in the denial process making it less likely to seek treatment or deny use once engaged in treatment and (2) damage to this region of the brain could account for decreased impulse control when clients try to stop cocaine but are unable to do so (Dackis & O'Brien, 2001). With no pharmacotherapy available to ameliorate the biological and psychological symptoms associated with crack cocaine addiction, it may be time to search for tools that reside within clients of color.

Religious Problem-Solving Styles

Given the evidence for the importance of understanding the psychospiritual worldview that clients bring into therapy, this paper presents three case studies viewed through the lens of a scientifically validated instrument, *Religious Problem-Solving Scale*, in the service of delivering manualized, cognitive behavioral therapy (a standard, evidence-based psychotherapy for substance abuse) (Pargament et al., 1988). For the purposes of this article, spirituality and religiousness are referred to in the broad sense as described by Pargament (1997) to include “institutional religious expressions and

personal religious expressions, such as feelings of spirituality, beliefs about the sacred, and religious practices” (p.4).

Pargament et al. (1988) identified and tested three religious problem-solving styles that individuals use to help deal with events in their lives; namely, Self-Directing, Deferring, and Collaborative styles. As a Self-Directing problem solver, a client takes responsibility to resolve problems. Although God is not involved in this process of problem-solving, it is not anti-religious. The client may believe that God gave him/her free will to actively resolve problems. As a Deferring problem solver, a client hands problems over to God and waits for resolution through God’s efforts alone. Lastly as a Collaborative problem solver, a client works with God in a joint effort to resolve problems.

The three composite case studies below represent each problem-solving style. The cases illustrate how clients entering substance abuse treatment for crack cocaine addiction use their underlying religious beliefs to help, delay, or stop the change process. These brief sketches reveal how religious beliefs may fortify and strengthen a client’s resolve for change or be an obstacle during the recovery process. As Pargament (2002) cautioned, “religion is a richer, more complex process than psychologists have imagined, one that has the potential both to help and to harm” (p. 168). Fictitious names are used for the three composite case studies who received manualized, cognitive behavioral therapy (CBT) at an inner-city, inpatient, research center.

Composite Client Case Examples

Jerome's Self-Directing Religious Problem-Solving Style

Jerome is a 42 year-old African American male in outpatient treatment for cocaine dependence who struggled to remain abstinent after entering treatment one month earlier. He accumulated four cocaine-free days in the first week, but Jerome became disappointed when he was not able to sustain his abstinence. As he worked on the (CBT) modules, it became clear that Jerome was not interested in obtaining new coping skills. He viewed coping skills and attendance at Narcotics Anonymous (N.A.) meetings as a “crutch...I need to do this thing for myself.” Over the course of 8 weeks of treatment, Jerome shared that he “came up in the Baptist faith,” and he didn’t want to go back to church until “I get it right with God by stopping my use.” Jerome’s Self-Directing, problem-solving style was an obstacle to receiving the support he needed to stop his cocaine use.

The “Downward Arrow Technique” (a common CBT technique that helps client delve deeper into core beliefs) uncovered a belief that God would not accept Jerome back until he stopped his cocaine use. Jerome’s Self-Directing style was based on a belief that “we are here to do God’s work and serve Him, not askin Him to bail us out every time we get in trouble.” Jerome, with encouragement from his therapist, worked on a cost-benefit analysis (CBT exercise to weigh out the advantages and disadvantages of holding a particular belief). Jerome revised his beliefs based on the bible story of the prodigal son stating “Jesus been there all long, He’s waitin, patient as can be, for me to return.” By challenging his belief, Jerome was able to view his addiction in a way that opened up new options for support in his recovery. He was able to return to “bible readin and

prayin” without losing his sense of responsibility to solve his own problems. Jerome made a goal to return to his church but not until “I can buy somethin to wear that makes me presentable.”

At first reading, it may seem that a Self-Directing style of problem-solving is anti-religious, and this may be the case for individuals who are atheists or agnostic in their beliefs. But in Jerome’s case, God played a very big part in his recovery. Part of Jerome’s motivation to stop cocaine use was to “get my blessins back”, and yet; Jerome’s underlying beliefs made it impossible to access his Higher Power while he was still active in his addiction. The parable of the prodigal son reminded him of another religious belief he held, “God forgives when you ask for forgiveness.”

Lamont’s Deferring Religious Problem-Solving Style

Lamont is a 58 year-old African American male in outpatient treatment for alcohol and cocaine dependence. Lamont indicated on the first of his twelve therapy sessions that “I’m still active in my addiction, but I’ll know when it’s time to set it aside...the Holy Spirit will move in me and give me the strength to do it.” Motivational Interviewing skills were not helpful because the client had no ambivalence about stopping the substances; he was willing to “set it aside,” just waiting on the Holy Spirit to move him. Each CBT module presented was politely received and then pushed away with the same response, “this is all well and good for some folks, but I’m waiting on my Lord and Savior, when the Holy Spirit moves through me, I’ll stop...it’s called a spiritual awakening.” Although Lamont was not attending a church during treatment, he shared that he was raised in the Pentecostal faith and attended church services with his mother and two aunts until the age of 14 years-old.

Lamont's Deferring problem-solving style proved problematic for the clinical social worker who wanted to respect the client's religious convictions while addressing what may be resistance disguised as religious fervor. This was not a case of simply rolling with the resistance (a common Motivational Interviewing technique) because Lamont was willing to stop, but it was "in the hands of the Holy Spirit." In an effort to honor the client's strong religious convictions, the social worker asked if it were possible that the Holy Spirit had sent Lamont the tools he needed to stop alcohol and cocaine by directing him to the resources of the treatment center in the forms of medication, medical care, and counseling sessions. The client became very quiet and replied "that makes sense because the Holy Spirit moves in others to help people." Lamont was able to preserve his religious convictions while investing some effort in behavioral change in preparation to receive the Holy Spirit. Lamont gained a measure of support from his religious beliefs that was currently unavailable to him through family and social service agencies where he admittedly "burnt every bridge."

Lamont belonged to a subgroup of clients who struggle with alcohol and cocaine dependence. Clients addicted to alcohol and cocaine pose a particular challenge because they tend to have more psychosocial problems and worse treatment outcomes, partly related to the difficult detoxification process of both substances (Heil, Badger, & Higgins, 2001; Kampman et al., 2004). Lamont reduced his alcohol and cocaine use during treatment but did not obtain a period of abstinence. Lamont agreed to enter a faith-based, inpatient program at the end of the study. The more passive Deferring problem-solving style may be an obstacle in addiction recovery where treatment goals demand the active engagement of clients to learn and practice skills to promote self-efficacy.

Annie's Collaborative Religious Problem-Solving Style

Annie is a 32 year-old Hispanic female receiving outpatient treatment for cocaine dependence. Annie became an active participant in her treatment from the very first session. She needed cocaine-free urine results to be reinstated in her position as an administrative assistant in a large insurance firm. She learned quickly and completed the practice work assigned at the end of each session. She faithfully attended N.A. meetings three times a week. Interestingly, Annie used prayer to fight cocaine cravings more than any other coping tool. She described intense cravings that came every evening and lasted about 20 minutes recycling every hour following the predictable pattern of her previous cocaine use.

In addition to using prayer and scripture readings to fight cravings, Annie was on an intercessory prayer chain at her Roman Catholic Church. Intercessory prayer is when others pray on behalf of a person with the intention of bringing about healing (Astin, Harkness, & Ernst, 2000). Annie revealed that “knowing that others are praying for me gives me strength to fight my cravings.” She also attended a healing service at her church every Wednesday evening. Annie remained abstinent throughout the 13-week study. When the blind was broken two years later, it revealed that Annie had received the placebo and had no pharmacological help during her treatment.

Annie considered God to be her partner, she and God were “workin this recovery together.” The collaborative approach to problem-solving is consistent with the Judeo-Christian religious perspectives (Pargament et al., 1988). Also, the collaborative style fosters support from a social recovery network that has been proven to improve substance

abuse treatment outcomes (AA World Services, 2001; Kaskutas, Turk, Bond, & Weisner, 2003; Roland & Kaskutas, 2002).

Discussion

The Religious Problem-Solving Scale (RPS) consists of 36 items (12 for each sub-scale) (Pargament et al., 1988). The scale is scored on a five point continuum from “Never” to “Always”. The RPS has evidenced high reliability and is commonly used for research purposes. However, some caveats are in order regarding how the instrument was used in the case studies presented here. The RPS was not administered to the three clients above. Instead the RPS was used as a lens to view the three composite cases and not administered as a vehicle for data collection. However, many quantitative instruments are available to formally measure religiosity and spirituality for research and clinical purposes (Hill & Hood, 1999; Stanard, Sandhu, & Painter, 2000).

Although assessments such as the RPS are proven research instruments that can be used in clinical practice, Pargament (2007) warned counselors that: “a dry set of intake questions or a few formal tests of spirituality in the first session or two will not provide the clinician the information...to move from assessment to intervention” (p. 201). Rather, he suggested that spiritual assessment and intervention builds over time as the relationship develops between therapist and client. Just as clients share more when they feel safe with the therapist, spiritual and religious beliefs are deeply personal and sharing evolves after setting the stage for a spiritual/religious dialogue.

The African American and Hispanic clients presented in the case studies above readily initiated discussions about their religious/spiritual beliefs and identified churches and faith-based, self-help groups as community resources. Clients in recovery from

addictions have been acculturated through the influence of the Twelve-Step Movement to accept and even embrace the religious and spiritual aspects of recovery. Although the composite case examples presented above represent individuals of color, the same principles are generalizable to a non-Hispanic white population and other ethnic groups. However, a more formal assessment about spiritual/religious beliefs and practices may be needed for other populations seeking treatment.

Recommendations

Although spiritual/religious assessment is stipulated for clinicians working in some healthcare settings, the protocol for how to assess the spiritual and/or religious beliefs and practices of clients continues to evolve. However, some guidelines are in order. As mentioned earlier, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the administration of a brief spiritual assessment in addiction services. Whether working in an addiction facility or working as a private practitioner with clients in recovery, a brief spiritual assessment can provide valuable information that enhances the therapeutic experience for clients.

JCAHO (2008) has provided a suggested (not mandated) list of questions that may be used in a brief spiritual assessment. In the service of providing a culturally sensitive spiritual assessment, (Table 1) suggests one possible set of questions that may be used by social workers treating clients with substance abuse problems. These questions have been adapted to accommodate practitioners working in addiction treatment from Hodge's (2006) brief spiritual assessment model. If the client responds negatively to the first question, the assessment may end there. Therefore, clients who do not hold religious or spiritual beliefs are not made uncomfortable with further questions.

Table 1: *Brief Religious/Spiritual Assessment Questions To Be Used in Addiction Treatment Settings.*

1	I was wondering if spirituality or religion is important to you in your recovery?
2	(If Yes) How do you use your spiritual or religious beliefs in recovery?
3	Do you attend a church or some other kind of spiritual community?
4	Are you struggling with any spiritual or religious concerns that we need to explore during your treatment?

Adapted from “A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation” by D.R. Hodge, 2006, *Social Work*, 51, pp. 319. Copyright 2006 National Association of Social Workers.

A brief religious/spiritual assessment helps the therapist gain insight into whether a client’s religious or spiritual beliefs serve as strengths or weaknesses in recovery. In addition, adapting the therapeutic space to include a client’s spiritual and/or religious beliefs may work toward relationship building to strengthen the therapeutic alliance overall.

Conclusion

In the clinical cases above, cognitive behavioral therapy worked well to uncover the underlying religious beliefs that may help, delay, or even stop the recovery process. The conclusion drawn from the anecdotal evidence presented, calls for inquiry into how clients use their religiousness/spirituality to cope with daily struggles in recovery, particularly the cravings and urges to return to a familiar, addictive lifestyle. Clinical social workers cannot ignore that underlying religious beliefs and assumptions may hold clients back in treatment as seen in the examples of Jerome and Lamont. On the other hand, a counselor may want to support and encourage a client such as Annie to integrate a religious support network into her recovery.

Strengthening Evidence-Based Therapy Relationships: Adapting Substance Abuse Psychotherapy to Meet Clients Higher Needs

“*What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?*” (Paul, 1967)

Introduction

How close are we to answering the well-known question above raised by Paul (1967) decades ago? The scientific community has moved closer according to Nobel Prize winner Eric Kandel (1998) who predicts “As the resolution of brain imaging increases, it should eventually permit quantitative evaluation of the outcome of psychotherapy” (p. 460). For now, comparative studies of psychotherapies declare a “tie score effect” among numerous therapeutic modalities (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Wampold et al., 1997). Rosenzweig (1936) proposed that common factors existed across psychotherapies and created a metaphor excerpted from *Alice in Wonderland* (Carroll, 1865/1962) where the Dodo bird served as judge for an inequitable race among the characters. Rosenzweig’s (1936) metaphor supported his proposal since the Dodo bird was unable to award a prize to a single winner and so he (the Dodo bird) proclaimed “Everybody has won and all must have prizes” (p. 412). Since Luborsky et al.’s seminal work found psychotherapies were generally equivalent in outcomes, this controversial finding has subsequently been referred to as the *Dodo bird effect*.

This paper considers the Dodo Bird effect and the research on Evidence-Based Therapy Relationships to explore how clients use their religious and/or spiritual beliefs during treatment for substance abuse. It examines how religion/spirituality, judged as demonstrably effective when integrated into psychotherapy, may strengthen the

therapeutic alliance for African Americans in outpatient treatment for cocaine dependence. Given the importance of the therapeutic alliance, therapists may be impacting the therapeutic relationship negatively by ignoring a proven coping mechanism for clients of color. Cervantes and Parham (2005) warn counselors that to only address the cognitive, affective, and behavioral dimensions of personality without including the spiritual essence for people of color may cause harm. The research evidence on the therapeutic alliance in psychotherapy and substance abuse treatment is explored. Additionally, a composite clinical case is presented as an example of how underlying religious/spiritual beliefs may benefit and/or hinder a client's substance abuse recovery.

Therapeutic Alliance

The concept of the therapeutic relationship can be traced back to Freud's writings on transference and countertransference (Horvath & Luborsky, 1993). As interest in the therapeutic relationship expanded, Greenson (1965) described the conscious aspects of the therapeutic relationship and coined the term "working alliance." As diverse psychotherapies produced similar effects with the first meta-analyses attempted by Smith and Glass (1977), the focus changed as researchers sought out the common factors found across different psychotherapeutic models (Horvath, 2001). The "alliance" coined earlier by Zetzel (1956) became the new focus of attention for clinicians and researchers. Clinical and research interest burgeoned during the 1970s as attempts were made to expand the concept of the alliance beyond its psychodynamic roots.

The concept of the alliance appealed more widely to clinicians with the reformulation of the pan-theoretical models of Luborsky (1976) and Bordin (1975). The pan-theoretical models posited the alliance "as an important ingredient in *all* helping

relationships and these new formulations of the alliance did not use concepts exclusive to the dynamic theoretical framework” (Horvath, 2001, p. 366). Bordin’s (1975) pan-theoretical model proposed a collaborative “working alliance” influenced by: the bond between the client and therapist, agreement between the client and therapist about the goals of treatment, and an agreement on the tasks that make up the therapy.

Bordin’s (1975) pan-theoretical model widened the divide between two established camps; one camp centered on the importance of the therapeutic relationship and the other on the importance of therapeutic techniques in psychotherapy. The divide emerged decades earlier during the 1956 debate between Rogers and Skinner at the meeting of the American Psychological Association (APA) (Goldfried & Davila, 2005). Rogers’ research agenda placed the therapeutic relationship in center stage stating “the only authority necessary is the authority to establish certain qualities of interpersonal relationship” (Rogers & Skinner, 1956, p. 1065). Skinner’s position emphasized the vehicle for change existed through techniques that challenged clients to learn new ways of functioning. Rogers’ position gained strength, and interest in the alliance piqued after a moderate finding between the therapeutic alliance and treatment outcomes across several treatment models that included a variety of client issues (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

Therapeutic Alliance in Substance Use Disorders

The dodo bird effect is well known in the field of substance abuse treatment research. Project MATCH (1997), a national, multi-site alcohol trial, was designed to evaluate patient-treatment matching utilizing three 12-week treatments: twelve-step facilitation (TSF), cognitive-behavioral coping skills treatment (CBT), or motivational

enhancement therapy (MET). With no robust matching effects found across the three types of therapy, Connors and colleagues (1997) analyzed Project MATCH data to evaluate the relationship between the therapeutic alliance and treatment outcomes. The data indicated that the therapeutic alliance predicted patient retention and positive drinking outcomes. More recent studies have consistently demonstrated the alliance predicted patient retention among clients treated for drug dependence (Barber et al., 2001; Meier, Barrowclough, & Donmall, 2005; Ruglass et al., 2012). Meier and colleagues (2006) examined retention rates for 187 clients in residential treatment for drug use. Strong support was found for the therapist rated alliance as a predictive factor for client dropout during treatment. Although the debate has moved towards rapprochement and there is some consensus that the relationship and technique both contribute to therapeutic change, the question remains: “Do treatments cure disorders or do relationships heal people?” (Goldfried & Davila, 2005; Hill, C., 2005; Norcross & Lambert, 2011, p. 4).

APA Interdivisional Task Force on Evidence-Based Therapy Relationships

In 1995, the controversial findings of The Society of Clinical Psychology, Division 12 of the APA, premised its Task Force review on psychotherapy techniques to establish empirically-supported treatments and gave short shrift to the role of relationships in psychotherapy (Goldfried & Davila, 2005). In 1999, APA, Division 29, the Division of Psychotherapy, responded with a task force to review research findings on the role of the therapeutic relationship (Norcross, 2001). Ten years later, the Division of Psychotherapy and the Division of Clinical Psychology of APA commissioned a second task force to update the previous task force findings. The purpose of the recent task force

was two-fold: “to identify elements of effective therapy relationships (what works in general) and to identify effective methods of adapting or tailoring treatment to the individual patient (what works in particular)” (Norcross & Lambert, 2011, p. 4). Meta-analysis of robust scientific research reviews for each relationship element concluded that: “The therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method” (Norcross & Wampold, 2011, p. 98).

As seen in Table 1 below, six relationship elements proved to be demonstrably effective: alliance in individual, youth, and family psychotherapy, cohesion in group therapy, empathy, and collecting client feedback. Three relationship elements proved to be probably effective: goal consensus, collaboration, and positive regard. Three other relationship elements were deemed promising but were without evidence to conclude that they were effective: congruence /genuineness, repairing alliance ruptures, and managing countertransference. Also, the task force commissioned meta-analyses on the research related to treatment outcome for adapting psychotherapy to eight patient characteristics. The panel judged four of the characteristics to be demonstrably effective in adapting psychotherapy: reactance/resistance, preferences, culture, and religion/spirituality and two other characteristics: stages of change and coping style to be probably effective. Two other patient characteristics, expectations and attachment style, were considered but had insufficient research to judge the benefits for patient adaptation. The task force utilized meta-analyses to conduct the research reviews to safeguard that the recommendations reflected a synthesis of all available research. The task force results and recommendations can be found in the National Registry of Evidence-based Programs and Practices (NREPP;www.nrepp.samhsa.gov/). Table 1 summarizes the task force

conclusions regarding the evidentiary strength of (a) elements of the therapy relationship and (b) methods of adapting psychotherapy to particular patient characteristics.

Table 1
Task Force Conclusions

	Elements of the relationship	Methods of adapting
Demonstrably effective	Alliance in individual psychotherapy Alliance in youth psychotherapy Alliance in family therapy Cohesion in group therapy	Reactance/resistance level Preferences Culture Religion and spirituality
Probably effective	Empathy Collecting client feedback Goal consensus Collaboration Positive regard	Stages of change Coping style
Promising but insufficient Research to judge	Congruence/genuineness Repairing alliance ruptures Managing countertransference	Expectations Attachment style

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Substance Abuse Treatment

Many different models of therapy are used to treat substance use disorders (SUDs), e.g. Twelve Step Facilitation Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, Family Therapy, Contingency Management Therapy, Psychodynamic and Psychoanalytic Therapies (Beck, Wright, Newman & Liese, 1993; Carroll & Rounsaville, 2007; Dowling, 1995; Miller & Rollnick, 2013; Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994). As presented earlier, there is much evidence to date from substance abuse research findings that the model of therapy is less significant than the therapeutic alliance developed between the client and therapist

(Barber et al., 1999; Barber et al., 2001; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Meier, Barrowclough, & Donmall, 2005; Meier et al., 2006; Ruglass et al., 2012). Interestingly, all therapeutic modalities used in substance abuse treatment share a common goal. The most important goal and formidable task for clients receiving substance abuse treatment is coping with cravings.

Challenges Related to Crack Cocaine Addiction

During the 1980s and 1990s, crack cocaine allowed for a cheaper high that devastated inner-city African American communities (Dunlap, Golub, & Johnson, 2006). The Treatment Episode Data Set for the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) shows a decline for cocaine admissions (as primary drug for treatment) in recent years. Cocaine admissions decreased considerably from 14% in 2000 to 8% in 2010. However, it should be noted that 71% of cocaine admissions were for the treatment of crack cocaine and 53% of those admitted were non-Hispanic Blacks.

In substance abuse treatment, clients often enter facilities with dismal track records for sustained abstinence. Relapse rates are quite high, 50% by the six-month mark following treatment completion (McLellan & Meyers, 2004). Crack cocaine addiction is quite difficult to treat because, among other reasons, cocaine craving serves as a negative reinforcer for the addiction cycle (Dackis & O'Brien, 2001). Brain-scan research provides biological reasons for the immense struggle of clients trying to stop crack cocaine use. For instance, individuals addicted to crack cocaine show reductions in neural density of frontal lobe regions on MRI examination (Childress et al., 1999). These reductions suggest two problems for crack cocaine users: (1) this could play a role in the denial process making it less likely to seek treatment or deny use once engaged in

treatment and (2) damage to this region of the brain could account for decreased impulse control when clients try to stop cocaine but are unable to do so (Dackis & O'Brien, 2001).

Cocaine Cravings

Some cravings/urges to use cocaine come from external cues, e.g. a street corner, a person that either sells drugs or uses drugs, a certain day of the week or time of the day. Internal cues present even more problems for clients, e.g. withdrawal symptoms, uncomfortable emotions, pleasant emotions or boredom. Winnicott's (1965) "holding environment", where a mother creates a safe space that does not impinge or limit the child, serves as a useful metaphor for building a working alliance in drug counseling. In individual drug therapy, it is the therapist's job to help the client recreate the craving and drug use experience in a safe "holding environment." Some discomfort allows the client to learn more about his/her triggers and practice alternative coping skills in the safe, nonjudgmental environment of the therapy sessions.

Fritz Perls, Gestalt therapy's founder, used the term "safe emergency" to describe the experience that psychotherapists create in sessions to promote clients' growth in a supportive environment (Perls, Hefferline, & Goodman, 1951). Cozolino (2010) tells us that therapists create "safe emergencies" by "exposing clients to unintegrated and dysregulating thoughts and feelings while offering them the tools and nurturance with which to integrate their experiences" (p.44). Drawing on another Winnicottian metaphor, the "good enough" mother does not stand in the way of the child's development to regulate emotions after failed encounters. By inference, the "good enough" therapist allows the client to struggle enough within the constructed "safe emergency" to build

coping skills that increase self-efficacy and by extension decrease risk of cocaine use. If the client is viewed as the expert on their craving process in a collaborative therapeutic effort, the client builds needed coping skills that serve him/her in the larger, more difficult drug environment.

“Safe Emergencies” Created to Promote “Language of Self Reflection”

The therapeutic alliance is forged through interpersonal dialogue between client and therapist. Moreover, language is the vehicle of change. Looking at three levels of language, Cozolino (2010) aptly describes what individuals struggling with drug and alcohol addiction know all too well. First, reflexive social language mirrors the external interpersonal world used in social situations. This is how clients avoid conflict by going along with the crowd. Secondly, internal dialogue refers to the voices in clients’ minds that are not shared with others. Internal dialogue is where admonishing parental voices are heard during and beyond childhood. Thirdly, the language of self-reflection is the language of potential change that moves clients along the change continuum.

Reflexive social language and internal dialogue are the levels of language that drive clients to use alcohol/drugs even after promising self and others they will no longer use. These two levels of language are “like over-learned motor skills that serve as mechanisms to maintain preexisting attitudes, behaviors, and feelings” (Cozolino, 2010, p. 170). This reflects the social-learning perspective of addictive behavior that views alcohol and drug addiction as “overlearned habits that can be analyzed and modified” (Marlatt & Gordon, 1985, p. 9).

Since religious/spiritual beliefs may be present in all three levels of language for clients, how can a therapist create a safe “holding environment” to promote the “language

of self-reflection” if a client’s underlying religious/spiritual beliefs are not given expression? The following composite case example utilizes Cognitive Behavioral Therapy (CBT), an evidence-based treatment for addiction, to uncover the client’s “permission giving thoughts” to use crack cocaine through the technique of thought replacement.

Composite Case Example

Rodney (fictitious name) is a 42 year old African American male who entered a pharmacological research trial at a large university for outpatient treatment of cocaine dependence. As a study participant, Rodney received CBT once a week for 12 weeks. Rodney was hopeful upon entering treatment and eagerly began his work in earnest. He remained abstinent for five consecutive days during the first week of treatment. He found comfort in the fact that cocaine use is a learned behavior that can be unlearned and replaced with new coping skills. In the first therapy session, Rodney identified his brother as a trigger because he lived in the same home and used crack cocaine. Rodney made a good decision to move in with his cousin who did not use drugs. The first Friday after entering treatment, Rodney picked up his paycheck at lunch and did not return to work that day.

Rodney’s paycheck supported a two day cocaine binge. Upon his return, Rodney and his therapist completed a transactional analysis (CBT exercise that breaks down drug use through a behavioral chain of events by uncovering antecedents to drug use, as well as, cognitions and affects before, during and after use). Rodney had begun to catch the “permission-giving” thoughts that tell him “just get yourself one, you worked all week, you deserve it”. Rodney identified this “internal dialogue” as “the voice of the devil

talking to me, and he always says the same thing on payday.” The voices represent the internal arguments for and against drug use and individuals sometimes use drugs to relieve the discomfort surrounding the choice. Unfortunately, it is much more challenging for Rodney because the “reflexive social language” acts in tandem with the “internal dialogue” to continue the addictive cycle. Rodney worries because he doesn’t want his “brother and associates to think I’m better than them.” The “reflexive social language” that Rodney engages in with associates (other crack cocaine users) positively reinforces drug use. His brother and associates have a vested interest in Rodney continuing crack cocaine use when they tell him he’ll never be able to stop: (1) because Rodney works and shares his drugs on payday with them, and (2) his brother and associates may have to look at their own behavior if Rodney stops.

Before entering the study, Rodney had two periods of sobriety over his lifetime. Upon questioning, he recounted how happy and productive he was during those times. Rodney attributed his success in sobriety to “my faith in my Lord and Savior.” During sobriety, he attended a Baptist church, the same family church he attended until age 13 when he became involved in street life that he described as “exciting and much more fun back then.” Within the safe “holding environment” of therapy, Rodney disclosed that he felt God had abandoned him because “it’s so much harder this time, God’s givin up on me this time around.” This belief held him back from reading the bible and praying as he had during his other periods of sobriety. This belief also made it difficult to return to the family church that helped him remain sober and the only safe haven in his drug-ruled neighborhood.

The therapist used a cost-benefit analysis (exercise to weigh out the advantages and disadvantages of holding a particular belief) to help Rodney understand how the belief that God had abandoned him may be holding him back in recovery. This exercise helped Rodney replace his current belief with “I’m the one that let go of God, He’s waitin on me.” In the eighth session, Rodney started to use the “language of self-reflection” and stated “It’s like they all in it together to make me use, my brother and associates who act like I’m disrespectin them if I don’t use, my family who accuse me of being high when I’m not, and the dealers who keep calling me on payday and say they got the best batch ever.” Rodney went on to explain that it became clear to him that he and his Lord are the only ones that can change this cycle.

Rodney returned to his “home meeting” (meeting that attendee feels comfortable enough to attend regularly) at Narcotics Anonymous (NA). He also returned to church where he states, “I feel like I belong there, and I can talk about stuff with other folks in recovery.” At the end of the study, Rodney shared with the therapist that the thing that helped him most with cravings was “readin the bible and prayin.” Rodney’s underlying religious beliefs were found in all three levels of language: reflexive social language that reinforced drug use gave way to the language of recovery in NA meetings and within his church community; internal dialogue that reflected the voice of the devil was countered with prayer and bible readings; and finally, the language of self-reflection showed up when Rodney realized that he could listen to voices other than the “devil” or his “associates.” Rodney listened and engaged with his Higher Power to become cocaine free. If Rodney had left his religious beliefs in the waiting room, the counseling sessions may have produced a different outcome.

The cognitive behavioral therapy in Rodney's case would have taken a different path with a therapist who was uncomfortable addressing the client's underlying religious beliefs. With a belief that God had abandoned him, Rodney would have been unable to engage in the helpful aspects of his religiosity. If he was unable to obtain abstinence, the belief that God had abandoned him may even have been reinforced. He would have been unable to gain strength from reading the bible and using prayer to fight cocaine cravings. The belief had fueled his shame and had kept Rodney from accessing a social support network at church and NA that countered the social support from his brother and associates to use cocaine. The composite case illustrates the breadth and depth of religious/spiritual issues that may be present in the therapeutic dyad. Nevertheless, most issues that arise in therapy are complex and regularly addressed in spite of the discomfort to client or therapist.

Discussion

The interdivisional task force of the APA (2009) concluded the alliance in individual psychotherapy and adapting patients' religion and spirituality into therapy are demonstrably effective and generate the best outcomes (Norcross & Wampold, 2011; Worthington, Hook, Davis, & McDaniel, 2011). African American, Hispanic, Asian, Native Hawaiian and Other Pacific Islander populations are projected to rise, or in the case of Hispanics triple, making minorities the majority by 2042 (Campbell, 1996). Given the evidence that African Americans and Hispanics actively engage their religious/spiritual beliefs in recovery, it may be time to adapt evidence-based therapies by incorporating religious/spiritual content as appropriate to meet the needs of the growing population of color in the United States (Bliss, 2009; Hodge, 2011; Petry, Lewis, &

Ostvik-White, 2008; Roland & Kaskutas, 2002; Stewart, Koeske, & Pringle, 2007; Vasquez, 2007; Whitley, 2011). With increased ethnic diversity, more minorities will seek substance abuse treatment. In addition, minority populations will gain more access to substance abuse treatment with the Mental Health Parity and Addiction Equity Act and implementation of the Affordable Care Act (“Mental Health Parity,” 2011; Stimpson, 2012).

Lastly, the economic state of the country requires austerity measures in all sectors of the economy including drug and alcohol research and treatment. Research findings suggest that African Americans may be pursuing a different path in recovery than Caucasians and further research is called for to improve treatment outcomes for African Americans (McKay, Lynch, Pettinati, & Shepard, 2003; Tonigan, 2003). There is some evidence that African Americans may use religious/spiritual beliefs as protective factors and resources for psychological coping related to cultural and racial oppression (Bliss, 2009; Cervantes & Parham, 2005; Roland & Kaskutas, 2002; Taylor, Chatters, Jayakody, & Levin, 1996; Taylor, Mattis, & Chatter, 1999). It is more important than ever to adapt evidence-based therapy relationships to specific client characteristics to retain minority participants in study trials (Hodge, 2011; Keller, Gonzales, & Fleuriet, 2005; Lindsey Davis, Broome, & Cox, 2002; Taylor, 2003) and to inform best practices with these populations. Certainly, the current evidence calls for more research adapting the religious and spiritual values of African Americans into substance abuse treatment.

Augmenting Scientific Data Through “Application Evidence”

Given the evidence for the importance of understanding the psychospiritual worldview that clients bring into therapy, these papers attempted to use “application evidence” to strengthen evidence-based practice (EBP) for clients who received cognitive-behavioral therapy (CBT) for cocaine dependence. In an effort to promote scientifically based social work practice, Gellis and Reid (2004) expanded the application of EBP to include data collected during clinical interventions with a single client, family, or small group to augment scientific research findings through “application evidence”. As these papers demonstrate, clinical social workers can move beyond mere consumerism of research findings and make contributions to scientific data through case study interventions based on EBP with specialized populations.

In the first paper, “application evidence” was used with manualized CBT, applying a scientifically validated instrument, *Religious Problem-Solving Scale*, as a lens for clinicians to understand and work with three clients in treatment for cocaine dependence. In the second paper, research on Evidence-Based Therapy Relationships was used to explore how clinicians may strengthen the therapeutic alliance by incorporating a client’s underlying religious beliefs to create a safe “holding environment” to practice “safe emergencies” in the treatment of substance abuse. In addition, religious and spiritual assessment questions, appropriate for clients in treatment for substance abuse, are recommended to address recent recommendations in the substance abuse field.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the administration of spiritual assessments in addiction services. JCAHO (2008) provides a suggested (not mandated) list of questions for use in a brief spiritual

assessment. The questions recommended here, based on JCAHO's template, are a start to the process of spiritual/religious assessment and intervention. Although many quantitative instruments are available to formally measure religiosity and spirituality in clinical practice, strategies for gathering information about religious coping and problem solving will be determined by each facility and its clinicians.

The clients who received treatment at an outpatient research center referenced above were open to using religious beliefs and faith-based resources to help the recovery process, but they initiated the discussion and identified community resources that were helpful to their recovery. More research is needed to determine whether clients will be as open to exploring underlying religious/spiritual beliefs through formal assessments initiated by clinicians. Through the influence of the Twelve-Step Movement, clients receiving substance abuse treatment have often been acculturated to accept and even embrace the spiritual aspect of recovery. However, a caveat is in order. Clients with agnostic or atheistic beliefs may be offended by religious/spiritual assessments, and other clients with religious/spiritual leanings may prefer to confer with their own religious leaders.

Role of Social Workers in Addiction Treatment and Research

The social work profession was founded on a scientific foundation through the work of Mary Richmond, who worked within the Charity Organization Society at the turn of the twentieth century. Mary Richmond rejected the moral model of the day that viewed alcoholics as “sinners” (Straussner, 2001). Although Richmond did not specifically address the spiritual/religious connections for clients, the diagnostic instrument she developed covered the medical, mental, environmental, social, and familial aspects that reflect the biopsychosocial assessment currently used in addiction treatment (Bliss, 2007; Straussner, 2001). As early as 1917, Richmond’s seminal work, *Social Diagnosis*, reflected the medical model that continues to dominate the addictions’ field today with the emergence of pharmacological research in the past two decades.

Although social workers today are encouraged to remain open to the psychospiritual dimension of clients, only 17% of NASW affiliated social workers believe that they possess the needed skill set to pursue religious or spiritual issues with clients (Canda & Furman, 1999; Hodge, 2006; Canda, Nakashima, & Furman, 2004). Given the evidence that African Americans and Hispanics actively engage their religious/spiritual beliefs in recovery, it may be time to adapt evidence-based therapies by incorporating religious/spiritual content as appropriate to meet the needs of the growing population of color in the United States (Bliss, 2009; Hodge, 2011; Petry, Lewis, & Ostvik-White, 2008; Roland & Kaskutas, 2002; Stewart, Koeske, & Pringle, 2007; Vasquez, 2007; Whitley, 2011).

As the United States minority population is projected to double by 2060 (Bernstein, 2012), social workers are in a position to take a leadership role in providing

an ethnoculturally competent assessment and treatment that includes clients' religious identification and/or spiritual orientation. With increased ethnic diversity, more minorities will seek substance abuse treatment. In addition, minority populations will gain more access to substance abuse treatment with the Mental Health Parity and Addiction Equity Act and implementation of the Affordable Care Act ("Mental Health Parity," 2011; Stimpson, 2012). Although social workers have played an active role in the treatment of clients with alcohol and drug addiction alongside psychiatrists and psychologists throughout the twentieth century, the clinical and research literature is limited compared to other disciplines. Social workers are poised to make a mark in the field of addiction, building on a person-in-environment perspective by remedying the paucity of research focused on the relationship between religiousness/spirituality and ethnicity in the substance abuse field.

Future Research

This project, rooted in social work values, is one step toward addressing the limited research and dialogue around the impact of religiousness/spirituality in substance abuse treatment with minority population. It demonstrates the value of applying evidence-informed assessments and treatments to address client need. This one step speaks to the need for more research on the therapeutic alliance with theistic clients, especially clients of color.

The therapeutic alliance has been established as an essential aspect of the therapeutic relationship. Unfortunately, the therapeutic alliance with theistic clients has remained unexamined to date in the research literature. There is some evidence that theistically inclined clients respond positively to the inclusion of religious/spiritual content in counseling sessions (Knox, Catlin, Casper, & Schlosser, 2005). Hence, future research is needed that examines the development of the therapeutic alliance when attention is given to religious/spiritual issues with theistic clients.

Also, composite case examples presented in this multi-paper examination examined Christian beliefs of clients. Although Christians represent the largest faith group in the United States (Hodge, 2006b), this may change if the minority population grows as expected. The research will need to be expanded to include underrepresented faith groups, such as followers of Islam and Eastern philosophies and religions that hold meaning for many of the world cultures.

Lastly, this dissertation project points to the strength of “application evidence” in social work practice. The case studies presented here speak to the contributions that social workers can make to the literature through practical application of research

findings. Evidence-based practice is often tested and validated with a population that may not translate well to clients with specific environmental challenges. Research findings applied to single case studies or to a series of cases in an agency may bridge the gap between research and social work practice and present evidence for additional research.

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