Benchmark - Treatment Interventions

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Substance Use Disorder (SUD) treatment interventions address a multitude of substances and client situations. The most common evidence-based SUD approaches include Motivational Interviewing (MI) for understanding the client's stages of change and their situation, 12-step Facilitation for alcohol and drugs, Seeking Safety for Post-Traumatic Stress Disorder (PTSD) and SUD, and Cognitive Behavior Therapy (CBT). Screens, assessments, and training round out the list of common treatments. Faith-based 12-step interventions cover topics in the "Big Book" (AA, n.d.) and spiritual (Hilliard, 2024). An integrated faith and CBT SUD treatment walks through common CBT techniques specifically for SUD clients (Reilly & Shopshire, 2019). CBT treatment includes the theory of person, constructs, processes, and techniques, providing a framework for the approach. The 12-step and CBT treatment interventions share commonalities. However, differences exist in philosophy; the 12-step relies heavily on the disease model, while CBT relies on constructivist philosophy and harm reduction regardless of abstinence (Newman, 2022) along with many other differences (Capuzzi & Stauffer, 2020). I lean toward an integrated CBT model with MI and faith incorporated. Many benefits to clients of faith-based and CBT approaches exist, and evidence from research demonstrates their efficacy. However, risks exist from a narrow focus and biases. These risks can be overcome with a comprehensive case conceptualization. A case conceptualization covers many considerations, including age, disabilities, developmental level, and culture. Using CBT and MI tools and assessments, the counselor can narrow the focus to the client's relevant topics for a personalized and specific plan. **THESIS**: Using integrated CBT, MI, and faith-based approaches, a comprehensive and practical treatment plan can address many considerations while adapting the approaches to the client's stages of change, behavioral, cognitive, and physical symptoms to achieve their well-being.

Empirically Researched SUD Treatment Interventions

Substance use disorder (SUD) treatment interventions with empirically researched evidence move addiction treatment from a pure disease model to a multi-faceted model (Capuzzi & Stauffer, 2020). Many evidence-based approaches exist for counselors to use when addressing SUD. Capuzzi & Stauffer (2020) list Motivational Interviewing (MI) to meet clients empathetically in their stage of change, cognitive behavior therapy to develop coping skills, and 12-Step Facilitation therapy for guided support and spiritual group support (Hai et al., 2019). Seeking Safety (Lenz et al., 2016) for SUD and trauma demonstrates efficacy through five principles: (a) safety for the individual, (b) integrating PTSD and SUD treatments, (c) support for hope and motivation, (d) integrated CBT and case management, and (e) the counselor's attributes presented in therapy. Additionally, brief interventions help counselors for mild severity or as screening such as CAGE (Basu, 2016), the brief version of the Addiction Severity Index (ASI) (ADAI, n.d.), or Brief Alcohol Screening and Intervention for College Students (BASICS), among others (Capuzzi & Stauffer, 2020). The power of these empirically based treatments (EBTs) for SUD sufferers lies in the integration of treatments to address the various issues uncovered in MI, screenings, assessments, and functional analysis of clients. Capuzzi & Stauffer (2020) demonstrate the variety through five triggers (social, environmental, emotional, cognitive, and physical). Wakeman et al. (2020) demonstrate the efficacy of pharmacological treatments for opioids and alcohol to ease clients through withdrawal symptoms and cravings. For uncooperative or those in denial, the Community Reinforcement and Family Training (CRAFT) offers a package of treatments aimed at the concerned significant others (CSO) for support and to avoid reinforcing substance use (Capuzzi & Stauffer, 2020). The addiction multi-faceted treatment model culminates in a robust treatment approach demonstrated to produce positive

outcomes for those suffering from SUD and who have created havoc in their lives and others. Faith-based interventions and variations of CBT have proven efficacious for SUD clients.

Faith-based 12-Step Intervention and Integrated CBT Interventions

Faith-based 12-Step Intervention

Faith-based SUD treatment intervention relies heavily on the 12-step program where "... only an act of Providence can remove it [substance abuse] from us" (AA, n.d., Step 1, p. 21). Many faith-based SUD programs rely directly on 12-step programs. These programs add Bible study, Scripture readings, prayer, lectures and sermons, ministerial counseling, and SUD counseling (Hilliard, 2024). Spirituality adds a dimension "relevant to chronic conditions with which patients in recovery must learn to live" (Van Denend et al., 2022, p. 3572). Some spiritual cultures admit to substances opening up the spirit world, exposing an individual "to an entity that leads to destruction" (Dubbini et al., 2020, p. 43). Adding thoughtful spirituality can serve as a resource in recovery through traditions, rituals, and community (Van Denend et al., 2022). Additionally, spirituality offers a reframing of guilt into acceptance and forgiveness. 12-step programs cover topics for the client to engage in weekly meetings, such as powerlessness over the substance, a decision to acquiesce to God, making a truthful and fearless inventory of moral character, and admitting our mistakes (AA, n.d.). Faith-based 12-step programs include prayer, a moment of silence, or a reading from the Big Book (AA, n.d.). The counselor expects the client to get a sponsor for times of cravings or weakness and attend regular meetings. A robust program includes concerned family or friends who enable clients (American Addiction Centers, 2024).

Integrated CBT, MI, and Faith Treatment Interventions

Many specific and varied programs use CBT techniques. For example, SAMHSA relies heavily on Cognitive Behavior Therapy (CBT) for SUD clients (Reilly & Shopshire, 2019). In 12

sessions, the process covers six cognitive behavioral treatments in group psychoeducational approaches, in-session exercises, and homework. A conceptual framework outlines events and three cues (behavioral, emotional, and cognitive). Homework includes thought and anger awareness records in a chart format modeled after CBT thought recording. Next, the counselor explains CBT concepts and control plans, including timeouts, talking to a trusted friend, and attending 12-step meetings like AA. Additionally, SAMHSA recommends getting support through religious communities, professionals, or self-help groups. The process adds education on the ABCD model and cognitive restructuring. Deep breathing and relaxation techniques offer relief from the cues and alternatives to damaging behaviors. These CBT techniques flow directly from Beck's CBT theory of the person, constructs, process of therapy, and techniques (Murdock, 2017). Adopting objective and subjective reality perspectives as a multi-causal model allows for treating the whole person, including culture (Bahu, 2019) and spirituality (Capuzzi & Stauffer, 2020). CBT's automatic thoughts, beliefs, and schemas of thoughts and beliefs create the cognitive model to guide treatments. The therapy process and a collaborative environment walk the client through stages of change. A derivative CBT program like SAMHSA's adaptation for SUDs, Bahu's (2019) culturally adapted CBT, or pure CBT, uses techniques appropriate to the client's stages of change to fit their unique situation (Capuzzi & Stauffer, 2020).

Differences Between Faith-based 12-Step and CBT Treatment Interventions

Although faith-based 12-step treatments and CBT share essential characteristics and complement each other, such as behavior change and homework, stark differences exist between the two approaches. Foremost, faith-based 12-step approaches use a disease model, self-help, and an abstinence philosophy (AA, n.d.; Newman, 2022). They primarily focus on the substance use issue, using faith to help the client move through the steps. Attending faith-based 12-step

meetings often requires a period of abstinence (AA, n.d.). Abstinence becomes a primary and immediate goal. The approach also informs the client that addiction resides beyond their control, so giving in to a higher power becomes essential. AA's 12-step disease model, faith, and addiction powerlessness carry throughout the process (American Addiction Centers, 2024). The powerlessness to addiction puts the client in a vulnerable position in which calling to a Higher Power becomes a motivation to attend meetings and remain abstinent (AA, n.d.; Hai et al., 2019). Hai et al. demonstrated that "religiosity ... contributed to increased compliance and sustained abstinence over six months among patients with SUDs" (p. 146), helping with long-term positive outcomes. Faith-based, 12-step programs also view relapses as critical events in which the client must reach out to their sponsor working with them until sober (AA, n.d.). Furthermore, the faith-based 12-step programs generally do not go through screening, assessments, MI, case conceptualization, or treatment planning with the client. The program follows a preset format determined by the local chapter regardless of new attendees.

In contrast, harm reduction and meeting clients where they are in their stage of change dominate the focus of CBT (Newman, 2022). The CBT approach focuses on engaging clients in any stage of change, including precontemplation and ambiguity (Capuzzi & Stauffer, 2020). According to the Beck Institute (Newman, 2022), CBT approaches focus on engaging the client to determine their situation holistically, including the substance and spiritual aspects of their lives. CBT consistently shows improvement in the client's Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7), suicide ideation, panic, and phobias, as Bahu (2019) demonstrated in a quantitatively assessed CBT programs. Counselors empower clients through CBT constructivist ideas by encouraging, educating, and building skills leading to behavior change. CBT techniques include identifying maladaptive cognitions (Murdock, 2017).

Next comes restructuring cognitions through specific treatment techniques such as MI, downward arrow, thought recording, and graded tasks in contrast to 12-step programs providing active treatments during sessions and as homework. CBT approaches expect relapses, and assessments, planning, and treatments incorporate relapse plans (Capuzzi & Stauffer, 2020). Counselors build a multi-disciplinary team, including family members, as appropriate, rather than solely using a sponsor for relapse. Unlike 12-step, CBT counselors construct comprehensive case conceptualizations from varied aspects of a client's life based on screening and assessments carrying out counselor and self-directed treatment interventions.

Analysis of the Integrated CBT, MI, and Faith I Prefer, with Reasons, Benefits, and Risks

I prefer integrated and flexible CBT, MI, and faith-based approaches. The benefits span stages of change, SUD, mental disorders, trauma, and PTSD. In addition, CBT interventions can be adapted to spirituality, varied clients, and cultural situations.

Reasons

Addressing stages of change through unconditional positive regard (UPR), observation, and questioning (Socratic method and MI) proves useful in addressing the client's stages of change (Kazantzis et al., 2021). Using UPR and MI techniques addresses the early stages of change by acknowledging their situation, fears, and goals empathetically and collaboratively. In the early stages of resistance MI helps the counselor "roll with resistance" (Capuzzi & Stauffer, 2020). MI demonstrates safety to a client who is ambiguous or fearful (Lenz et al., 2016). The counselor builds collaboration and calms the client, freeing them to share and explore their situation, resulting in a comprehensive case conceptualization (Kazantzis et al., 2021).

Benefits

Substance use Disorder sufferers benefit from CBT (Reilly & Shopshire, 2019) through careful alignment of treatments to case conceptualization (Kazantzis et al., 2021). CBT shows

outcome efficacy for frequency and quantity of alcohol and other substances of 15% to 20% in a meta-analysis of 30 Randomized Control Trials (RCT) (Magill et al., 2019). The benefits include reduced use, improved coping skills, and cognitive and environmental trigger identification. Approaches of CBT help mental disorders such as less depression and anxiety, reduce panic attacks, less suicide ideation, and improved behaviors based on maladaptive beliefs (Bahu, 2019; Capuzzi & Stauffer, 2020). For veterans with PTSD, spirituality, especially post-conventional spirituality, in which individuals critically contemplate spiritual issues, allows them to better deal with morally ambiguous situations in their past and present, providing flexibility in dealing with maladaptive cognitions (Usset et al., 2020).

Risks of CBT Treatment Interventions

Risks of limiting treatments to CBT may ignore essential aspects of the client affecting their outcomes if not adequately addressed (Capuzzi & Stauffer, 2020). Family of origin issues may hide relationship structures such as triangulation, communication patterns, substance use patterns, subsystems, and enmeshment (Murdock, 2017). Specific medical or pharmacological issues might be missed as not relevant in CBT, as well as social issues like finances and mobility. Social anxiety in group therapy may be a risk as well. Additional risks regarding the counselor's well-being, biases, and self-care might impinge on treatments. A subtle risk of Potentially Morally Injurious Events (PMIEs) involves veterans who feel guilt, reluctance, or suffer from more PTSD will experience poorer outcomes (e.g., higher scores on the Moral Injury Questionnaire) without faith (Usset et al., 2020). Lastly, myopic cultural views about treatment affect outcomes by counselors acting low on the cultural competence scale in cultural destructiveness, incapacity, or blindness (SAMHSA, 2014, TIP 59).

Positive Outcomes

The positive outcomes occur in situations of PTSD, trauma, and mental disorders (Capuzzi & Stauffer, 2020). Developing skills in the CBT approaches, MI, and case conceptualization across a diverse population becomes imperative for a competent counselor. Securing supervision, consulting, and working with a multi-disciplinary team creates a powerful treatment effort for SUD clients. In addition, integrating spirituality with CBT improves outcomes by reducing anxiety and depression while building hope, self-esteem, social support, and meaning, which increases efficacy (Leung & Li, 2024). The mechanisms of aligning treatment with symptoms holistically play an essential role in the effectiveness of CBT used for SUD, reducing risks, improving mental disorders, and in multiple client and cultural contexts (Capuzzi & Stauffer, 2020).

Considerations for Age, Disabilities, Developmental Level, Culture

Using a comprehensive case conceptualization, an integrated CBT approach considers the client's age, disabilities, developmental level, and culture (Capuzzi & Stauffer, 2020). Other considerations include motivations, triggers, internal and external consequences, the negative and positive consequences, and their expectations. Many other considerations exist, such as: (a) their language and communication, (b) geographical location, (c) worldviews and values, (d) family and kinship, (e) gender roles and sexual orientation, (f) socioeconomics, (g) immigration and migration status, (h) acculturation and enculturation, (i) heritage, and (j) religion (SAMHSA, 2014, TIP 59). The counselor must account for numerous considerations, including organizational dimensions. A selection of adolescents, disabilities, and cultural considerations are addressed in this section. In practice, the counselor narrows the considerations down to the relevancy of the client's situation (Capuzzi & Stauffer, 2020). Screening, assessments,

observations, and MI narrow the considerations, uncovering the relevant considerations affecting the client.

Addressing motivation at a client's stage of change must be carefully considered, and client engagement must be ensured by following the four pillars of MI, especially early in the process (Capuzzi & Stauffer, 2020). Considering high ambivalence, low confidence, low or no desire for change, and the importance placed on not making a change often exists for adolescents. The power imbalance with the counselor, cognitive development to assess relationships (Cook & Monk, 2020), and a drug culture reinforcing use (SAMHSA, 2014, TIP 59) add complications. Recognizing adolescents' need for autonomy become imperative in addressing this group. In addition to MI, music or sand play as treatments have proven effective in opening up traumatized children, adolescents, and adults (Fleet et al., 2023). Disabilities play an interesting role in addressing clients from multiple perspectives of physical and mental development and mental disorders. Disabled or non-verbal clients can address their anxiety, pain, fear, and dissociation through soothing touch and examine places, things, events, people, life transitions, and traumas, resulting in phenomenological changes.

Cultural considerations vary dramatically, so carefully discovering the client's culture and heritage uncovers nuances in their language and modes of communication, such as Latinos' appreciation of *simpatico*, *platica*, and *personalismo* and how the *hefe* affects their decision-making (SAMHSA, 2014, TIP 59). Identifying triggers for trauma victims through behavior treatments (Reilly & Shopshire, 2019) to avoid activating the original trauma (Usset et al., 2020), resulting in harm reduction. Those embedded in a drug culture find themselves reinforced for substance use disorder in multiple aspects of the sub-culture (SAMHSA, 2014, TIP 59). Some find benefits in self-medication, creating reinforcement and positive expectancy (Capuzzi &

Stauffer, 2020). An in-depth understanding of these considerations gives the counselor much insight into how to approach and how not to approach clients for treatment interventions.

By carefully observing, questioning, screening, and assessing clients openly, without bias, and nonjudgmentally issues tied to age, disabilities, and culture can be identified (Capuzzi & Stauffer, 2020). Motivations, triggers, benefits, and consequences of use and expectations can be isolated and captured in a unique and personalized case conceptualization. This process requires patience and cycling back as new considerations for co-discovery emerge.

Concluding Thoughts

To conclude, numerous evidence-based treatment interventions exist to help SUD clients overcome their symptoms and achieve well-being. The paper covers several common evidence-based SUD interventions (Capuzzi & Stauffer, 2020). A faith-based 12-step (AA, n.d.; American Addiction Centers, 2024) and integrated CBT discussion describes approaches to SUD clients with evidence from case studies (Bahu, 2019; Dubbini et al., 2020; Van Denend et al., 2022) resulting in comprehensive case conceptualizations. Next, a discussion examines the philosophical difference between the disease model of the 12-step harm reduction and the holistic constructivist viewpoint of the integrated CBT approach (Newman, 2022), including techniques and approaches to relapses (Capuzzi & Stauffer, 2020). The evidence from Bahu (2019) shows that integrated CBT improves anxiety and reduces suicide ideation, panic, and phobias, providing a powerful tool for treatment intervention. In addition, meta-analyses (Hai et al., 2019), a theoretical framework study (Fleet et al., 2023), interpretative phenomenological analysis (Cook & Monk, 2020), and RCTs (Leung & Li, 2024; Magill et al., 2019) demonstrate CBT efficacy. I lean towards an integrated CBT, faith, and MI approach because of the tools to address stages of change, especially in the early stages, to roll with the resistance, collaborate

with the client, and build comprehensive case conceptualizations. The benefits of treatment occur through the alignment of case conceptualization to treatment interventions for coping skills, identifying maladaptive thoughts and triggers, and reducing panic attacks and anger, among others (Kazantzis et al., 2021). Risks of myopic or narrow views and biases, of not including family of origin, or resurfacing PMIEs for veterans and trauma victims can find their way into the process. The benefits exceed the risks for clients if the counselor seeks to uncover the relevant considerations buried in clients' situations, cultures, ages, disabilities, and developmental levels, among many others. An integrated CBT with faith and MI brings a powerful, evidence-based treatment intervention package to the client regardless of their stage of change, addressing their situation holistically to achieve their well-being.

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