Alcohol Treatment and Cognitive–Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion

David R. Hodge

Cognitive–behavioral therapy (CBT) is an effective modality for the treatment of alcoholism. Given widespread interest in incorporating spirituality into professional treatment, this article orients practitioners to spiritually modified CBT, an approach that may enhance outcomes with some spiritually motivated clients. More specifically, by integrating clients' spiritual beliefs and practices into treatment, this modality may speed recovery, enhance treatment compliance, prevent relapse, and reduce treatment disparities by providing more culturally congruent services. The process of constructing spiritually modified CBT self-statements is described and illustrated, and suggestions are provided for working with client spirituality in an ethical manner. The article concludes by emphasizing the importance of this approach in light of the growing spiritual diversity that characterizes contemporary society.

KEY WORDS: alcoholism; cognitive–behavioral therapy; religion; spirituality; spiritually modified CBT

Alcoholism is a major social problem. In the United States, the total economic costs to society from alcohol abuse have been estimated at $148 billion (Simon, Patel, & Sleed, 2005). According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2000a), over 700,000 Americans receive treatment for alcoholism on any given day. Treatment options have historically consisted of two relatively distinct alternatives: mutual aid groups (for example, Alcoholics Anonymous [AA]) and professional treatment (for example, mental health centers) (Magura, 2007).

Among professional treatments, one of the more effective approaches used to treat alcoholism is cognitive–behavioral therapy (CBT) (Longabaugh et al., 2005). Despite the effectiveness of CBT with some clients, this and other treatment modalities are ineffective with many others wrestling with alcohol dependency (Corte, 2007). Furthermore, among those who successfully complete treatment, relapse is often a problem (Corte, 2007; Piderman, Schneekloth, Pankratz, Maloney, & Altmüller, 2007). In short, research on treatment effectiveness is still in its infancy, and additional work is needed to enhance outcomes.

One approach that may enhance outcomes, at least for some clients, is the incorporation of spirituality into traditional CBT protocols. Although spirituality is a common dimension in mutual aid groups, it is comparatively rare in professional treatment settings (Magura, 2007). A survey of addiction treatment professionals (N = 317) found that 84 percent believed that spirituality should be emphasized more in treatment (Forman, Bovasso, & Woody, 2001). The importance of incorporating spirituality into treatment is also reflected in recent changes instituted by the Joint Commission—the most prominent health care accrediting organization in the United States—which now requires behavioral health organizations providing addiction services to administer a spiritual assessment (Hodge, 2006b; Koenig, 2007).

The purpose of this article is to acquaint readers with spiritually modified CBT, an approach that may speed recovery, enhance treatment compliance, prevent relapse, and reduce treatment disparities by providing more culturally congruent services. Although most practitioners are interested in incorporating spirituality into treatment, they also report receiving little, if any, training on the topic during their graduate education (Sheridan, 2009). The need for content on spirituality seems particularly pressing in light of the Joint Commission’s new requirements. If accrediting organizations are going to require service providers to explore client spirituality, then content on how to help clients operationalize their spiritual strengths is vital. Spiritually modified CBT...
incorporates clients’ spiritual strengths in ways that build on existing practice knowledge and skill sets in the area of CBT (Longabaugh et al., 2005).

Toward this end, the research on spiritually modified CBT is reviewed, rationales for its applicability with alcohol treatment are provided, positive outcomes that may be enhanced are delineated, and the process of constructing spiritually modified CBT self-statements is described and illustrated. To help ensure that this process occurs professionally, suggestions are offered for working with client spirituality in an ethical manner. First, however, the terms spirituality and religion are defined, and the role of client preferences in enhancing outcomes is discussed.

SPIRITUALITY AND RELIGION: DISTINCT BUT OVERLAPPING CONSTRUCTS

Although spirituality and religion are often used interchangeably, they can be seen as distinct but overlapping constructs (Canda & Furman, 2010; Derezotes, 2006). Spirituality is commonly understood as a person’s existential relationship with God or the Transcendent (Gallup & Jones, 2000; Gilbert, 2000), whereas religion is often viewed as an expression of the spiritual relationship in particular forms, beliefs, and practices that have been developed—in community—with others who share similar experiences of transcendent reality (Gotterer, 2001; Miller, 1998). At the risk of oversimplifying, spirituality emphasizes the personal, and religion emphasizes the corporate.

Conceptualized in this manner, most people are both spiritual and religious (Pargament, 2002). Although some people express their spirituality solely in individualistic terms, apart from others, most people, as social beings, express their spirituality in some type of religious setting (Marler & Hadaway, 2002; Scott, 2001). This setting may be more traditional (Catholic Church) or alternative (for example, in what some call New Age religion or the syncretistic movement).

Spirituality and religion can be understood as continuous constructs (Gallup & Jones, 2000; Miller, 1998). For some, spirituality and religion play a minimal or even nonexistent role (Scott, 2001). For others, at the opposite end of the continuum, spirituality and religion play a central role in informing people’s worldviews (Gallup & Lindsay, 1999; Van Hook, Hugen, & Aguilar, 2001). It is for people on this end of the continuum that incorporating spirituality and religion into CBT may be particularly salient in enhancing effectiveness.

ROLE OF CLIENT PREFERENCES

Widespread agreement exists that clients’ beliefs, values, and preferences play an important role in treatment effectiveness (Sue & Sue, 2008). Interventions typically reflect the worldviews of the individuals responsible for their design and development (Blume & de la Cruz, 2005; Gilligan, 1993). Adapting therapeutic strategies to take into account clients’ unique cultural values may enhance outcomes (Castro, Nichols, & Kater, 2007).

As implied earlier, spirituality and religion play a motivating role in many people’s existence (Gallup & Jones, 2000). For such individuals, life is viewed through a spiritual prism (Richards & Bergin, 2000; Van Hook et al., 2001). Decisions are guided by spiritual frames (Maslow, 1968). It is to be expected that many such individuals will prefer to incorporate spirituality into the therapeutic conversation (Hodge, 2004; Hodge & Williams, 2002).

Indeed, according to Gallup data reported by Bart (1998), 81 percent of the general public desire to have their spiritual values and beliefs integrated into the counseling process. Similarly, studies of various client samples have also found that most respondents want practitioners to incorporate their spiritual beliefs into the therapeutic enterprise (Arnold, Avants, Margolin, & Marcotte, 2002; Larimore, Parker, & Crowther, 2002; Mathai & North, 2003; Rose, Westefeld, & Ansley, 2001; Solkhah, Galanter, Dermatis, Daly, & Bunt, 2009). For instance, in one therapeutic community devoted to helping clients (N = 322) overcome alcoholism and other types of chemical dependency, the authors found that 84 percent of clients wanted more emphasis on spirituality in treatment (Dermatis, Guschwan, Galanter, & Bunt, 2004).

These data suggest that many clients wrestling with alcoholism want to incorporate their spiritual and religious strengths into treatment. Although integrating spirituality and religion into CBT is innovative, it is not without precedent (Miller, 1998). Indeed, a number of studies have been conducted on CBT that has been modified to include clients’ spiritual values.

RESEARCH ON SPIRITUALLY MODIFIED CBT

Spiritually modified CBT is a therapeutic modality in which standard CBT treatment protocols are
modified with spiritual beliefs and religious practices drawn from clients’ spiritual worldviews (Hodge, 2006a). The cognitive restructuring techniques and the behavioral assignments are identical to traditional CBT (Nielsen, 2004). However, once unproductive beliefs and behaviors are identified, they are replaced with salutary schema and actions drawn from clients’ spiritual narratives (Ellis, 2000).

Although spiritually modified CBT has not been used to address alcoholism, it has been used with diverse groups to treat a variety of problems (Stoltzfus, 2008). For instance, Taoistically modified CBT has been used with clients wrestling with neurosis (Xiao, Young, & Zhang, 1998). CBT modified with tenets from the Latter Day Saint tradition has been used to treat perfectionism (Richards, Owen, & Stein, 1993). A generic spirituality has been used to help clients cope with stress (Nohr, 2000), depression (D’Souza, Rich, Diamond, Godfrey, & Gleeson, 2002; D’Souza, Rodrigo, Keks, Tonso, & Tabone, 2003), and bipolar disorder (D’Souza et al., 2003).

Other studies have examined a number of issues among adherents of Christianity and Islam. CBT modified with Christian beliefs and practices has been used to address compulsive disorder (Gangdev, 1998) and, most notably, depression (Hawkins, Tan, & Turk, 1999; Johnson, Devries, Ridley, Pettorini, & Peterson, 1994; Pecher & Edwards, 1984; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). Similarly, Islamically modified CBT has been used with clients wrestling with anxiety (Azhar, Varma, & Dharap, 1994), depression (Azhar & Varma, 1995b), bereavement (Azhar & Varma, 1995a), and schizophrenia (Wahass & Kent, 1997).

It is noteworthy that, in at least one area (Christian clients with depression), spiritually modified CBT can be considered a “well-established” evidence-based intervention, based on the criteria used by the American Psychological Association’s Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1995; Chambless & Ollendick, 2001; Hodge, 2006a). In general, the outcomes obtained with spiritually modified CBT are either similar or superior to the outcomes obtained with traditional CBT (Hodge, 2006a; McCullough, 1999).

The positive findings obtained with diverse problems imply that the effectiveness of spiritually modified CBT is not limited to any single issue. Rather, the favorable results suggest that this approach will also yield positive outcomes when used to help clients dealing with alcoholism. Indeed, both theoretical and empirical rationales exist that support the supposition that alcohol treatment, in particular, may benefit from the incorporation of spirituality and religion into CBT. Although spirituality and religion are typically intertwined in the lives of clients, they are considered separately for the purposes of the following discussion.

**ENHANCING TREATMENT WITH SPIRITUALITY**

Some observers have hypothesized an intrinsic link between spirituality and alcoholism (Freeman, 2006; Miller, 1998). Indeed, this is a key premise on which AA is based, along with other spiritually based mutual aid groups dealing with alcoholism (Muffler, Langrod, & Larson, 1992). Although the mechanisms are not fully understood, spirituality is posited to counter the impulse to misuse (or in some cases, use) alcohol (Piderman et al., 2007).

For instance, Miller (1998) posited that developing a deep, personal spirituality may help address the inner, psychodynamic factors that underlie alcohol use. Cultivating one’s sense of connection with the Transcendent may serve to alleviate, or even displace, the desire to use alcohol (Piderman et al., 2007). As Miller summarized, spirituality serves to, in some sense, drive out alcoholism by promoting a sense of wholeness or completeness.

Similarly, others have hypothesized that spirituality counters the impulse to use by providing a sense of meaning and purpose in life (Carroll, 1993). Within this understanding, people drink to fill a void created by lack of purpose in life. Spirituality provides an alternative, transcendent sense of purpose that, in turn, alleviates the desire to use alcohol (Freeman, 2006).

Regardless of the specific mechanisms, a growing body of empirical research supports the notion that spirituality and alcohol use are inversely connected. Over 100 studies have examined the relationship between various measures of spirituality and religion and alcohol or drug use (Koenig, 2007; Koenig, McCullough, & Larson, 2001). Although researchers are just beginning to tease out the differences between spirituality and religion (Hodge, Cardenas, & Montoya, 2001; Marsiglia, Kulis, Nieri, & Parsai, 2006; Ritt-olson et al., 2004), most studies indicate that higher levels of spirituality are associated with lower levels of alcohol use (Geppert, Bogenschutz, & Miller, 2007). Although the relationships are
nuanced, research indicates that spirituality is a protective factor that inhibits alcohol use and may facilitate recovery.

For example, one prospective study examined the relationship between personal prayer and recovery from alcoholism (Walker, Tonigan, Miller, Comer, & Kahlich, 1997). Prayer is commonly understood as a spiritual exercise that serves to strengthen a person’s relationship with God or the transcendent (Kirkpatrick, 1995). This study found that personal prayer by clients in an alcohol treatment program was linked to better outcomes (Walker et al., 1997).

**ENHANCING TREATMENT WITH RELIGION**

Religion may inhibit alcohol use through at least three possible mechanisms (Koenig et al., 2001). These mechanisms might be summarized under the headings of positive peer groups, moral values, and increased coping skills. More specifically, participation in religious communities may reduce the likelihood of choosing friends who use alcohol (Koenig et al., 2001). Religious communities tend to be populated by individuals who are less likely to use alcohol or use it moderately (Gorsuch, 1993). Forming close social bonds with other individuals who tend not to drink can inhibit alcohol use.

Concurrently, involvement in religious communities may instill moral values that proscribe alcohol use (Koenig et al., 2001). Most major faith traditions in the United States either prohibit alcohol use or encourage moderation (Gorsuch, 1993). Through exposure to such teaching—which is modeled by other members of the community—individuals may be more inclined to adopt similar patterns in keeping with the values of their particular community.

Finally, coping skills may be increased as a result of having access to social support networks of individuals who typically deal with problems without resorting to alcohol use. In addition, new, nonalcohol-based coping strategies may be modeled by other members of the community. The development and adoption of alternative coping strategies may reduce the probability of turning to alcohol during times of stress (Koenig et al., 2001).

To summarize the aforementioned mechanisms in a single sentence, religion may inhibit alcohol use through acculturation into peer groups characterized by nonalcohol-using norms that serve to instill moral values that discourage alcohol use. As implied earlier, a growing body of research supports this supposition. Various measures of religion tend to be linked with lower levels of alcohol use (Geppert et al., 2007; Koenig, 2007; Koenig et al., 2001). For example, increased church attendance is typically associated with lower levels of alcohol use.

It is important to note that the overlapping nature of spirituality and religion complicate attempts to make clear demarcations regarding theoretical pathways. Because religion tends to mediate spirituality in the lives of most individuals, the various mechanisms discussed earlier also tend to be intertwined (Geppert et al., 2007). Religious teachings, for instance, may reinforce a sense of transcendent meaning and purpose in life that is derived through one’s spirituality. Similarly, having a Higher Power may also enhance one’s ability to cope with stress by providing a significant Other to turn toward during difficult circumstances (Pargament, 1997).

The theoretical pathways and empirical data suggest that incorporating spirituality and religion into CBT may enhance treatment effectiveness. Effectiveness, however, is a multifaceted construct. Consequently, integrating clients’ spiritual and religious values into traditional CBT protocols may engender a number of potentially positive outcomes.

**POTENTIAL OUTCOMES**

Previous research has suggested that spiritually modified CBT may enhance at least four outcomes when used with clients who are spiritually motivated (Azhar & Varma, 2000; D’Souza & Rodrigo, 2004; Propst, 1996). These outcomes can be summarized as follows: faster recovery, enhanced treatment compliance, lower levels of relapse, and reduced treatment disparities. It is important to emphasize that all four of these outcomes will not necessarily be experienced by every client. Rather, they represent potential outcomes that some spiritually engaged clients may experience.

**Faster Recovery**

Faster recovery is a plausible outcome because spiritually modified CBT taps two “motivational
engines” (Hodge, 2008; Koenig, Larson, & Matthews, 1996). Although the decision to seek treatment is often multifaceted, assistance is often sought when the problems caused by alcohol use become unmanageable (Cohen, Feinn, Arias, & Kranzler, 2007). Thus, clients are motivated to change by their inability to manage their lives in a satisfactory manner.

In addition to this traditional “secular” motivational engine, spiritually modified CBT also taps clients’ spiritual motivation. Adapting interventions so they resonate with clients’ spiritual belief systems can enhance motivation to change (Beitel et al., 2007; Margolin, Beitel, Schuman-Olivier, & Avants, 2006). Spiritual themes provide a “motivational language” that can be used to encourage the implementation of CBT protocols (Propst, 1996). Harnessing both secular and sacred motivations may speed recovery by compounding clients’ desire to address the problem (Azhar & Varma, 2000; D’Souza & Rodrigo, 2004; Propst et al., 1992).

**Enhanced Treatment Compliance**

Another way in which outcomes may be enhanced is in the area of compliance. Treatment retention is a significant issue in alcohol treatment (Substance Abuse and Mental Health Services Administration, 2006). Attrition is particularly problematic among ethnic minority clients, who frequently encounter practitioners from the dominant culture (Jacobson, Robinson, & Bluthenthal, 2007; Nellori & Ernst, 2004).

In the same way that retention can be improved among African Americans by matching them with African American practitioners who share their worldviews (Wintersteen, Mensinger, & Diamond, 2005), incorporating clients’ spiritual and religious values into treatment can also reduce attrition (D’Souza & Rodrigo, 2004). Treatment adherence is increased by adapting interventions so that they better reflect clients’ spiritual values (Beitel et al., 2007; Margolin et al., 2006; Wolf, 1978). For instance, framing treatment as a form of spiritual practice can help mitigate the stigma often associated with seeking therapeutic help and elicit community support (Azhar & Varma, 2000).

**Lower Levels of Relapse**

Outcomes may also be enhanced at various post-treatment follow-up points. As success is achieved in treatment, clients often tend to relapse (Piderman et al., 2007). As the problems that caused the original decision to seek treatment become more manageable, the impetus to continue implementing the traditional CBT protocols can dissipate.

Constructing CBT protocols in a manner that harnesses spirituality can provide a rationale for spiritually motivated clients to continue to implement the protocols (D’Souza & Rodrigo, 2004). A felt spiritual rationale continues to exist when the felt secular rationale is no longer operative (Beitel et al., 2007; Margolin et al., 2006). In turn, the implementation of such spiritually based interventions can result in lower levels of relapse (Elsheikh, 2008; Jarusiewicz, 2000; Lau & Segal, 2007; Sterling et al., 2007; Taub, Steiner, Weingarten, & Walton, 1994).

**Reduced Treatment Disparities**

Finally, spiritually modified CBT may engage clients who would otherwise fall outside the system. Many people with an alcohol disorder never seek treatment (Cohen et al., 2007). In some cases, clients are hesitant to receive services because of perceptions that practitioners are not sensitive to spiritual concerns (Richards & Bergin, 2000).

Spiritually modified CBT may appeal to a subset of the population that is currently served by clergy members or receives no services at all (Cohen et al., 2007). Individuals who are normally uninterested in seeking alcohol treatment may be more open to treatment that incorporates spirituality as a central dimension of therapy. By making interventions relevant to the felt needs of spiritually motivated individuals, treatment disparities can be reduced as those previously unserved receive services (Azhar & Varma, 2000; Bowen et al., 2006).

Given these potential outcomes, some practitioners may want to use spiritually modified CBT protocols in their work with clients wrestling with alcoholism (Forman et al., 2001). Because most practitioners appear to have received little training in how to construct spiritually modified CBT protocols, a brief overview of the construction process may be warranted (Sheridan, 2009).

**USING SPIRITUALLY MODIFIED CBT IN PRACTICE SETTINGS**

Constructing a spiritually modified intervention can be viewed as an iterative, three-step process (Hodge & Nadir, 2008). The three steps can be summarized as follows: understanding the underlying therapeutic concept, ensuring the congruence of the concept with the client’s worldview, and rearticulating the
concept in language that resonates with the client’s spiritual values. Although the steps are presented in the next section in a sequential manner, in practice settings the process is often operationalized in a more circular, iterative manner. The process is iterative in the sense that practitioners and clients may collaboratively discuss this process in a back-and-forth manner for some time until agreeing on a culturally congruent spiritually modified CBT self-statement. After each step is described in more detail, the construction process is illustrated with a self-statement drawn from the work of Albert Ellis (2000), who is widely viewed as a central founder of the contemporary CBT movement (Beck, 1976; Ellis, 1962).

The Three-Step Construction Process
The first step in the process is to develop a thorough understanding of the therapeutic precepts embedded in secular CBT protocols. Reflecting the secular culture in which CBT was developed, the self-statements typically used in CBT convey therapeutic concepts that are “packaged” in secular language, or language that is devoid of transcendent concepts (“Secular,” 2005). The therapeutic concepts that are thought to engender wellness must be identified and separated from the secular phraseology. In other words, the underlying concepts must be isolated from the secular terminology used to express the concepts.

After distinguishing the underlying therapeutic concept, the second step is to discuss the therapeutic concept with clients to ensure that it is consistent with their spiritual narratives. Indicators of wellness are not necessarily universal constructs that transcend cultures (Cross, 2001; Jafari, 1993). As noted in the DSM–IV (American Psychiatric Association, 2000), indicators can vary from culture to culture. A therapeutic concept that indicates wellness among clients who are members of the dominant secular culture may not indicate wellness among clients from other cultural groups, such as Native Americans (Cross, 2001) or Muslims (Jafari, 1993). Accordingly, it is important to discuss the underlying therapeutic concept with clients to ensure that it is congruent with their spiritual narratives.

If the concept is congruent, the third step is to collaborate with clients in repackaging the concept in terminology drawn from clients’ spiritual narratives (Hodge & Nadir, 2008). In other words, the concept is rearticulated in vocabulary that reflects clients’ spiritual values. Ideally, the final self-statement resonates with clients’ spiritual beliefs and their religious practices.

To restate the three steps, the underlying therapeutic concept is identified, discussed with the client to ensure congruence with the client’s belief system, and then rearticulated in language drawn from the client’s spiritual narrative. It is important to acknowledge the complexity of this “translation” process. As multilingual individuals are well aware, language and concepts are intertwined. Concepts, in a certain sense, are often inferred by language. Parsing therapeutic concepts from the secular vocabulary in which they were originally expressed is often challenging, as is the process of restating concepts in clients’ spiritual vocabularies. Working with inferred, abstract concepts can be difficult, even with the help of clients. To help readers better understand this process, the following content illustrates the construction process using CBT protocols designed to address alcohol use.

Illustrating the Construction Process
As implied earlier, CBT is often used to identify and address unproductive thoughts that underlie decisions to use alcohol (NIAAA, 2000a). Practitioners work with clients to ascertain thoughts, feelings, and circumstances that precede alcohol use. Once identified, unproductive schema and behaviors can be replaced with more salutary alternatives that inhibit use.

For instance, in some cases, feelings of anxiety or depression may precede alcohol use. Clients may have difficulty accepting such disturbances and turn to alcohol to cope (Ellis, 2001). To assist clients in dealing with the feelings in a more productive manner, practitioners might use the following self-statement designed by Ellis (2000):

My disturbed feelings, such as anxiety or depression, are quite uncomfortable but they are not awful and do not make me a stupid person for indulging in them. If I see them as hassles rather than horrors, I can live with them more effectively and give myself a much better chance to minimize them. (p. 33)

Although the central therapeutic concept can be expressed in many ways, the key issue is that emotionally difficult feelings are not intolerable but, rather, unpleasant entities that can be managed.
Consistent with Ellis’s (2000) atheistic worldview, the concept is stated in secular terminology and human agency plays a central role in the self-statement. The statement contains no declarative authority beyond that of the help-seeking individual.

This value-informed phrasing may have minimal resonance with some spiritually motivated clients (Nielsen, Johnson, & Ridley, 2000). The following statement articulates the same concept using spiritual concepts. In this example, the statement is constructed to reflect concepts commonly affirmed among devout Latino Pentecostals (Hall, 2001; Wilson, 2008):

God promises never to let me experience more than I can bear. Although feelings such as anxiety or depression are uncomfortable, I can manage them by turning to God. I am not bad or a sinner for having such feelings, rather I have unique dignity, worth, and strengths because I am a child of God, created in His image.

In this formulation, human agency is supplemented by God’s control of the universe, his promise of victory, and his desire to help his struggling children overcome fleeting negative emotions. Arguments against feelings of unworthiness are anchored in the client’s status as a person created in the image of God in addition to the client’s verbal declaration of worth. Thus, in addition to increasing the statement’s degree of cultural relevance, arguments are incorporated into the self-statement. Furthermore, these arguments typically carry the weight of revealed truth for devout Latinos within this Christian tradition (Dobbins, 2000).

**Working with Client Spirituality**

In the process of developing and implementing spiritually modified CBT statements, it is critical to respect client autonomy (NASW, 2000). Practitioners must honor clients’ right to spiritual self-determination, regardless of whether they personally agree with clients’ choices. The focus must remain on operationalizing clients’ strengths to ameliorate problems rather than changing clients’ beliefs and values.

One practical way to achieve this goal is to work within the parameters of clients’ religious tradition (Hamdan, 2008). As noted earlier, although spirituality is individualized, it is typically expressed within the parameters of a religious context, which is one reason why the Joint Commission’s assessment requirements call practitioners to determine clients’ religion at the start of the assessment process (Hodge, 2006b; Koenig, 2007). By working within clients’ chosen metaphysical framework, practitioners communicate respect for client autonomy.

Developing familiarity with common beliefs and practices within various religious traditions can also aid this process. Within Islam, for instance, common tenets include belief in the temporal reality of the world, in the importance of the hereafter, that afflictions exist for a divine purpose, and that Allah is in supreme control of events and cares for those who trust him (Hamdan, 2008). Understanding such salutary cognitions helps practitioners construct spiritually relevant statements. Although clients must always be allowed to confirm or discard working self-statements tentatively offered by practitioners, having a working knowledge of common beliefs can enhance the construction process and communicate respect for clients’ belief systems.

Collaborating with clergy can also be helpful in identifying salutary beliefs and practices (Gilbert, 2000). Assistance from spiritual experts within clients’ religious traditions can help in constructing protocols that resonate spiritually. Ideally, these protocols double as a form of spiritual practice, providing spiritually motivated clients with an additional rationale for implementing the protocol (Carroll, 1993).

The practice of prayer, for instance, has been linked to long-term abstinence (Elsheikh, 2008). Thus, practitioners might work with clients and clergy from theistic traditions to construct self-statements that can be fashioned into the form of a prayer. Similar efforts might be undertaken with clients from Buddhist or Hindu traditions, in keeping with research linking meditation practices from these traditions with recovery and abstinence (Bowen et al., 2006; Lau & Segal, 2007; Taub et al., 1994).

The importance of practitioners remaining within their areas of therapeutic expertise should also be mentioned (NASW, 2000). This article focuses on CBT in light of existing research on this modality and widespread practitioner familiarity with the underlying skill sets (Longabaugh et al., 2005). It should be noted, however, that spirituality cannot be reduced solely to cognitive or behavioral concepts. In addition to concepts such as spiritual narratives, spirituality also includes rich experiential and relational dimensions.
Research has suggested that these dimensions can also play a role in recovery (Carroll, 1993; Elsheikh, 2008; Jarusiewicz, 2000; Sterling et al., 2007). Practitioners schooled in object relations theory may have the necessary training to help clients explore how their perceived relationship with the Transcendent relates to alcohol use, particularly if they have a working knowledge of the clients’ belief systems and are collaborating with clergy (Jankowski, 2002). Careful consideration of one’s level of expertise, however, should precede such explorations.

CONCLUSION
The nation’s religious diversity is increasing rapidly (Melton, 2003). According to some estimates, the United States is now the most religiously diverse nation on the globe (Eck, 2001). Throughout these various cultures that compose the nation’s emerging spiritual mosaic, people wrestle with alcoholism.

In keeping with this reality, numerous stakeholders have expressed an interest in incorporating spirituality into professional treatment, including clients (Arnold et al., 2002; Dermatis et al., 2004; Solkhah et al., 2009), practitioners (Forman et al., 2001), accrediting agencies (Koenig, 2007), and NIAAA (2000b). In response to these voices, this article orients practitioners to spiritually modified CBT, an approach that may speed recovery, enhance treatment compliance, prevent relapse, and reduce treatment disparities by providing more culturally congruent services. Given the nation’s growing diversity, further research on this modality should be a priority to fully map the potential offered by such treatments.

REFERENCES
D’Souza, R., Rodrigo, A., Keks, N., Tonso, M., & Tabone, K. (2003). An open randomized control study of an add-on spiritually augmented cognitive behavior therapy in patients with depression and hopeles-


and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36*, 400–408.


David R. Hodge, PhD, is assistant professor, School of Social Work, Arizona State University, and senior nonresident fellow, Program for Research on Religion and Urban Civil Society, University of Pennsylvania. Address correspondence to the author at Mail Code 3920, 411 North Central Avenue, Suite 800, Phoenix, AZ 85004-0689.

Original manuscript received June 9, 2008
Final revision received September 3, 2009
Accepted September 24, 2009