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INNOVATIONS IN PRACTICE

Integrating the models of addiction into humanistic counseling for individuals with substance use disorders

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Abstract
The models of addiction represent a framework for conceptualizing clients with substance use disorders. These models include the biological, sociocultural, psychological, moral, spiritual, and holistic models. They can be incorporated in humanistic counseling sessions to facilitate client insight into their substance use and to develop client-led treatment plans.

KEYWORDS
humanistic approach, substance use disorders, models of addiction, recovery, client-centered

INTRODUCTION

Counselors treating substance use disorders (SUDs) subscribe to a variety of belief systems. Some counselors, for example, are staunch proponents of the notion of SUDs as a disease and others tailor their treatments to match client characteristics (Crabb & Lintnen, 2007; Moyers & Miller, 1993). A significant number of counselors tend to be less flexible with regard to their etiology beliefs and treatment approaches (Crabb & Lintnen, 2007; Nielson, 2016). Furthermore, some SUD treatments adhere to a specific treatment philosophy or offer limited options for treatment approaches. Clients presenting with SUDs, similarly, come to counseling with etiology beliefs and treatment preferences (Swift et al., 2019). As a result, clients may be required to participate in treatment approaches that are inconsistent with their etiology beliefs regarding their substance use and recovery (the process of implementing goals to maintain abstinence or reduced use). This discrepancy is problematic because it can be detrimental to the quality of the working alliance, and researchers have found a positive association between counselors accommodating client beliefs regarding etiology and counseling outcomes (Atkinson et al., 1991; Constantino et al., 2018).

The fundamental tenets of humanistic counseling and their inherent factors play an important role in counseling outcomes for clients diagnosed with SUDs (Scholl et al., 2012). More specifically, some of these factors include counselor empathy, the quality of the counselor–client relationship, and respect

for client autonomy, subjective beliefs, and self-righting capacity (Rogers, 1961, 1977). These factors have been shown to reduce resistance dynamics between counselor and client (Moyers & Miller, 2013), reduce attrition from SUD treatment (Meier et al., 2005), and thereby increase positive treatment outcomes.

It is critical to identify strategic ways to mobilize the foundational humanistic factors in SUD counseling. One solution lies in the models of addiction; a framework used to train mental health and addiction professionals in how to conceptualize and treatment plan with clients with SUDs. The models of addiction represent empirically based perspectives on the causes of SUDs and treatment approaches for recovery. They are labeled and described differently by different scholars; however, this article focuses on the biological, psychological, moral, sociocultural, spiritual, and holistic models of addiction. Rather than use them solely as a tool for client conceptualization for the counselor, the approach described in this article involves bringing these models into the session so that clients can use them as tools to make sense of their beliefs about substance use and recovery. This enables the counselor to (a) meet the client where they are, resulting in a strong counselor–client relationship and development of a client-led treatment plan; (b) address barriers to recovery posed by the client's beliefs; and (c) elicit breadth and depth of the client's views on their substance use and recovery in order to set the stage for a more holistic recovery.

The models of addiction approach entails the application of several fundamental humanistic tenets. These tenets include (a) belief in a holistic, rather than reductionistic, approach to counseling, (b) responsiveness to the client's subjective experience, (c) belief that human behavior results primarily from the individual's sense of purpose rather than cause-and-effect, and (d) effective counseling is based on a "good human relationship" between the counselor and client (H. L. Ansbacher, 1990, p. 46). A good relationship was defined as an egalitarian relationship in which both individuals share mutual respect for one another (H. L. Ansbacher & R. R. Ansbacher, 1956). In addition, Bohard (2003) asserted that humanistic counseling entails "relating to human-beings in growth-producing ways" (p. 146). Humanistic counselors do not act upon clients, they act with them in a manner that confirms their potential for growth (Rogers, 1961; Tryon & Winograd, 2011).

VALUING THE CLIENT'S STRENGTHS AND PERCEPTIONS

Carl Rogers (1961) viewed clients as possessing a *self-righting* capacity. He described this capacity as a "directional trend which is evident in all human life—the urge to expand, extend, develop, mature—the tendency to express and activate all the capacities of the organism, or the self" (p. 351). As a result, humanistic counselors empower their clients to make optimal use of their inner resources and strengths (Scholl et al., 2014). Consistent with the greater aim of evoking the client's inner resources and self-identity, humanistic counselors promote the client's optimal engagement and active agency in therapy (Norcross & Lambert, 2019). Furthermore, a client's choices and actions are intrinsically motivating when they are integrated with their values, preferences, self-concept, sense of purpose, and personal goals (Constantino et al., 2019; Swift et al., 2019). For this reason, counselors who provide autonomy-supportive approaches (e.g., discussing a variety of treatment approaches) also promote optimal client engagement and progress toward client goals (Aggarwal et al., 2016).

One might reasonably expect a treatment that is consistent with a client's etiology beliefs to also be perceived as credible. In his *social influence theory*, Strong (1968) asserted that a client's view of a treatment's credibility is akin to a common factor in effective counseling. Strong viewed counseling as a social influence process in which the counselor's effectiveness is a function of three primary counselor characteristics: *expertness*, *trustworthiness*, and *attractiveness* (i.e., counselor likeability and relatability). Counselor expertness is potentially enhanced by client perceptions of the counselor's problem etiology and treatment plan as logical and effective (Devilly & Berkovec, 2000). Research indicates that employing a treatment approach matching the client's etiology beliefs is associated with relatively more positive therapeutic outcomes (Addis & Jacobson, 1996; Atkinson et al., 1991).

Consistent with social influence theory, a meta-analysis of 24 independent studies (Constantino et al., 2018) indicated that clients' perceptions of treatment plans as credible were positively associated with counseling outcomes. Other researchers found that providing a credible treatment rationale positively predicted client outcome expectations (Ametrano et al., 2017). A client who believes that their substance use problem results from relationship problems might find a cognitive-behavioral approach less credible than a treatment that aligns with their etiological beliefs (Constantino, et al., 2019). Plausibly, eliciting and incorporating clients' beliefs regarding the etiology of their problems contributes to the credibility of the treatment plan (Kirsch & Henry, 1977). Scholars reported that clients' views of treatment credibility are subject to change over the course of treatment as the counselor–client relationship grows stronger (Hardy et al., 1995; Mooney et al., 2014). All the prevailing models of addiction have elements that can be related to a given client's belief system.

RESPONSIVENESS TO CLIENT PREFERENCES

Researchers use numerous terms to refer to the practice of matching treatment approaches to the individual client. These terms include treatment matching, individualizing, adapting, matchmaking, and responsive matching or responsiveness (Norcross, 2012). An important aspect of all these approaches is understanding and intentionally responding to the preferences of the client. Swift and colleagues (2019) identified counselor preferences (e.g., counselor personality), activity preferences (e.g., talking about one's emotions), and treatment preferences (e.g., 12-step approach) as the primary categories of preferences held by clients (p. 156). A number of quantitative and qualitative client preference assessment instruments have been developed (Swift et al., 2019). These instruments commonly assess the clients' preferences for activities and type(s) of therapy. For example, with regard to the type of therapy, the Treatment Preference Interview (Vollmer et al., 2009) assesses clients' "beliefs about the causes of the problem" and the rater can choose from a variety of options including relationship conflicts, biological makeup, and lack of willpower that resemble the models of addiction (Swift et al., 2011, p. 303). Importantly, research indicates that the more effective responsive approach is to match the treatment to the client's preferences, beliefs, and personality, rather than to their mental health problem (Addis & Jacobson, 1996; Atkinson et al., 1991; Constantino et al., 2018).

THE WORKING ALLIANCE

The working alliance is one of the ways researchers have operationalized and researched factors such as responsiveness to clients' preferences and beliefs. The working alliance construct underscores a view of counseling as relational and consists of three primary components: the task, goal, and bond (Bordin, 1979). The *task* refers to the degree of consensus between the counselor and client regarding the appropriateness of the tasks that comprise the treatment. The *goal* refers to the agreement between the counselor and client regarding the appropriateness of collaboratively identified therapeutic goals. The *bond* refers to the client's sense of connection with the counselor (Bordin, 1979).

The working alliance is associated with other favorable variables for those enrolled in SUD treatment. For example, researchers discovered that counselors' assessment of the working alliance after the first session of SUD counseling accounted for 52% of the variance in a regression model predicting treatment dropout (Knuuttila et al., 2012). Other researchers have found correlations between high self-report of working alliance and lower substance use. Maisto et al. (2015) found that the working alliance (as perceived by both counselor and client) is linked to clients' increased belief in their ability to not consume alcohol in the face of relapse triggers which was associated with clients drinking less often and in lower quantities after completing treatment.

Motivational interviewing (MI) is a humanistic approach that entails applying Rogerian concepts of valuing the client's strengths, perceptions, and incentives to change (Miller & Rollnick, 2013).

Wiprovnick et al. (2015) discovered that the client's experience of the counselor's empathy was associated with less consumption of alcohol at posttest among individuals with subclinical alcohol use concerns who participated in four sessions of MI. Based on previous work (Elliott et al., 2011), empathy is "a perspective-taking process in which the therapist takes the perspective of the client and attempts to understand it as best as possible" (Wiprovnick et al., 2015, p. 132). The models of addiction provide the counselor with a concrete framework for how to empathize with the client and avoid imposing their views on the client.

The models of addiction approach is a unique contribution to the literature in that it involves a set of skills to help the client arrive at their own counseling goals and treatment plan. The application of these skills can raise client insight and motivation since a holistic exploration of the client's substance use is undertaken. Furthermore, this approach is specific to individuals with SUDs rather than generalized to matching for broader mental health counseling.

THE MODELS OF ADDICTION

The models of addiction are designed to illuminate the reasons that SUDs occur and how to recover from them. They are traditionally taught in introductory addiction counseling courses. Acquisition of these models serves several functions for counselors including (a) setting the stage for counselors to reflect upon the causes of SUDs and paths to recovery; (b) helping counselors identify their own beliefs and biases about the origins of SUDs; and (c) increasing counselors' ability to treatment plan as the models of addiction inform the conceptualization of the client (Thombs & Osborn, 2019). The models of addiction tend to fall within the categories of biological, psychological, moral, spiritual, sociocultural, and holistic.

The biological model consists of two branches: the genetics branch represents the perspective that genetic vulnerability is a primary cause of SUDs. The disease branch of this model centers on the viewpoint that SUDs are a "chronic, relapsing disorder" (National Institute on Drug Abuse, 2020). Brooks and McHenry (2015) use the metaphor of a "glow stick" when explaining the disease branch of the model:

> Once a glow stick has been broken and the chemicals mix, the chemical makeup of the stick changes, never to return to its original state. As with the glow stick, the medical model suggests that once the process of a disease such as addiction is fully activated in an individual predisposed (e.g. genetically) to the disease, changes occur within the individual that can never be reversed. (p. 117)

Some liken SUDs to cancer: a disease that will worsen if left untreated, go into remission if treated, and can resurface even when treated.

Psychological model advocates espouse that cognitive, affective, and behavioral factors are the root cause of SUDs. Interventions such as relapse prevention (Marlatt, 1985) are founded upon behavioral principles maintaining that exposure to certain situations or internal experiences can trigger thoughts, feelings, and actions that result in substance use. Additionally, "emotional pain" (Doweiko, 2019, p. 359) and more recently attachment theory (Flores, 2004) are frequently believed to be at the core of SUDs. The psychological model is also inclusive of trauma and mental health disorders as main influences on SUDs.

The moral model of addiction, contrary to the biological model, holds that the addictive use of substances occurs because of the decisions of the individual (Thombs & Osborn, 2019). In other words, an individual with an SUD can control their substance use yet makes the decision not to do so. The inability to choose alternatives to substance use is viewed as internal weakness on the part of the addicted person (Doweiko, 2019). Those who embrace the moral model believe that engaging in addictive behaviors is "… a violation of moral, ethical, or religious standards" (Miller et al., 2019,

p. 26). Individuals with SUDs who support this model range from those mired in shame from believing they are a bad person for using substances to those who believe they can improve their discernment related to substance use in order to rectify the substance use issue (Thombs & Osborn, 2019).

The spiritual model is based on existential, spiritual, and religious elements. Individuals who hold this perspective believe that an internal emptiness, lack of meaning, and religious and/or spiritual deficits lead to addictive behavior (Doweiko, 2019). Hence, the road to recovery is to connect with one's purpose in life and/or address the concerns in one's religious and/or spiritual life. Religio-spiritual challenges can include spiritual bypass in which the person utilizes their spirituality as a defense mechanism from engaging in the emotional vulnerability and hardships that come with a holistic recovery (Fox et al., 2017). The *Alcoholics Anonymous Big Book* is aligned with the spiritual model given the prominent role of a higher power and "prayer and meditation" (Alcoholics Anonymous World Services, 2001, p. 59). Like any of the models of addiction, overlap exists between the spiritual and moral models.

The sociocultural model pertains to the systems in a person's life playing the main causal role in their SUD (Thombs & Osborn, 2019). These systems range from one's family of origin and home life to one's work or school environment and finally to one's local and worldwide occurrences (Myers & Sweeney, 2004). Examples of systemic impact include individuals with substance use concerns who are enabled to consume alcohol or drugs by family and friends, are affected by growing up in a family in which one or more members struggled with a SUD, or have increased their use of substances to cope with the effects of the COVID-19 pandemic, systemic discrimination, or incidents of social injustice. Culture in this model refers to the intersection of personal culture (e.g., generation in which one grew up, race, ethnicity, religion, gender identity, sexual orientation, and beyond) and substance use. The experience of microaggressions or internal conflict about an aspect of one's cultural identity, for instance, may challenge one's recovery, while making contact with the meaning in one's culture and resources that affirm one's cultural identity may enhance recovery (Thombs & Osborn, 2019).

The holistic model of addiction, also referred to as the biopsychosocial model incorporates all of the above models. Whereas the definition of each of the previous models includes the belief that the respective model is the main cause of the SUD, supporters of this model believe that a multitude of variables are involved in the development of SUDs. The implication is that a holistic treatment approach that draws upon interventions that target each of the above models is most beneficial to the client (Doweiko, 2019; Thombs & Osborn, 2019).

The next sections of this article contain information on utilizing the models of addiction as a framework for eliciting the client's subjective experience for collaborative assessment and treatment planning.

ASSESSING THE CLIENT'S MODELS OF ADDICTION

Implementing the models of addiction in counseling is not dependent upon the client's willingness or ability to discuss or make changes to their substance use, nor the severity of the SUD. This approach necessitates the client sharing their thoughts on their use, including the opinion that it is not problematic. The counselor promotes meaningful dialogue by providing a framework with concrete questions for discussion. Counselors are encouraged to invite the client to share their thoughts, feelings, experiences, and beliefs about their substance use during the initial session(s) (Miller et al., 2019). A prompt might be, "Your beliefs about your substance use will be helpful in us working together and setting goals for our sessions. Tell me your thoughts about your substance use and the role it plays in your life. This includes ways in which your substance use has caused stress or problems for you and ways in which your use has been helpful or non-problematic." This prompt opens the models of addiction discussion while reducing the risk of a defensive dynamic (Miller & Rollnick, 2013; Miller et al., 2019).

Informing clients on the models of addiction

Now, the counselor provides information on the models of addiction. Counselors should avoid referring to the models as the "models of addiction" unless clients use this language themselves (Miller & Rollnick, 2013; Miller et al., 2019). Consistent with a humanistic stance of nonjudgmentalism, the counselor can use terms such as "reasons for substance use," "triggers for substance use, and "roots of substance use." The discourse can begin by the counselor noting that substance use is affected by a multitude of factors that fall within one or more categories or models. The counselor explains that they desire to understand the client's beliefs about causes of their substance use as their beliefs will inform treatment options and ensure their preferences are honored to the utmost extent.

The models of addiction approach is designed to prevent counselors from meeting with a client with a preferred model of addiction already in mind. The model emphasizes that the counselor is gaining understanding of the client's subjective identification with one, several, or none of the models. The models of addiction are used to elicit the client's actual beliefs without implying any sort of external evaluation, judgment, or pressure to select one particular model (Rogers, 1961). The counselor explains each model succinctly and encourages the client to ask questions. The counselor should mention that multiple models of addiction often explain an individual's substance use and that it is possible that none of the six models individually or collectively account for their use in full. In this case, the counselor encourages the client to describe their own unique model or ideas about the reasons for their substance use. After dialoguing about the models of addiction, the counselor asks the client to identify the models that relate to their substance use in any way. The "Questions to Draw Out the Client's Model(s) of Addiction" from Table 1 are infused among a high volume of reflective listening

TABLE 1 Questions to draw out the client's model(s) of addiction

Disease Model
How, if at all, have genetics played a role in your substance use?
Do you believe your substance use is a disease, like cancer?
How (if at all) has your substance use affected your brain and body?
How (if at all) has your substance use been difficult to control at times?
Psychological Model
How (if at all) have you used substances to manage stress or "emotional pain"?
How (if at all) have traumatic events that you have experienced impacted your substance use?
How (if at all) have you used substances to manage other mental health concerns (e.g., depression, anxiety, etc.)?
Moral Model
Do you believe that you can control your substance use?
Do you believe that problems with self-discipline are one of the main reasons you have had problems with your substance use?
Do you believe that your substance use problems are related to your decision-making?
Do you believe that weaknesses in who you are as a person have affected your substance use?
Spiritual Model
How (if at all) have struggles with meaning and purpose contributed to your substance use?
How (if at all) have spiritual or religious struggles played a role in your substance use?
Sociocultural Model
How (if at all) did the family environment in which you grew up play a role in your substance use?
How (if at all) have the persons around you in your daily life played a role in your substance use?
How (if at all) has your current environment (e.g., work, school, local and worldwide happenings) impacted your substance use?
How (if at all) has your culture (e.g., ethnicity, religion, gender identity, sexual orientation, etc.), including experiences of discrimination, affected your substance use?
Holistic Model
Do you believe that most/all of the models have affected your substance use in some way?

Note. When asking questions from *Table 1*, counselors should explain to clients that they seek to understand the client's beliefs about their substance use and that there are no "right" or "wrong" responses. Counselors ask clients to elaborate, particularly on closed-ended questions, which can initially yield brief responses.

skills during this discussion (Miller et al., 2019). The counselor processes each area noted by the client as well as reasons for the models that do not fit for them.

Models of addiction assessment activity

To facilitate depth and clarity on the client's beliefs, a models of addiction drawing activity can be used. The client creates a pie of the models of addiction in which they draw a large circle to represent the pie, or whole of their substance use, and slices of pie to represent each model of addiction. The client is informed that the size that they draw each slice symbolizes their belief in its significance as a causal factor in their substance use (Myers et al., 2012). The client is also given the option of not including all six models, adding their own model that is unique from the other six to the drawing, or using only their own model of addiction.

The debriefing of this activity is another opportunity for the counselor to explore the experiences that inform the client's models of addiction. The counselor implements follow-up questions that elicit examples of the model in action such as "What lets you know that this model plays such a large or small role in your substance use?" Furthermore, drawing out the client's examination of models they portrayed as lower in salience can occur using the solution-focused counseling (O'Connell, 2012; O'Hanlon & Weiner-Davis, 2003) and MI (Miller & Rollnick, 2013) inspired prompt of, "Even though the _____ model was depicted as least relevant to your substance use, it still is a piece of the pie for you. Tell me more about how, even if in a small way, aspects of the _____ model affects your cocaine use." Subsequently, the counselor can inquire what it means to the client to identify factors associated with their substance use.

Aligning with and extending the client's models of addiction

Skills for understanding the client's perspective of their substance use, challenging any incongruence in the client's perceptions, and sharing information that might be helpful to the client are paramount. The counselor begins with approaching sessions from the client's viewpoint on their substance use; for instance, a client who espouses the sociocultural model perspective for their substance use might remark, "I've been thinking about cutting down on pot. I think it's a matter of spending time with some different people. I'm always hanging around the friends I smoke with." This client statement is reflective of the sociocultural model because they view environment as a main factor in their use and that if changes occur there, they may be able to reduce use.

Aligning in this situation involves using reflective listening to support the client in elaborating on these sociocultural factors. The counselor can implement prompts such as "Tell me more about how those you are around affect your pot smoking," "What other social or environmental factors have been affecting your pot use?" and "What are your thoughts on how you might change your social scene and how might those changes impact your pot use?" As the substance use history progresses, the counselor will usually begin to hear themes of one or more models of addiction. These will arise naturally from the client. It is also important to remain open to new, unexpected, themes that do not quite fit any of the models of addiction. When a model of addiction emerges, be sure to zero in and incorporate prompts to encourage client elaboration.

The counselor should inquire about the experiences that have shaped the client's perspectives on their substance use. For instance, if a client states, "I think I have a problem. My drug use controls me at times and I just have a hard time avoiding it." The counselor could then follow up by prompting, "Can you give me an example of a time when your drug use controlled you?" The counselor then seeks to determine the client's etiology beliefs that underlie the statement. To do this, the counselor may inquire, "What do you believe factors into your struggles to control your drug use?"

In addition to being consistent with humanistic philosophy, obtaining a holistic view of one's substance use problems is essential, since research indicates that the development and maintenance of SUDs is multifactored (e.g., Zlovensky et al., 2010). Hence, other models may be implicated in a client's use that have been overlooked. One method to address this is to invoke questions from Table 1 that have yet to be explored. Another option is for the counselor to utilize skills to *extend* the client's model of addiction. For instance, assume that through assessment with a client, it becomes clear the client has not recognized the correlation between their mental health symptoms and their substance use (psychological model). If this is the case, the counselor can bring up the possibility that psychological factors may also be involved. The counselor could state,

> You have described times in your life when you are possibly experiencing symptoms of depression. Remember that psychological model we talked about? I recall you mentioning in our first session that this model did not fit for you, but I'm wondering if there is a connection between those symptoms and your substance use.

Matching the client's language, potentially increases the client's openness and awareness to a psychological model. The counselor and client can now examine a more integrated approach to treatment.

During the models of addiction assessment, it is important to offer the full spectrum of models for discussion, including the moral model. This enables comprehensive appreciation and validation of the client's subjectively held views. Although some of the models are deficit based, they may reflect the client's subjective thought processes. If a client feels ashamed or helpless to enact changes in their life due to the models of addiction they espouse, the counselor should devote time to extending their models of addiction. Through this avenue, the counselor can explore whether other models more effectively explain their lived experience with substance use concerns. Counselor and client can also examine the costs and benefits of living in accordance with these self-beliefs and the value in recognizing the role of other models.

Bringing others' models of addiction into the room

The counselor can assist the client in deepening their insight into the effect of significant others' models of addiction on their own lives by figuratively bringing the significant others' models of addiction into the counseling room. This involves inquiring about people who the client has spent large amounts of time with and/or has had an impact on their lives. The counselor poses prompts such as "If this person was in this office with us and I asked them what they believe factors into your substance use, what would they say to me?" As in the previous exercise, the counselor asks about actions or comments made by these individuals that would indicate their beliefs about the client's substance use. The client then processes the impact of their significant others' beliefs about their substance use on them. It is particularly important to be aware of when the clients' significant others espouse a moral model of addiction as this has potential to negatively affect the client in a sizable way. For example, if this individual perceives the client should be able to manage their substance use but is a weak person who simply needs to be more disciplined or wiser in their approach to substance use, this can increase the client's sense of shame.

TREATMENT PLANNING

The counselor assists the client in determining the model(s) of addiction to target as treatment goals. If clients prefer a present and future focus for counseling rather than examining the causes of their substance use, the models of addiction approach can be pared down to informing the client about the models of addiction, then transitioning into the treatment planning process described below. Clients

TABLE 2 Counseling approaches across the models of addiction

Biological	Psychological	Moral	Spiritual	Sociocultural	Holistic
Twelve-step facilitation or referral	Integrated treatment for co-occurring disorders	Harm reduction approaches	Twelve -step facilitation	Couples and family counseling	*Approaches that integrate multiple models of addiction*
Medication for substance use disorders (SUDs)	Cognitive-behavioral approaches (e.g., relapse prevention)	Harm reduction mutual help group support (e.g., SMART Recovery)	Spiritual mutual help group referral (e.g., Overcomers Outreach, 12-Step)	Mutual help group referrals for family members (e.g., Al Anon or Alateen)	
Neurocounseling	Psychotropic medication for mental health disorders		Spiritual counseling	Exploration of client's culture as it relates to substance use	
Psychoeducation on SUDs and the brain	Trauma-informed approaches		Facilitate connection to faith community	Psychoeducation on skills for responding to social pressure to use	
			Facilitate utilization of spiritual practices	Identification of social supports and unhelpful relationships	
			Existential approaches		

Note. This is not an exhaustive list of counseling approaches across the models of addiction.

can set goals based on one model that stood out from their assessment or choose goals that each reflect a different model. The counselor then presents the treatment modalities they can provide or refers the client to those that correspond with the models of addiction for the client's treatment goals. Table 2 contains a chart that situates different SUD counseling approaches within the models of addiction. This is equivalent to the *menu of options* approach in MI (Miller & Rollnick, 2002). For example, if the client seeks to address family stress and the influence of their partner's substance use (sociocultural model), couples or family counseling may be indicated and could be offered by a counselor trained in these approaches. Movement toward incorporating multiple models of addiction into the treatment modalities may be preferable to ensure a holistic treatment plan. *Extending skills* enable the counselor to help the client consider a plan integrating several models.

Counselors should also provide the client with an opportunity to pinpoint any strengths or resources they possess within the models that will support their treatment goals. The counselor initiates this dialogue by inquiring about periods when the client has successfully abstained from substance use or adhered to reduced substance use goals they had previously set. The counselor could pose the question, "What was helpful in not using or in reducing your use?" and help the client link their response to the models implicated in their success. For instance, the client may note that their family was supportive of them entering counseling and has helped them avoid relapsing in the past (sociocultural).

Some clients do not wish to focus on their substance use as a treatment goal and/or do not believe that their substance use is problematic. Even in the case of clients mandated to attend counseling, goals can be set or discussed. The counselor can preserve the professional relationship with the client while building meaningful treatment goals by aligning with them rather than attempting to extend their consideration of additional models of addiction. This is similar to the idea of *rolling with resistance*

which entails reflecting the client's rationale for not changing in order to avoid creating a resistance dynamic with the client (Miller & Rollnick, 2002).

Additionally, the counselor invites the client to explore the warning signs (based on the models of addiction) that will let them know that their substance use has begun to cause stress or problems in their life. The client may state, for example, that if they are unable to stick to the limits they set on frequency and quantity of use (disease model) or they find themselves using substances in order to deal with life challenges (psychological model), they will be concerned about their use. The counselor should help the client to elaborate on what these warning signs will look like. A final option is to use the MI technique of *shifting focus*; finding out what the client would prefer to attend to in counseling given that they do not want to address their substance use (Miller & Rollnick, 2002).

In the following section, a vignette demonstrating the application of the models of addiction approach is presented. Background information on the client will be provided along with a summary and quotes from the counselor–client interactions that highlight portions of the assessment and treatment planning process. The client and vignette below are fictitious. A discussion of implications and limitations will conclude the article.

CASE VIGNETTE

Ann is a 52-year old Caucasian female client hospitalized for several days due to intra-abdominal bleeding. She was highly intoxicated on alcohol at the time of hospitalization. A hospital social worker conducted a brief substance use assessment and discovered Ann's pattern of alcohol use is consistent with an alcohol use disorder. The physicians monitored Ann for withdrawal symptoms, but a medical detoxification was not needed. The social worker referred her to several treatment programs to seek out after leaving the hospital. Ann agreed to go to the site of an intensive outpatient program (IOP) for SUDs but after receiving an initial assessment, refused to attend IOP, noting she did not feel comfortable sharing about herself with the group. She did agree to attend five individual sessions and remained open to reconsidering the IOP at some point.

The diagnosis resulting from the assessment was alcohol use disorder, severe. Ann and her ex-husband, Alex, divorced about 5 years ago. Based on Ann's reports, Alex also appeared to consume alcohol at a SUD level. The relationship, which lasted 22 years, was highly toxic, particularly when both had been consuming alcohol. Ann dissolved the marriage and expressed regret about not leaving the marriage earlier. Ann and her brother grew up in a family in which her parents frequently argued. There is a history of SUDs on her father's side of the family. Ann began to encounter problems from drug and alcohol use in high school and college. She was able to succeed academically in high school and college despite substance use. Over the past several years, she has worked part-time as a computer network support specialist.

Ann reported consuming three to four drinks of alcohol on lower drinking days and 8–10 drinks on higher drinking days. Ann stated that she drinks alcohol 5–6 days per week. Her score on the Alcohol Use Disorders Identification Test (AUDIT) was 29, indicating the possibility of a severe alcohol use disorder (Babor et al., 2001). She is not currently experiencing any withdrawal symptoms. She uses marijuana 2–3 times per year and recounted no use of other substances over the past 20 years. Ann quit alcohol use 10 years ago and cut down on her drinking initially after getting divorced; however, that use has resumed to high levels.

Initial assessment

The counselor first asked Ann her thoughts and feelings about her alcohol use. Ann stated that the events of the hospitalization were a "wake-up call" for her, that she had "let [her] drinking get out of hand," and that "[she] just needs to use a little more self-control." Ann stated that while she has not

taken a drink since entering the hospital, she does plan to most likely resume drinking again, but in a moderate way. The first moments of the session already suggest that the moral model is an element of the client's self-assessment of her use. The counselor presented the models of addiction and asked Ann to process which (if any) of the models seemed to have explanatory power regarding her alcohol use.

Ann: I think the psychological model and the moral model make some sense to me. I drink a lot of the time when I am stressed or when I just want to have some fun with my friends. I noticed that when I got divorced I was able to quit drinking at first. I even went to a few AA [Alcoholics Anonymous] meetings, but that didn't last for very long. I was probably drinking more than I was before I got divorced once I started back. And I do feel like I've had some hard things to deal with in my life.

Counselor: Tell me more about the hard things you have been through and how they are related to your drinking [Counselor uses a prompt to encourage Ann to explore a connection with the psychological model further].

Ann: I've been thinking about this more since I was in the hospital and had to talk to the social worker. I drank because of anxiety I had about the problems between my ex and I. Since we divorced, things have been worse in some ways. I'm trying to reset my life and I wonder if I was the problem in our marriage. I drink to deal with this too.

Counselor: You have used alcohol in the past and present to try to manage difficult feelings [Counselor reflects the psychological model]. You also mentioned that the moral model may impact your drinking as well.

Ann: Well, I feel like now, especially since I've not been drinking, that if I really focus myself, I can drink less. Ya know, so that I don't end up in this same situation.

Counselor: It sounds like you believe that you can control your drinking, if you go about things in an effective way [Counselor uses a reflection to match Ann's moral model beliefs. Counselor does not attempt a broader exploration of her models of addiction at this point as this could result in a resistance dynamic, which might be detrimental to the counseling relationship].

Ann: Yeah. Staying sober these last couple days has shown I might be able to do this. Not only that, but I don't know that my drinking is nearly as bad as the social worker and doctors seemed to think. I'm still working, I pay my bills, I have friends, I've come here to talk to you. I know people with drug problems who drink way more than me.

Ann completed the models of addiction pie activity and drew the psychological model as 30% of the pie, the sociocultural model as 20%, the moral model as 20%, the biological model as 15%, and the spiritual model as 15% of the pie.

Extending Ann's models of addiction

The counselor remarked to Ann, "As I look back at your 'reasons for alcohol use pie,' I'm reminded that the biological, spiritual, and sociocultural models formed pieces of your pie. Tell me more about how these pieces have affected your substance use." This prompt nonjudgmentally invites Ann to look holistically at causes of her substance use. Ann replied that feeling lost regarding the purpose of her life has been an underlying trigger to her troubles with alcohol (spiritual model). She added that in retrospect, "I'm not sure that the biological or sociocultural models have a lot to do with my drinking." The counselor utilized some of the questions associated with each model so that Ann could examine each one. The facilitative questions about the sociocultural model sparked insights for Ann that the majority of people she spends time with, consume alcohol or drugs on a consistent basis and that alcohol use almost always occurs when she socializes with these peers. Ann also shared further about her family experiences and their effect on her current alcohol use.

The biological model dialogue began with the counselor asking Ann, "How (if at all) has your substance use been difficult to control and if so, what does this mean for you moving forward?" Ann stated she did believe cutting down on her alcohol use would be a challenge, more so because it has become a "habit" for her. She commented that now that the alcohol is out of her system, she feels better able to reduce her risk for future alcohol problems. When asked by the counselor if she believes she is addicted to alcohol, Ann replied that she was and could be again, if she is not careful. She denied that alcohol use was like a disease for her, attributing her alcohol problems to poor decision-making, lack of self-discipline, and low self-esteem.

Counselor: [selectively prompting the biological model for purposes of extending Ann's consideration of additional models of addiction]. The idea of your drinking as a disease does not resonate with your experience. You did note that you were addicted. Say more about what let you know that you were addicted to alcohol.

Ann: Before I ended up in the hospital, I had gotten to a point where I was drinking more than I wanted to and each day I would say to myself that I'm not going to drink as much, but nothing changed. I knew I could lose my job if I made an error while hungover or still drunk, but I was still struggling to reign things in.

Later in the session, the counselor asked about significant others' models of addiction and their impact on her.

Ann: My parents don't understand why I don't cut down or stop drinking. They're fed up with me and they don't make much of an effort to spend time with me anymore like they used to. They have said over and over again that I choose drinking over them. They're probably right and that makes me feel terrible.

Counselor: It sounds like you feel a sense of guilt. That you should have been able to control your drinking and that your relationship with your parents deteriorated, in part, because of this [reflecting the moral model embedded within Ann's statement].

Treatment planning

During the treatment planning phase, the models of addiction are incorporated by channeling the discussion on causes of substance use into treatment planning approaches. The counselor told Ann that together, they would come up with goals for their counseling and objectives for accomplishing the goals. The counselor first asked Ann about how the models of addiction could guide her selection of treatment options. Ann noted that the psychological model needs to be central to her recovery. She stated that in processing the models, she is now increasingly aware of feeling psychologically wounded from her marriage as well as her childhood and interactions with her parents. Ann articulated that a sociocultural perspective would be helpful because she believes that she cannot maintain certain friends or peers while meeting her treatment goals. The following dialogue ensued about the biological model.

Ann: I'm still not sure that I want to stop drinking for the rest of my life. I just can't picture it. And what if it's just not necessary.

Counselor: I can hear that the idea of abstinence seems possibly unneeded and daunting. Ann, in your AUDIT, you endorsed items that indicate your body is physically addicted to alcohol. In our session you have discussed reasons to believe that moderating your drinking may be unrealistic and how part of your beliefs that you can or should have command over your alcohol consumption were influenced by the opinions of your parents.

Ann: I am not going to IOP. I am not going to AA. I do feel different not drinking and the logical part of me knows that continuing to not drink is the least risky thing to do. I can agree to not drink as a goal, but I want to have open the possibility that I can try drinking again at a more reasonable level. I'm open to coming in to see you every week for as long as you recommend. As we talked about, I'll consider IOP if things don't go well.

Counselor: Got it. Your plan at this point is for abstinence and we can discuss a goal for how long you want to maintain this before we re-evaluate. You mentioned that the sociocultural model is important to your recovery, but that you currently don't want to be in AA or IOP which have the benefit of group support. What thoughts do you have on building in social supports that will help you not drink as well as avoiding friends or family who might trigger you to drink?

The counselor also inquired about Ann's strengths across the models of addiction. Ann commented that she does feel a level of connection with a church in her community, attending about once every two months (spiritual model). She feels connected with the pastor and a few friends who she used to spend time with who do not use substances. Ann stated she would set a meeting with the pastor to get spiritual assistance with her struggles (including those with alcohol), strive to attend church at least once every other week, and re-engage with old friends from her church (sociocultural model). The counselor made sure to describe other modalities for the client to ponder as part of the treatment plan based on the models of addiction assessment such as existential approaches to address her purpose in life concerns, relapse prevention to aid with abstinence, and the possibility of family sessions.

IMPLICATIONS AND LIMITATIONS

Incorporating the models of addiction in SUD counseling unlocks multiple therapeutic possibilities. In the case of Ann, the models of addiction provide a common language or scaffolding for client sense-making of their etiology beliefs on their substance use. Counselors can then meet clients where they are while extending their views to see a fuller picture of the influences on their use and options for treatment. They also offer flexibility to the counselor, as this approach is transtheoretical, leaving room for specific theories or interventions to be used concurrently or subsequently. Although this approach focuses primarily on rapport building, conceptualization, and treatment planning, the models of addiction approach can be infused into ongoing sessions. These processes can be similarly applied in assessing the models of addiction with loved ones of persons with SUDs during family sessions or individual sessions with the loved one. Thus, significant others can receive information from the counselor on the different models, identify their beliefs and biases, and recognize how their beliefs and biases affect their own self-care and relationship with the person with the SUD.

One can observe that the models of addiction approach are grounded in principles and literature on humanistic counseling. The client's self-righting capacity is mobilized, and working alliance is strengthened to a large degree since clients lead the exploration into the presenting concern and the treatment planning process (Bordin, 1979; Rogers, 1961). This approach embodies a respect for the client's point of view in general and etiology beliefs about their substance use, specifically. At the same time, from a humanistic perspective including the importance of providing a growth-producing relationship, it would be negligent for the counselor to withhold professional knowledge or refrain from offering input based upon their training and expertise (e.g., Rogers, 1961).

This model has important implications for culturally responsive practice. More specifically, it is consistent with a *philosophy of client activation* which entails spending time gaining understanding of the client's beliefs and preferences to foster a deeper connection with the client and to promote their sense of personal agency (Alegria et al., 2019). Client activation is intended to empower clients increasing the extent to which they are active participants in their own counseling process. Aggarwhal et al. (2016) reported that there is a tendency among counselors working with clients from diverse populations to become less collaborative and more directive resulting in lower levels of engagement

in therapy. This contention is further supported by studies reporting that racial and ethnic minorities report lower levels of activation in their treatment (Eliacin et al., 2018; Lubetkin, et al., 2014). Counselors adopting the models of addiction approach with all clients are likely to be more culturally responsive and foster higher levels of activation in their work with clients from diverse populations.

The models of addiction approach is limited in that there is no research evaluating its effectiveness. Utilization of the models of addiction also requires a thoughtful understanding of these concepts on the part of the counselor in order to explain and deconstruct them meaningfully with the client. This approach is also not as immediately useful if the client has no buy-in to examine their substance use in this manner. Additional challenges include identifying ways to integrate these techniques into one's work if constrained by the limits of time or the structure of assessment and treatment planning at one's clinical setting. However, the models of addiction approach can be amended by the counselor in order to work within the requirements of their practice.

CONCLUSION

The models of addiction approach is guided by humanistic counseling and provides new techniques for helping clients access and utilize their own inner wisdom about the causes and solutions to their substance use concerns. Clients explore the impact of biological, sociocultural, moral, psychological, spiritual, and holistic factors on their substance use and recovery from substance use issues. The client takes the lead in constructing the treatment plan, including identifying their beliefs about what recovery looks like for them through the lens of the six models and transferring their strengths within these models to the treatment plan. In sum, these unique avenues to building rapport, client conceptualization, and treatment planning are based on the research on humanistic factors that suggest that valuing the client's etiology beliefs, responsiveness to client preferences (Addis & Jacobson, 1996; Atkinson et al., 1991; Constantino et al., 2018), and cultivating a strong working alliance play a role in positive treatment outcomes (Maisto et al., 2015).

REFERENCES

Addis, M. E., & Jacobson, N. S. (1996). Reasons for depression and the process and outcome of cognitive-behavioral psychotherapies. *Journal of Consulting and Clinical Psychology*, *64*(6), 1417-1424. https://doi.org/10.1037/0022-006X.64.6.1417

Aggarwal, N. K., Pieh, M. C., Dixon, L., Guarnaccia, P., Alegria, M., & Lewis-Fernandez, R. (2016). Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. *Patient Education and Counseling*, *99*(2), 198-209. https://doi.org/10.1016/j.pec.2015.09.002

Alcoholics Anonymous World Services, Inc. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Alcoholics Anonymous World Services, Inc. https://www.aa.org/the-big-book

Alegria, M., Ali, N., & Fuente, L. (2019). Strategies for promoting patient activation, self-efficacy, and engagement in treatment for ethnic and racial minority clients. In M. T. Williams, D. C. Rosen, & J. W. Kanter (Eds.), *Eliminating race-based mental health disparities* (pp. 61-78). New Harbinger.

Ametrano, R. M., Constantino, M. J., & Nalven, T. (2017). The influence of expectancy persuasion techniques on socially anxious analogue patients' treatment beliefs and therapeutic actions. *International Journal of Cognitive Therapy*, *10*(3), 187-205. https://doi.org/10.1521/ijct.2017.10.3.187

Ansbacher, H. L. (1990). Alfred Adler's influence on the three leading cofounders of humanistic psychology. *The Journal of Humanistic Psychology*, *30*(4), 45-53.

Ansbacher, H.L., & Ansbacher, R. R. (Eds.). (1956). *The individual psychology of Alfred Adler*. Harper and Row.

Atkinson, D. R., Worthington, R. L., Dana, D. M., & Good, G. E. (1991). Etiology beliefs, preferences for counseling orientation, and counseling effectiveness. *Journal of Counseling Psychology*, *38*(3), 258-264. https://doi.org/10.1037/0022-0167.38.3.258

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for use in primary care* (2nd ed.). Geneva 27, Switzerland: World Health Organization.

Bohard, A. C. (2003). Person-centered psychotherapy and related experiential approaches, In A. S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (2nd ed., pp. 107-148). Guilford.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252. https://doi.org/10.1037/h0085885

Brooks, F., & McHenry, B. (2015). *A contemporary approach to substance use disorders and addiction counseling* (2nd ed.). American Counseling Association.

Constantino, M. J. Coyne, A. E., Boswell, J. F., Iles, B. R., & Visla, A. (2018). A meta-analysis of the association between patients' early perception of treatment credibility and their posttreatment outcomes. *Psychotherapy*, *58*(4), 486-495. https://doi.org/10.1037/pst0000168

Constantino, M. J., Visla, A., Coyne, A. E., & Boswell, J. F. (2019). Cultivating positive outcome expectation. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work: Volume 1: Evidence-based therapist contributions* (3rd ed., pp. 461-496). Oxford University Press. https://doi.org/10.1093/med-psych/9780190843953.001.0001

Crabb, A. C., & Linton, J. M. (2007). A qualitative study of recovering and nonrecovering substance abuse counselors' belief systems. *Journal of Addictions and Offender Counseling*, *28*, 4-20. https://doi.org/10.1002/j.2161-1874.2007.tb00028.x

Devilly, G. J., & Borkovec, T. D. (2000). Psychometric properties of the credibility/expectancy questionnaire. *Journal of Behavior Therapy and Experimental Psychiatry*, *31*(2), 73-86. https://doi.org/10.1016/S0005-7916(00)00012-4

Doweiko, H. E. (2019). *Concepts of chemical dependency* (10th ed.). Cengage.

Eliacin, J., Coffing, J. M., Matthias, M. S., Burgess, D. J., Bair, M. J., & Rollins, A. L. (2018). The relationship between race, patient activation, and working alliance: Implications for patient engagement in mental health care. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), 186-192. https://doi.org/10.1007/s10488-016-0779-5

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43-49. https://doi.org/10.1037/a0022187

Flores, P. J. (2004). *Addiction as an attachment disorder*. Jason Aronson.

Fox, J., Cashwell, C. S., & Picciotto, G. (2017). The opiate of the masses: Measuring spiritual bypass and its relationship to spirituality, religion, mindfulness, psychological distress, and personality. *Spirituality in Clinical Practice*, *4*(4), 274-287. https://doi.org/10.1037/scp0000141

Hardy, G. E., Barkham, M., Shapiro, D. A., Reynolds, S., Rees, A., & Stiles, W. B. (1995). Credibility and outcome of cognitive-behavioural and psychodynamic-interpersonal therapy. *British Journal of Clinical Psychology*, *34*(4), 555-569. https://www.doi.org/10.1111/j.2044-8260.1995.tb01489.x

Kirsch, I., & Henry, D. (1977). Extinction versus credibility in the desensitization of speech anxiety. *Journal of Consulting and Clinical Psychology*, *45*(6), 1052. https://doi.org/10.1037/0022-006X.45.6.1052

Knuuttila, V., Kuusisto, K., Saarnio, P., & Nummi, T. (2012). Effect of early working alliance on retention in outpatient substance abuse treatment. *Counselling Psychology Quarterly*, *25*(4), 361-375. https://doi.org/10.1080/09515070.2012.707116

Lubetkin, E. I., Zabor, E. C., Brennessel, D., Kemeny, M. M., & Hay, J. L. (2014). Beyond demographics: Differences in patient activation across new immigrant, diverse language subgroups. *Journal of Community Health*, *39*(1), 40-49. https://doi.org/10.1007/s10900-013-9738-1

Maisto, S. A., Roos, C. R., O'Sickey, A. J., Kirouac, M., Connors, G. J., Tonigan, J. S., & Witkiewitz, K. (2015). The indirect effect of the therapeutic alliance and alcohol abstinence self-efficacy on alcohol use and alcohol-related problems in Project MATCH. *Alcoholism: Clinical and Experimental Research*, *39*(3), 504-513. https://doi.org/10.1111/acer.12649

Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (pp. 3-70). Guilford Press.

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, *100*(3), 304-316. http://doi.org/10.1111/j.1360-0443.2004.00935.x

Miller, W. R., Forcehimes, A. A., & Zweben, A. (2019). *Treating addiction: A guide for professionals* (2nd ed.). Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.

Mooney, T. K., Connolly Gibbons, M C., Gallop, R., Mack, R. A., & Crits-Christoph, P. (2014). Psychotherapy credibility ratings: Patient predictors of credibility and the relation of credibility to therapy outcome. *Psychotherapy Research*, *24*(5), 565-577. https://doi.org/10.1080/10503307.2013.847988

Moyers, T. B., & Miller, W. R. (1993). Therapists' conceptualizations of alcoholism: Measurement and implications for treatment decisions. *Psychology of Addictive Behaviors*, *7*, 238-245. https://psycnet.apa.org/doi/10.1037/0893-164X.7.4.238

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, *27*(3), 878. https://doi.org/10.1037/a0030274

Myers, J. E., Clarke, P., Brown, J. B., & Champion, D. A. (2012). Wellness: Theory, research, and applications for counselors. In M. B. Scholl, A. S. McGowan & J. T. Hansen (Eds.), *Humanistic perspectives on contemporary counseling issues* (pp. 17-44). New York, NY: Routledge.

Myers, J. E., & Sweeney, T. J. (2004). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology*, *60*(3), 234-244.

National Institute on Drug Abuse. (2020). *Drug misuse and addiction*. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

Nielson, E. M. (2016). Substance abuse counselors' recovery status and self-schemas: Preliminary Implications for empirically supported treatment implementation. *Journal of Drug and Alcohol Research*, *5*, 235982. https://doi.org/10.4303/jdar/235982

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work: Volume 1: Evidence-based therapist contributions* (3rd ed.). Oxford University Press. https://doi.org/10.1093/med-psych/9780190843953.001.0001

Norcross, J.C. (2012, video). *Customizing mental health treatment*. Psychotherapy Networker.

O'Connell, B. (2012). *Solution-focused therapy* (3rd ed.). Sage.

O'Hanlon, B., & Weiner-Davis, M. (2003). *In search of solutions: A new direction in psychotherapy* (2nd ed.). W. W. Norton & Co.

Rogers, C. R. (1961). *On becoming a person*. Houghton Mifflin.

Rogers, C. R. (1977). *Carl Rogers on personal power*. Delacorte.

Scholl, M. B., Kendrick, E., Wilkes, D. & Hagedorn, W. B. (2012). Humanistic perspectives on substance abuse counseling. In M. B. Scholl, A. S. McGowan, & J. T. Hansen (Eds.), *Humanistic perspectives on contemporary counseling issues* (pp. 85-115). New York, NY: Routledge.

Scholl, M. B., Ray, D. C., & Brady-Amoon, P. (2014). Humanistic counseling process, outcomes, and research. *The Journal of Humanistic Counseling*, *53*(3), 218-239. https://doi.org/10.1002/j.2161-1939.2014.00058.x

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, *15*(3), 215-224. https://doi.org/10.1037/h0020229

Swift, J. K., Callahan, J., Cooper, M., & Parkin, S. R. (2019). Preferences. In J. C. Norcross & B. E. Wampold (Eds.), *Psychotherapy relationships that work: Volume 2: Evidence-based therapist contributions* (3rd ed., pp. 157-184). Oxford University Press. https://doi.org/10.1093/med-psych/9780190843960.001.0001

Swift, J. K., Callahan, J., & Vollmer, B. M. (2011). Preferences. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 301-315). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.001.0001

Thombs, D. L., & Osborn, C. J. (2019). *Introduction to addictive behaviors* (5th ed.). Guilford Press.

Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. *Psychotherapy*, *48*, 50-57. https://doi.org/10.1037/a0022061

Vollmer, B., Grote, J., Lange, R., & Walker, C. (2009). A therapy preferences interview: Empowering clients by offering choices. *Psychotherapy Bulletin*, *44*, 33-37.

Wiprovnick, A. E., Kuerbis, A. N., & Morgenstern, J. (2015). The effects of therapeutic bond within a brief intervention for alcohol moderation for problem drinkers. *Psychology of Addictive Behaviors*, *29*(1), 129-135. https://doi.org/10.1037/a0038489

Zlovensky, M. J., Kashdan, T. B., Gonzalez, A., & Hogan, J. (2010). Vulnerability to substance use disorders in adulthood. In R. E. Ingram & J. M. Price (Eds.), *Vulnerability to psychopathology: Risk across the lifespan* (2nd ed., pp. 141-175). Guilford Press.

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