Chapter 8

Spirituality and Substance Misuse

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Introduction

Substance misuse psychiatry is concerned with what happens when people use psychoactive substances in such a way that they cause harm to themselves and others. It is, therefore, a field of clinical practice and scientific enquiry that is concerned with people's relationships with themselves and others and the wider order of things, but especially with the object of their 'addiction'. Necessarily, this engages it with spiritual concerns and in fact the field has a history of engaging with spiritual as well as medical ways of thinking. The definition of spirituality offered in Chapter 1 is one which emerged from a study of the addictions literature.

Much can be, and has been, said about exactly how behavioural patterns of substance misuse should be defined. Such definitions are largely beyond the scope of this chapter, but of central importance to the field today is the concept of the dependence syndrome, which has influenced both ICD-10 (World Health Organization 1992) and DSM-IV (American Psychiatric Association 1994) classifications of substance use disorders. This has largely replaced, or else has come to define, the concept of addiction in clinical practice and scientific research. It is a biopsychosocial understanding of

addiction that has now withstood the test of several decades of research. It has the benefit of clarifying what addictive behaviour is about in such a way as to enable us to see both what the spiritual issues entailed in that behaviour might be, and also what the biopsychosocial correlates of spirituality are.

For example, the element of subjective compulsion, defined within the dependence syndrome in such a way as to include both craving and impaired control over substance-related behaviour, touches on important concerns of both Buddhist and Christian spirituality (Cook, 2006; Groves, 1998; Groves & Farmer, 1994). Because these traditions each have something important to say about the spiritual nature of addiction, it is not surprising that Christian and Buddhist, and other faith-based, treatment programmes have been founded as a response to the suffering with which addiction is associated. On the other hand, the model of the dependence syndrome reminds us that there is a biopsychosocial dimension to spiritual problems. This is true not only within the field of substance misuse but in all areas of human experience. Spiritual problems are inextricably linked to the business of being human, and are generally not well understood if completely divorced from this physical, psychological and social reality.

The substance misuse field also has another important lesson to offer about the relationship between spirituality and psychiatry in general. Whilst dependence is a particularly important complication of substance use, it is not best understood in isolation. Dependence is, rather, a problem which emerges within a context in which a group of people engage in psychoactive

substance use, of whom only some become dependent. It is therefore a problem of appetitive behaviour, an aspect of human experience in which we are all involved. (Plato considered the appetitive or desiring faculty to be one of two 'irrational' aspects of the human soul, alongside a third, rational, faculty. See Lee 2003, pp.139-149.) The spirituality of substance misuse is therefore not only a concern of patients, or addicts; neither is it only a concern of those who consider themselves to be in some way 'religious', for it is a matter which concerns us all.

History

Whatever the conceptual relationship between spirituality and addiction, there is a specific history which helps to illuminate why spirituality has become a particular concern of substance misuse psychiatry. In the western world, at least up until the end of the 18th Century, problems such as drunkenness were not particularly distinguished from other social and moral concerns, for example, theft, adultery or gluttony. For some, the failure to distinguish between such problems is understood as being the basis of the now discredited 'moral model'. But it is doubtful that this model ever properly existed in quite the way that some people seem to imagine. Rather, drunkenness was something that people were responsible for, in the same way that they were responsible for other social and personal vices. A few people were, perhaps, relative saints, but most people in society were sinners, of one kind or another.

In 17th Century Europe, thought and belief about almost all aspects of human life began to be influenced by the intellectual movement now known as the Enlightenment. The Enlightenment emphasised reason and science as the basis for understanding human problems, thus excluding the authority of religious traditions and scriptures (see, for example, Honderich, 1995, pp.236-237). From the late 18th Century onwards, this movement appears to have begun to influence thinking about drunkenness. In 1785, Benjamin Rush published *An inquiry into the effects of ardent spirits upon the human body and mind with an account of the means of preventing and of the remedies for curing them* (Rush, 1943) and in 1804 Thomas Trotter published *An Essay, Medical, Philosophical, and Chemical, On Drunkenness and Its Effects On the Human Body* (Trotter, 1988). Addiction (or, rather 'chronic inebriety') became a medical concern in addition to being a religious concern. In this context, a disease model of addiction became popular, although it was rarely completely divorced from the moral model. This disease was understood, in one form or another, as being a disease of the will, a disease caused by alcohol.

The disease model, in somewhat modified form, was adopted in the 20th Century by Alcoholics Anonymous (AA), and it was the history of this organisation that was to have particular influence over the perception of addiction as a spiritual problem in North American and Europe. AA, founded in Akron, Ohio, by two alcoholics in 1935, drew on both religious and medical sources for its understanding of alcoholism. The former came mainly from the Oxford Group, an evangelical Christian movement of the time. The latter came, amongst other places, from Dr William Silkworth, the physician who

treated one of the founders of AA, and who later contributed a medical foreword to the 'Big Book' of AA (Alcoholics Anonymous 1976, pp xxiii-xxx). It is estimated that Silkworth treated more than 50 thousand alcoholics during the course of his lifetime (Kurtz 1991, pp21-22). Although he adopted a specific physical disease model of alcoholism which did not stand the test of time (he understood alcoholism as being a form of physical allergy to alcohol), he also saw very little hope for recovery unless the alcoholic experienced a 'psychic change'. For this change to come, about he saw the need for 'something more than human power' (Alcoholics Anonymous 1976, p xxvii).

The founders of AA also drew on the work of William James, who wrote a seminal book on the psychology of religion: *The Varieties of Religious Experience* (James 1985). Within the pages of this volume may be found many psychological accounts of religious experience, which include reference to those of people who struggled with chronic drunkenness or, as we would say, alcohol dependence. The case of S.H. Hadley is recounted by James at some length (pp.201-203). Hadley saw himself as a hopeless case, a 'homeless, friendless, dying drunkard', who had suffered from delirium tremens (p.210). Having found himself praying in a prison cell, he went on his release to a meeting at a Mission Hall at which Jerry M'Auley, a man known for his work amongst drunkards, was preaching. Responding to the call at the end of the meeting, Hadley describes how, with a breaking heart, he prayed 'Dear Jesus, can you help me?' At this, a profound affective change came about: 'indescribable gloom' was replaced with 'glorious brightness'. Hadley concludes his account:

> *'From that moment till now I have never wanted a drink of whiskey, and I have never seen money enough to make me take one. I promised God that night that if he would take away the appetite for strong drink, I would work for him all my life. He has done his part, and I have been trying to do mine.' (p.203)*

The Varieties of Religious Experience left its mark on AA. Although the latter was initially a Christian movement, it acquired a wariness of established religion which bears much of the character of James' own suspicion of doctrinal formulation and religious belief. It saw, nonetheless, a key need for spiritual transformation in recovery from alcoholism and it offers a 'spiritual but not religious' way of finding this, which is accessible to people of all faiths or none. It is, essentially, a secular form of spirituality (Kurtz, 1996).

From the story of two alcoholics seeking to help one another in America in the 1930s, AA has become a worldwide organisation of more than two million members in over 100 thousand groups operating in more than 150 countries.[1] The philosophy of AA was also adopted by various sister organisations, each seeking to help people with different addictions, including Narcotics Anonymous (NA), Cocaine Anonymous (CA), and Gamblers Anonymous (GA), and also seeking to help families and children of those who are addicted, including AlAnon (for spouses and partners of alcoholics), Alateen (for teenage children of alcoholics, and Families Anonymous (FA; for families

[1] http://www.alcoholics-anonymous.org.uk

of members of NA). Furthermore, although firmly rooted as a mutual help movement, the philosophy of AA has also influenced professionally-led treatment and has been adopted by both residential and community based programmes (Cook 1988a, b). In general, all mutual help groups based upon the philosophy of AA, as expressed in its '12 Steps', are referred to as 12 Step groups and the treatment programmes based upon this philosophy are often referred to as 12 Step treatment programmes or, more popularly, the 'Minnesota Model', reflecting the early development of programmes of this sort in Minnesota in the 1940s and 1950s.

Whilst AA and its sister organisations offer a non-religious, non-denominational, approach to spirituality as a pathway to recovery from addiction, various religious or faith based organisations (FBOs) continue to offer different forms of spirituality anchored within their own faith traditions. Thus, Christian (Moos, Mehren & Moos, 1978; National Institute on Drug Abuse, 1977), Buddhist (Barrett, 1997), Islamic (Abdel-Mawgoud, Fateem & Al-Sharif, 1995), Native American (Garrett & Carroll, 2000) and other programmes have been described in the literature, each offering their own distinctive approach to spirituality either as a response in itself, or else in combination with various secular and scientific interventions.

At the same time, mainstream healthcare provision and scientific research, within the addictions field in the western world, have tended to focus on physical, social and psychological interventions which do not require, or even allude to, the need for any spiritual change. Other mutual help groups have

been established which do not require the assent to spirituality, even in a secular form, that is so central to AA (Humphreys, 2004, pp.33-93). The world of substance misuse treatment today is thus heterogeneous. However, the worldwide impact of the spirituality of AA, and the significant non-statutory provision of FBOs, have ensured that spirituality is a subject for discussion amongst lay and professional, those with their own experience of addiction and those who study the addictive behaviour of others, within treatment communities and faith communities. Spirituality is a feature of the addictions treatment landscape.

Spirituality as a Protective Factor

Before considering the treatment literature in detail, it would be well to consider briefly the literature suggesting that spirituality provides a protective factor against substance misuse. Various measures of religious behaviour, religious affiliation, or 'religiosity' are inversely correlated with substance use and misuse (Koenig, McCullough & Larson, 2001, pp.169-172; Koenig, 2005, pp.109-112; Chamberlain & Hall, 2000, pp.189-197). There is debate about how this effect may operate. For example, affiliation with a faith community may instil moral values which operate against substance use – especially illicit substance use – or substance abuse. However, it is also known that religion is associated with various measures of mental well-being (Koenig, 2005, pp.43-81; Chamberlain & Hall, 2000, pp.118-137) and may reduce substance misuse by improving coping skills or reducing perceived stress. On the other hand, the effect may simply be a function of conforming to the norms of a social group in which substance use or misuse are less acceptable. Church-

affiliated young people are clearly offered drugs at a rate not very different to that of other young people and so, whatever the mechanism of the protective effect may be, it is not simply a case of their being hidden away from drug using peers (Cook, Goddard & Westall, 1997).

Measures of religiosity are clearly related to spirituality and it would appear that spirituality is also protective against substance misuse (Leigh, Bowen & Marlatt, 2005; Stewart, 2001; Zimmerman & Maton, 1992). Spirituality appears to exert a protective effect in both high and low risk groups (Ritt-Olson *et al.,* 2004).

It may be helpful to consider an example of this kind of research. In a study of 7661 church affiliated young people (age 12 to 30 years), agreement with statements reflecting church attendance, Christian belief and spiritual practices (prayer and bible reading) were generally found to be associated with lesser likelihood of having smoked cigarettes, drunk alcohol or used illicit drugs (Hope & Cook, 2001). However, church attendance appeared to be more important in the 12 to 16 year age group, and belief and bible reading appeared to be more important in the 17 to 30 year age group. Perhaps for younger people, socialisation within a faith community provides protection against substance misuse, but for older young people it is the internalisation of faith, and expression of this in personal spirituality, which provides protection.

Spirituality in Substance Misuse Treatment Programmes

Spirituality may be variously understood, and spiritual issues differently addressed, in different kinds of treatment programmes. Broadly speaking, these can be considered in three groups: 12 Step spirituality, spirituality rooted in the faith traditions of FBOs, and non-specific explorations of spirituality that might take place in any other treatment programme.

12 Step Spirituality

The principles adopted by 12 Step groups and 12 Step programmes are summarised in the so-called '12 Steps' as written down by the original founders of AA, adapted with only minor modifications by AA's sister groups. They are expressed in the first person, reflecting their origins in the personal experiences of the founders:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him* praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps we tried to carry this message to alcoholics and to practice these principles in all our affairs.

(Alcoholics Anonymous 1977, original emphases preserved)

The influence of the spirituality of the Oxford Group is visible here, with its emphasis on personal confession and repentance of sin. However, the influence of *The Varieties of Religious Experience* may also be discerned: in the lack of religious doctrinal language and emphasis upon God (or a 'Higher Power') as understood and experienced by the individual members of AA.

The first three steps are concerned with relationship, especially relationship with the object of addiction (in this case alcohol) over which the individual

finds themselves to be powerless, and relationship with a transcendent power towards which the individual must turn for help. This transcendent, or ‘Higher’, Power provides a subject for much debate. The explicit reference to ‘God’ in Steps 3, 5, 6 and 11 undoubtedly provides the occasion for many a person attending AA only once or twice and then declaring that it is ‘too religious’. However, in practice, all 12 Step groups and programmes are open to people from all faiths and none. God is understood by the individual – according to their own faith tradition, or on the basis of folk religion, or on the basis of a person notion of the Divine which is unique to that individual. Alternatively, a Higher Power is construed in some even less religious way as being ‘the group’, or the 12 Step programme itself. What is important is that a power outside of oneself is identified – a power greater than self which is not self. It is not so much that the member of AA has to believe in God (although many do) as that they must believe that they are ‘not God’.

Steps 4 to 10 are concerned with confession and repentance, to use Christian terminology, but are here referred to as the taking of a moral inventory and making amends. The concern with relationship between self and a transcendent order is anchored here in relationships with others – especially others who have been harmed by the addict in the course of the history of their addictive behaviour. It is sometimes said that the disease model offers a way of avoiding personal responsibility but, in contrast, members of AA, at least those who work through the steps in a serious way, are engaged deeply with personal responsibility, both for what they have done and for working at their own recovery.

Finally, Steps 11 and 12 are concerned with on-going spiritual practice and sharing with others what has been learned. It is clear that this on-going spirituality is founded in the personal spiritual experience of the individual. It is not a theoretical programme, but one which can only be based upon a personal spiritual ‘awakening’ or conversion. Such an experience might be sudden, as in the case of S.H. Hadley, or it might be gradual, but it is in such an experience that hope is to be found.

What does all this mean in practice? Attendance at meetings of AA and/or its sister fellowships (as they are called) is considered to be vital to the process. The steps are ‘worked’ by individual members with the assistance and guidance of a ‘sponsor’, a more experienced member who acts as mentor and guide. In general, asking whether or not a member of AA or other 12 Step fellowship has a sponsor provides a good indication of whether they are actually taking the programme seriously. There is also an extensive literature supportive of 12 Step spirituality and recovery. A key place within this literature is held by the ‘Big Book’ (Alcoholics Anonymous 1976), which outlines the nature of the problem, the approach taken by AA in response, and provides accounts of the experiences of some of the early members. The Big Book of AA is paralleled by comparable works in each of the other 12 Step fellowships (e.g. Narcotics Anonymous 1986).

Spirituality in the programmes of Faith Based Organisations

It is not possible to review here the spiritual traditions of all the world's religions. Chapter 12 of this book explores the general relationship between spirituality and religion in further detail. However, some examples can be given of the various connections made between the spiritualities of particular religions and the spiritual condition of addiction. It is also important to consider what takes place in practice in addiction treatment programmes provided by FBOs.

For Christianity, the problem is less in making connections between spirituality and addiction than in choosing between various possible theological understandings of what addiction is all about. At some level, there appears to be a general consensus that it is concerned with 'sin' or rebellion against God but this can mean very different things to different people. For some it implies that 'addiction is (a) sin', for others that 'sin is addiction'. Even these two, apparently similar, models can result in very different approaches to helping people caught in the web of addiction. The one appears very much like the moral model in religious clothing. The other reduces addiction to being merely an expression of the human condition, a condition of which we are all a part, and risks losing any distinctive understanding of what it is to be addicted. There are, of course, many nuances and subtleties which distinguish the ways in which these models might be expressed, such as that put succinctly by Linda Mercadante in the title of her book *Victims and Sinners* (Mercadante, 1996).

Elsewhere (Cook, 2006), I have explored some of the common ground that is mapped out both by scientific studies of addiction and some foundational Christian texts. Like Mercadante, I conclude that for Christian theology it is grace rather than sin that is central and that it is grace which (in non-theological language) the 12 Step programmes have also identified as vital to recovery from addiction. Grace, in Christian terms, is concerned with the relationship between God and human beings, a relationship within which God is always generously self-giving despite, and even because, of human powerlessness and self-imprisonment. Christian spirituality, like 12 Step spirituality, is more concerned with the human need to look beyond ourselves than it is to focus on our own faults and failings - the solution is to be found in relationship with the Divine reality that is both deeply within us and also outside and beyond us.

Buddhism also finds resonance with the language of addiction. For Buddhism, concepts such as 'dependence' and 'craving' are associated with the very problems that are at the root of all human suffering. Thus, for example, Paramabandhu Groves defines craving as:

> 'the urge or desire to obtain an experience other than the one we are experiencing at present' (Groves, 1998)

Such urges and desires can express themselves in subtle and varied ways, but they are not alien to any of us. As with Christian spirituality, we find here a reminder that the phenomenon of addiction is something which affects us all,

which is a part of the human condition. However, the focus is more on recognising why craving is unhelpful and how we may better deal with it. The answer to the latter is to be found in the development of ‘skilfulness’ – a quality which includes elements of wisdom, attentiveness, and compassion – which enables us to view our actions and motives differently and to break away from the unhealthy motivation that is inherent within craving. In contrast to Christianity, Buddhism does not require a focus on relationship with God, but it shares a recognition that unhealthy attachments to things that are ‘not God’ are at the root of human suffering.

Even these two brief examples will immediately draw attention to the different ways in which faith traditions might suggest remedies for the addictive state. Thus, within the revealed monotheistic faiths, Judaism, Christianity, and Islam, spirituality in the programmes offered by their associated FBOs is most likely to take the form of prayer, worship and study of scripture. For Buddhist groups, spirituality might look much more like cognitive therapy (Avants & Margolin 2004) coupled with meditation rather than prayer.

Nor will all Christian programmes look alike. In some, visible reliance is placed upon secular psychological and medical techniques, with spirituality providing more of a motivating factor or rationale (see, for example, Judge, 1971). In others, exactly the opposite is true, with the emphasis entirely upon prayer, bible study and Christian faith, and with secular therapies almost or completely absent (see, for example, Gruner, 1979).

Spirituality in Secular Treatment Programmes

Treatment programmes that follow neither a 12 Step programme nor the spiritual tradition of a FBO, might be considered 'non-spiritual'. Whilst a chaplain, or chaplaincy team, is usually available within NHS Trusts in the UK, it is very much up to individual patients whether or not they take the opportunity to talk to a chaplain about the spiritual aspects of their problem. It seems that patients in substance misuse services in the UK rarely take this opportunity. However, various surveys show that patients in substance misuse services (at least in the USA) do consider spirituality to be important (Arnold *et al.,* 2002; Carroll, McGinley & Mack, 2000; Dermatis *et al.,* 2004; McDowell *et al.,* 1996).

There are implicit and explicit ways in which spirituality may be addressed, even within secular and medical substance misuse treatment programmes, that do not follow the traditions of a FBO or a 12 Step programme. It seems almost impossible to discuss problems of substance misuse without there being a spiritual dimension to the conversation, even if the word 'spirituality' is not actually used. For example, the definition of spirituality employed in Chapter 1 was derived from a review of the literature on addiction and spirituality (Cook, 2004). This analysis of some 263 publications revealed 13 conceptual components employed within this literature in the process of defining the concept of spirituality. These were:

- *Relatedness*
- *Transcendence*

- *Humanity*
- *Core/force/soul*
- *Meaning/purpose*
- *Authenticity/truth*
- *Values*
- *Non-materiality*
- *(Non)religiousness*
- *Wholeness*
- *Self-knowledge*
- *Creativity*
- *Consciousness*

Of these, the first two, relatedness and transcendence, are much the most commonly cited (34% and 41% respectively of papers studied, but included in 62% and 53% respectively of questionnaires used to measure spirituality in addictions research). Inevitably, interventions for substance misuse involve considerations of relatedness – for it is the relationship with the object of addiction which is at the heart of the problem, and relationships with self and others almost inevitably suffer as a result. Transcendence, if understood in the narrower sense of the Divine or a 'Higher Power', is not integral to secular treatments for substance misuse. However, if understood in a broader sense of recognizing the inadequacy of personal resources, failed previous attempts to address the problem, or of the need to accept help from others, transcendence may be considered a key premise to engaging in any helping relationship – including that offered by a substance misuse treatment service.

This very brief analysis of spirituality within secular substance misuse treatment must obviously be balanced by the recognition that there are particular dynamics, including biological as well as psychological and social disturbances, which are unique to the dependence syndrome and are not experienced by all human beings. However, the extent to which spirituality and addiction touch on universal aspects of the human condition – in particular our relationships with ourselves, others and the world around us – is important. It is this which creates a point of contact between therapist and service user, and it is this which offers an antidote to the stigma associated with the moral model.

There are explicit ways in which spirituality may be addressed within secular treatment programmes. For example, where relapse prevention programmes address the need for lifestyle balance, spiritual as well as biological, psychological and social aspects of human lifestyle can constructively be addressed (Moss, Cook & Sandoz, 2007). Even where plurality of faith tradition makes it difficult to address spirituality through any common understanding of religion, many NHS and other substance misuse treatment programmes do allow some educational input from 12 Step group members, or else allow such groups to meet on their premises. This is not to suggest that such treatment programmes adopt 12 Step spirituality, but at least that patients are afforded the opportunity to be acquainted with what these groups have to offer, and to discuss concerns that they may identify regarding this. Similarly, techniques of mindfulness and skilfulness, although associated with

the Buddhist tradition, find parallels within cognitive-behavioural psychology, and may be accessible to people who would not ordinarily think of themselves as interested in Buddhism.

It is also possible to introduce discussion of spirituality in a neutral way, without favouring any particular spiritual tradition, and doing so in a non-threatening and non-judgemental way can be helpful (Jackson & Cook, 2005). There is evidence that staff attitudes in the UK may not make this easy to do in practice (Day *et al.,* 2005), although attitudes would appear to be more positive in the USA (Forman, Bovasso & Woody, 2001; McDowell *et al.,* 1996). Personal awareness on the part of staff concerning their own spirituality, and the preferences and prejudices associated with this, is undoubtedly important as a first step to ensuring that service users are given the opportunity to discuss spirituality during the course of their treatment.

Treatment Outcome Research

Only three relevant outcome studies of addiction treatment programmes with good methodology (longitudinal design, comparison groups, high follow-up rates and reliable/valid measures) have been published to date (Humphreys & Gifford, 2006). Two of these studies are of 12 Step programmes, and one is of a Christian programme:

1. Rudolf Moos and his colleagues (Moos, Mehren & Moos, 1978) studied 97 men in a residential Salvation Army treatment programme for the treatment of ‘skid row’ alcoholics. The spiritual components of the

Salvation Army programme included attendance at AA meetings as well as more specifically Christian counselling and worship. The programme also included therapy groups and community meetings, educational input, vocational rehabilitation, and opportunity for recreation. Residents improved significantly on 7 out of 9 outcome measures, and those who participated more actively did significantly better on 4 of these measures in comparison with those who participated less actively. Comparisons with half-way house and hospital based programmes were favourable.

2. 'Project MATCH', compared the efficacy of 12-Step facilitation (TSF) with cognitive behavioural and motivational enhancement therapy (Project MATCH Research Group 1997) over a 12 week period, using manual based treatments for alcoholism. TSF aimed to encourage involvement in AA and a beginning of working the 12 steps. 952 patients were randomised between interventions in the out-patient arm of the study, and 774 in an aftercare arm of the study which followed in-patient or day-patient treatment. Outcomes between groups were comparable, with TSF clients faring as well as those in other groups, and with benefits maintained at three year follow-up (Project MATCH Research Group 1998). In fact, TSF if anything showed slight advantages.

3. Humphreys and Moos (Humphreys & Moos 2001) studied 1774 substance dependent veterans treated either in a 12-step orientated programme, or in a cognitive-behaviourally orientated in-patient programme. The 12-Step programme patients spent on average 39% of their time in 12-Step related activities, as compared with only 4% for patients in the cognitive-behavioural programme. Patients in the 12-step group showed higher rates of abstinence at follow-up at 1 year after treatment (45.7% v 36.2%) and also significantly lower treatment costs.

A larger number of studies have been published in the literature in which various measures of outcome and spirituality have been related, although they do not meet all of the criteria specified by Humphreys and Gifford (above). In Table 8.1 details are provided of thirteen studies in which abstinence and spirituality have been related. It will be seen that the relationship is almost invariably positive (i.e. spirituality is associated with abstinence). The main exception to this is the study of clergy alcoholics published by Fichter in 1982 (pp.140-142) in which spirituality appeared to be unrelated to abstinence. The study by Fiorentine and Hillhouse is perhaps also an exception, and will be discussed further below, in the next section.

In Table 8.2 details are provided of six studies in which length of sobriety and abstinence have been related. Here again there appears to be a positive relationship, with spirituality usually predicting longer sobriety, although again

there are two studies, Brown and Peterson (1991) and Rush (2000), in which no significant relationship of this kind was found.

The limitations of this evidence base are apparent. All of the studies in Table 8.2, and all but one of the studies in Table 8.1 were conducted in the US, which may limit applicability of the findings to Europe or other parts of the world. Similarly, the studies in both Tables are concerned primarily with 12 Step spirituality. Exceptions to this include one study in which attendance at religious services predicted abstinence as a treatment outcome (Brown *et al.,* 2004) and another in which the focus of interest was on traditional spiritual practices in a study of Native-American subjects (Stone et *al.,* 2006). In many studies, the faith tradition of subjects was not specified and where it was, the bias was almost always towards Christianity (excepting Stone *et al.,* 2006). The instruments used to measure spirituality as a variable, and the underlying conception of spirituality that they reflect, were diverse.

Despite the various limitations of these studies, on the basis of the evidence to date, it would appear that treatment in programmes which incorporate spirituality is at least as effective as other forms of treatment. Further, there is reason to believe that spirituality is positively associated with abstinence and/or length of abstinence as an outcome measure following treatment of various kinds and/or involvement in 12 Step mutual help groups.

Treatment Process Research

Spirituality may be conceived of as either an independent or a dependent variable in treatment research. If spirituality is a universal attribute, measurable in a similar way to personality, it may prove to reflect receptiveness to treatment, or to certain kinds of treatment, or it may function as a prognostic indicator. It may mediate other outcomes such as abstinence, or reduced substance use, or it may simply be understood as reflecting a better quality of outcome or a better quality of life. In addition to this, spirituality might be considered a function of treatment environment, and the spirituality of therapists (in relation to the spirituality of patients/clients) might be an important influence in treatment. These possibilities suggest complex and various ways in which spirituality could impact upon treatment process, and multivariate studies of high quality methodology will be required to unravel them.

Table 8.3 summarises ten studies in which spirituality has been examined in relation to the process of treatment of, and/or recovery from, substance misuse. Again, it will be seen that there is a universally positive relationship between spirituality and the treatment process, with spirituality tending to increase during treatment/recovery and/or being perceived by subjects as an important part of the treatment/recovery process. However, in one study (Borman & Dixon, 1998) spirituality increased during treatment in both 12 Step and non-12 Step treatment programmes. This perhaps provides a reminder that spirituality is an aspect of the treatment process that may be implicit as well as explicit, and that it deserves attention not only in explicitly

spiritual approaches to treatment, but in all forms of treatment for substance misuse.

Two further studies are worthy of further comment. The study by Chen (2006) arguably qualifies for Humphreys' and Gifford's criteria of longitudinal design, comparison groups, high follow-up rates and reliable/valid measures. Attrition rates were low (28% amongst those attending NA and participating in a 12-Step course, and 26% in a group attending NA only) and valid/reliable measures were used. The study was of prison inmates and it remains to be seen how they fare when they are released from prison. However, those receiving a 12 Step 'course' (a total of 480 hours over 6 months, providing comprehensive explanations of the 12 Steps) in addition to NA attendance demonstrated a higher sense of coherence and meaning in life, and reduced anxiety, depression and hostility, over the 12-month course of the study, as compared with those who did not.

The study by Fiorentine and Hillhouse (2000; see also Table 8.1) is also of interest in terms of the light that it sheds on treatment process. This was also a prospective longitudinal study of good design, although without a comparison group. Measures of spirituality were concerned here with embracement of 12 Step ideology and it is again disappointing that other, more generally relevant, measures were not employed. Whilst acceptance of 12 Step ideology was found to predict attendance at 12 Step meetings, it was also found that acceptance of the ideology predicted abstinence independently of this. In particular, the aspects of ideology that were found to

be important for attendance were recognition of the need for lifelong attendance at 12 Step meetings, and the need to surrender to a 'Higher Power'. The aspect of ideology predicting abstinence, however, was the idea that a return to controlled or non-problematic use would never be possible. The authors state that their 'findings suggest that the spiritual emphasis of 12 Step programs does not assist in the process of recovery' (p.385). This is argued on the basis that the spiritual emphasis of the programme (which they understand only in relation to the aspects of ideology relating directly to a 'Higher Power') must exclude some potential members. While this may be the case, their overall conclusion regarding spirituality is highly debatable. Clearly there is a complex relationship between the component beliefs of 12 Step ideology, some of which might appear more immediately 'spiritual' than others, but all of which are inter-related as comprising a whole package.

The qualitative studies summarised in Table 8.3 show that subjects recovering from substance misuse believe that spirituality is an important part of the process of their recovery and that this may take different forms, according to faith tradition, involvement with a 12 Step programme and other factors. Taken together, the studies in this Table, both quantitative and qualitative, reveal varying understandings of what spirituality is, amongst both researchers and research subjects. These understandings generally reflect different selections, emphases upon, and combinations of the thirteen component concepts of spirituality referred to above (described in more detail elsewhere - see Cook, 2004). Future research needs to more clearly identify them and examine their inter-relationships and inter-dependence.

Conclusions

Spirituality and substance misuse are intimately related. This relationship is partly a product of history, especially the history of religious concern with the morality of substance misuse and the history of the 12 Step movement and its spiritual response to addiction. There also appears to be a more fundamental relationship which touches upon the very core of what it means to be a human being: the experience of being related to self, others and a wider, 'transcendent' reality, and the experiences of personal freedom and choice which are so severely compromised in the addictive state. These relationships are borne out by qualitative and quantitative research, which shows that there is an evidence base both for a protective effect of spirituality against the development of substance misuse and also for spirituality as an important variable for study in substance misuse treatment research.

Yet if spirituality is reduced merely to a variable of objective importance for evidence based medicine, its true importance will have been missed. It is concerned both with the objective and subjective aspects of the practice of substance misuse psychiatry and with the subjectivity of what it is to be human. This is something which should draw together therapist and patient in a way which both respects and transcends the social boundaries that are defined by professional relationships.

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Table 8.1 Studies of spirituality and abstinence in recovery from substance misuse

Study	Study design	Substance	Subjects								Measure of Spirituality	Findings
			Number (n)				Age (yrs)	Religion	Ethnicity	Selection Criteria		
			Male	Female	Gender NS	Total						
The rehabilitation of clergy alcoholics: Ardent spirits subdued (Fichter 1982)	Cross-sectional	Alcohol	677	0		677	NS	Christian	NS	Clergy treated for alcoholism	Clergy Lifestyle Project; Tape recorded interviews	Level of spirituality unrelated to abstinence but is related to AA involvement
The role of spirituality in recovery from chemical dependency (Johnsen 1993)	Cross-sectional (6 months after discharge from treatment)	Various	40	10		50	Mean 36.8	NS	NS	Random sample of In-patients from a California 12 Step treatment programme	Spiritual Practices Questionnaire	Use of prayer/meditation significantly associated with abstinence at 6 months follow-up.
Measurement of materialism and spiritualism in substance abuse research (Mathew et al 1995)	Cross-sectional comparison of groups, plus test-retest reliability (7 days interval)	Various	79	64		143	Mean 43/38/33	Christian 82% Agnostic/ other 18%	NS	3 groups: 1. Individuals recovering from Substance use disorder, for >6months 2. Clergy controls 3. General population controls	Mathew Materialism-Spiritualism Scale (MMSI)	MAST positive controls lower than recovering group for G,M,& C subscales of MMSI

AA through the eyes of its older members (Washburn 1996)	Qualitative	Alcohol	3	3		6	60-82	NS	NS	Older AA members	Ethnographic interview	Spirituality perceived as a key theme by older abstinent AA members
The effects of spiritual practices on recovery from substance abuse (Carter 1998)	Cross-sectional comparison of 2 groups	Various	39	22	2	63	NS	NS	NS	2 groups: 1. Addicts in recovery 2. Addicts with history of multiple relapses	Brown-Peterson Recovery Progress Inventory (B-PRPI)	Alcoholics/addicts with fewer relapses and long term recovery indicated increased spiritual practices
Factors influencing recovery from different addictions (Koski-Jännes & Turner 1999)	Cross-sectional	Various	38	38		76	25-76	NS	Finnish - NS	Recovered addicts (3 yrs) responding to newspaper advertisements	Questionnaires & interviews	Spirituality (& 12 Step groups) important in maintaining change in recovery following 12 Step treatment for alcohol/drug addictions
Exploring the additive effects of drug misuse treatment and Twelve-Step involvement: does Twelve-Step ideology matter? (Fiorentine & Hillhouse 2000)	Prospective longitudinal – 8 month follow-up	Various	121	235		356	18-55	NS	Caucasian 30% African-American 43% Mexican/ Central American 23% Other 4%	Out patients in substance misuse treatment programmes in Los Angeles	Embracement of 12 Step Ideology Scale [Modified]	Acceptance of 12 Step ideology predicts attendance at 12 Step meetings; Acceptance of ideology predicts abstinence independently of attendance
Spirituality and addiction: Relationship to recovery and relapse (Jarusiewicz 2000)	Cross-sectional comparison of 2 groups	Various	24	16		40	31-72	NS	NS	Recovering (n=20) & relapsing (n=20) patients at addiction treatment facility in central New Jersey	Spiritual Beliefs Scale; Faith Development Interview Guide	Recovering individuals have greater faith & spirituality than those relapsing

Spirituality, religious problem-solving, and sobriety in Alcoholics Anonymous (Oakes, Allen & Ciarrocchi 2000)	Cross-sectional with retrospective report	Alcohol	41	37		78	23-71	Mostly Christian	Caucasian 85% African-American 8% Native-American 6% Other 1%	AA members drawn from groups in 6 US states	AA Involvement Scale; Religious Problem Solving Scale; Spiritual Experience Index; Religious Background & Behaviour Questionnaire; Purpose in Life Questionnaire	AA involvement is single most important predictor of abstinence & sobriety; Religious problem solving/coping style possible mediator of relationship between spirituality & sobriety; Difficulties of definition of spirituality acknowledged
Spiritual and religious support in recovery from addiction among HIV-positive injection drug users (Avants, Warburton & Margolin 2001)	6 month longitudinal design	Drugs	30	13		43	Mean 40	NS	Caucasian 40% African-American 49% Hispanic 12%	HIV positive drug users in methadone maintenance programme	Spiritual Support (1 item only)	Perceived spiritual comfort & support at entry to treatment with methadone maintenance was an independent predictor of abstinence from illicit drug use by HIV positive injection drug users
Alcoholics Anonymous and church involvement as predictors of sobriety among three ethnic treatment populations (Roland & Kaskutas 2002)	Longitudinal – 12 month follow-up	Alcohol	506	345		851	More than half age 30-44 yrs	NS	Caucasian 63% African-American 30% Hispanic 7%	Enrolled in Alcohol treatment programme in north California	Religious Background & Behaviour Questionnaire	African-American subjects more religious than Caucasian/Hispanic; High AA attendance associated with higher rate sobriety in all groups

Factors associated with treatment outcomes in an aftercare population (Brown, B.S. et al 2004)	Longitudinal – 6 month follow-up	Various	145	49		194	Mean 35 yrs	NS	African-American 96%	Probationers & parolees in drug-free out-patient programmes in Baltimore	Religious service attendance; Beck Hopelessness Scale	Optimism/Pessimism & Religious observance significant predictors of subs use in follow-up
Traditional practices, traditional spirituality, and alcohol cessation among American Indians (Stone et al 2006)	Cross-sectional – but part of an ongoing longitudinal study	Alcohol	696	284		980	17-77	Native-American	Native-American	Parents of children age 10-12 yrs on four American-Indian Reservations - involved in 3 yr on-going study	Measure of Traditional (Native-American) Spirituality (4 item)	n=133 subjects were "non-alcohol users"; Of remainder: 37% had stopped using alcohol & 34% had 1 or more alcohol/drug treatment; 68% of total sample had a lifetime history of alcohol abuse; Participation in traditional activities, and traditional spirituality associated with positive effect on alcohol cessation

NS – Not specified
AA – Alcoholics Anonymous

Table 8.2 Studies of spirituality and length of sobriety in recovery from substance misuse

Study	Study Design	Substance	Subjects							Measure of Spirituality	Findings
			Number (n)			Age (yrs)	Religion	Ethnicity	Selection Criteria		
			Male	Female	Total						
Assessing spirituality in addiction treatment and follow-up: Development of the Brown-Peterson Recovery Progress Inventory (B-PRPI) (Brown, H.P. & Peterson 1991)	Cross-sectional (but with pre & post treatment measures in sample 3)	Various	55	53	108	17-63	NS	NS	2 samples: 1. Members of AA groups in north central Mississippi (n=35) 2. Members of 12 step groups in central & south-west Mississippi (n=58) 3. 12 Step out-patient treatment (n=15)	B-PRPI	No correlation spirituality & length of sobriety
Spirituality and purpose in life in alcoholism recovery (Carroll 1993)	Cross-sectional	Alcohol	100	0	100	26-81	NS	Majority Caucasian	Members of AA groups in north California	Step Questionnaire; Purpose in Life Questionnaire (PIL)	AA attendance & Practice of Step 11 both correlated with PIL & length of sobriety
The spiritual experience in recovery: A closer look (Sandoz, C.J. 1999)	Cross-sectional	Alcohol	26	30	56	Mean 45	NS	Caucasian 90%	Members of AA groups in south New Jersey	AA Practices and Spiritual Experience	Claimed spiritual experience associated with: older age, longer sobriety, heard more 5th steps, made more 12th step calls

Power, spirituality, and time from a feminist perspective: Correlates of sobriety in a study of sober female participants in Alcoholics Anonymous (Rush 2000)	Cross-sectional	Alcohol	0	125	125	Mean 47	NS	Caucasian 94% Other 6%	Snowball sample of female AA members	Spiritual Orientation Inventory	Number of AA meetings attended weekly contributed significantly to spirituality. Spirituality higher for those involved in their religion. No correlation spirituality & length of sobriety
Spirituality, contentment, and stress in recovering alcoholics (Poage, Ketzenberger & Olson 2004)	Cross-sectional	Alcohol	35	18	53	24-77	NS	Caucasian 89% Hispanic 6% African-American 4% Native American 2%	Members of AA groups in west Texas	Spirituality Assessment Scale (composite from other scales)	Length of sobriety significantly associated with spirituality. Spirituality & contentment positively related. Spirituality correlated with lower stress in women but not men
Helping, spirituality and Alcoholics Anonymous in recovery (Zemore & Kaskutas 2004)	Cross-sectional	Alcohol	118	80	198	21-82	NS	Caucasian 83% African-American 7% Latino 7% Asian-Pacific Islanders 2% Native-American 1% Other 1%	Convenience sample of recovering alcoholics	Daily Spiritual Experiences Scale	Longer sobriety predicted higher theism, self-transcendence & AA achievement

NS – Not specified
AA – Alcoholics Anonymous

Table 8.3 Studies of spirituality as part of the substance misuse treatment/recovery process

Study	Study design	Substance	Subjects								Measure of Spirituality	Findings
			Number (n)				Age (yrs)	Religion	Ethnicity	Selection Criteria		
			Male	Female	Gender NS	Total						
A retrospective study of the concept of spirituality as understood by recovering individuals (Mathew et al 1996)	Retrospective comparison pre/post recovery	Poly	65	58		123	Mean 43/33	NS	NS	Recovering addicts in US with minimum 6 mths abstinence (n=62); Normal controls (n=61)	Mathew Materialism & Spiritualism Scale (MMSS); Cognitive Pattern Questionnaire	Increase in spirituality in recovery
Spirituality and the 12 steps of substance abuse recovery (Borman & Dixon 1998)	Retrospective comparison pre/post treatment	Various			42	42	NS	NS	NS	Out-patients in 12 Step (n=28) and non-12 Step (n=14) treatment programmes in central Indiana	Spiritual Well-Being Scale (SWBS)	Spirituality increased during treatment in both 12 step & non-12 step groups
Exploring the spiritual experience of the Twelve Steps of Alcoholics Anonymous (Sandoz, J. 1999)	Cross-Sectional	Alcohol	27	30		57	45	Protestant 26% Catholic 64% Other 11%	Caucasian 93% African-American 4% Mixed 4%	AA members, recruited from groups in south New Jersey	AA Practices & Spiritual Experiences	82% AA members claimed to have had a spiritual experience (72% slow, 22% slow & sudden, 6% sudden); spiritual experience significantly associated with completion of Steps 4,5,8 & 9.

The relationship among substance abuse counselors' spiritual well-being, values, and self-actualizing characteristics and the impact on clients' well-being (Brooks & Matthews 2000)	Pre & Post-treatment measurement of SWBS.	Poly	14	31	94	139	NS	NS	NS	3 samples from Virginia: 1. Random sample of in-patient counsellors (n=11); 2. Convenience sample of out-patient counsellors (n=34); 3. Convenience sample of in-patient treatment programme patients (n=94)	Rokeach Value Survey; Spiritual Well-Being Scale (SWBS); Personal Orientation Inventory	Half variance of SWBS accounted for by self acceptance (POI), loving & wisdom (RVS); Wisdom negatively correlated with SWB; Patients SWB increased during in-patient treatment
The role of religion and spirituality in recovery from drink problems: A qualitative study of Alcoholics Anonymous members and south Asian men (Morjaria & Orford 2002)	Qualitative	Alcohol	10			10	36-57	Catholic 50% Hindu 30% Sikh 20%	S. Asian 50% Caucasian 50%	2 UK samples: 1. White AA members (n=5) 2. S. Asian in NHS/Non-statutory treatment for alcohol problems (n=5)	Taped Semi-structured interview	AA members experienced conversion (cf “Big Book” of AA); S Asian men underwent re-affirmation of existing religious beliefs
A focus group analysis of relapse prevention strategies for persons with substance use and mental disorders (Davis & O'Neill 2005)	Qualitative	Various	15	12		27	Mean 44	NS	African-American 77% European-American 22%	People in later stages of substance abuse treatment at a Chicago rehabilitation centre	Focus groups	Engaging in prayer or relying on a “Higher Power,” participating in a meaningful activity, and thinking differently about life are important strategies in sustaining abstinence

Qualitative interviews on substance abuse relapse and prevention among female trauma survivors (Harris, Fallot & Berley 2005)	Qualitative	Various		27		27	Mean 42	NS	African-American 81% Caucasian 19%	Women with history of physical/sexual abuse & mental health & substance abuse disorders at an urban US mental health agency	Semi-structured interview	Connection, self-awareness, sense of purpose & meaning, and spirituality all considered by subjects to be supportive of recovery Individual relapse prevention skills alone appeared insufficient to sustain abstinence
Correlates of therapeutic involvement among adolescents in residential drug treatment (Hawke, Hennen & Gallione 2005)	Cross-sectional	Drugs	142	38		180	13-18	NS	Hispanic 20% African-American 36% Caucasian 46%	Adolescents in 5 residential drug treat programmes in New Jersey	Spirituality items from Personal Experience Inventory	Self-esteem and Spirituality strongly correlated with therapeutic involvement
Social support, spiritual program, and addiction recovery (Chen 2006)	Longitudinal – 1 yr study period	Drugs	93			93	Mean 36	NS	Jewish 71% Arab 29%	Inmates of 3 Israeli prisons: Gp 1: NA & 12 Step programme participants (n=43) Gp 2: NA attendance only (n=50)	Meaningfulness subscale of Antonovsky's Sense of Coherence Scale	12 Step programme participants demonstrated higher sense of coherence & meaning in life (& reduction of negative emotions)
Religious and spiritual elements of change in Sikh men with alcohol problems: A qualitative exploration (Morjaria-Keval 2006)	Qualitative	Alcohol	15			15		Sikh	S Asian	Sikh men living in UK Midlands showing successful change of drinking behaviour for at least 4 mths	Taped, semi-structured interview	Transition "amli" (drunk) to "amritdhari" (baptised) associated with critical transformation process involving religious adherence, purification & seeking redemption.

NS – Not specified
AA – Alcoholics Anonymous
NA – Narcotics Anonymous