Dialogue

The Relationship Between Addiction and Religion and its Possible Implication for Care

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Spirituality is a topic of increasing interest to clinicians and researchers interested in addiction because its perceived role in the promotion of meaningfulness in the recovery from addiction. Our review of the literature evaluates different domains relative to the relation between addiction, religion, and psychiatric treatment. Spirituality as a protective or precipitating factor for substance use and as a key component of recovery will be debated. Illustrations of its potential and limitations as a component of treatment will be presented. Types of investigation and integration of this dimension in an eventual therapeutic process strictly respecting the needs and specificities of each one will be discussed.

Keywords addiction; recovery; religion; religious; religiousity; spirituality; spiritual well-being

Introduction

Religion, in its broad definition including both spirituality (being concerned with transcendence or addressing the ultimate questions about life’s meaning) and religiousness (specific behavioral, social, doctrinal, and denominational characteristics) is a concept, which is encountered with increasing frequency in the contemporary addiction literature (Mohr and Hugulet, 2004). The history of drug use is intertwined with spirituality and religion, use of psychoactive agents being proscribed in certain religious traditions and prescribed in other religious rituals (Miller, 1998).

I appreciate the subject of spirituality and addiction, and I have read the paper with interest and with a sense of gratitude to the author who was able to dedicate his/her time to explore this meaningful area.

The paper helps me to ask myself questions and to raise comments.

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In most cases, religion acts as a protective factor against drug addiction (Cook, 2004; Zimmerman and Maton 1992) and is a component of the recovery process (Avants, Warburton, and Margolin, 2001; Flynn, Joe, Broome, Simpson, and Brown, 2003; Carter, 1998). However, in some circumstances, religion may precipitate or contribute to maintain drug use. The aim of the present paper is to address different areas pertaining to the relationship between religion and addiction. After having defined the concepts of spirituality and religion, we will look into the behavioral patterns provided through the major works on the subject of drug consumption. We will attempt to determine how religion interacts with drug use and how spirituality could be integrated in the treatment of addictions. The evolution of clinical symptoms and the outcome regarding possible abstinence and recovery will be also discussed. We will also discuss the reasons for which, in spite of the enthusiasm of patients, the caretakers remain disinclined to investigate the religious dimension and take this into account in the formulation of the biopsychosocial model and treatment strategies. Lastly, we will mention some of the standardized instruments designed to measure the degree of spirituality and its limits, as well as future needed research that could allow us to better understand religious factors and specific processes that promote abstinence and harm reduction from addiction.

Religion and Spirituality

From an etymological point of view, the word “spirituality” designates a quality that is pertaining to the spirit, freed from all material needs. There are numerous definitions of spirituality.

Most include experiences that contribute to inner meaning and self-transcendence within or apart from a religious setting.

In a descriptive study clarifying the ways in which the concept of spirituality is understood and employed in practice by clinicians and researchers, Cook (2004) developed a definition of spirituality which might receive widespread assent within the field. Spirituality was defined as a universal dimension of human experience arising in three ways: within the inner subjective awareness, relationships with others of a community, and/or a relationship with something that is transcendent and beyond the self (Cook, 2004).

Spirituality is multidimensional, complex, dynamic, bounded (culture, time, place, etc.), and includes at least behavior (religious and spiritual practices), belief (deity, interrelatedness of living beings, soul or spirit and life beyond material existence, etc), lifestyle, and experience (mystical and convicational experiences, serenity, and oneness) (Miller, 1998).

Religion seems to be defined as a social phenomenon or an organized structure with the purpose of developing the spirituality of its members (Miller, 1998). Religion, from the etymology viewpoint “reliquari” has the meaning of being scrupulous or exacting in the performance of rituals. This is understandable since the Romans conceived “religion” as the performance of the correct rituals, in the correct manner, at the correct time. In a second time, Jews and Christians introduced a second meaning of “reliquari,” which tends to relate to men (or a group of men) and nature but always on the basis of a link to a divinity, or divinities. The religious principals expose the reasons or methods of this “reliquari” but the religion can produce, the entirely opposite effects leading humanity to war and division.

Religion can be defined by its three grand characteristics: the beliefs, religious practice, religious sentiments where the faith and the union in the same community of those who share the same faith. For this reason, religion has been easier of the two to define and measure in operational terms (Miller, 1998).
The study of extinct religions, or existing ones, shows the universal character of this phenomenon and a very large variety in the doctrines and ritual practices. Generally we distinguish between religions (named primitives or animists), the oriental religions (Hinduism, Buddhism, Shinto, Confucianism, Taoism) and the monotheistic religions emanating from the Old Testament (Judaism, Christianity, Islam). Christianity, itself has given birth to several religions or Christian churches (Catholic, Orthodox, Protestants, Evangelical, etc.), which as we shall see, hold a distinct position pertaining to the consumption of psychoactive substances.

Addictive Behaviors and Religious Recommendations

From a Judeo-Christian perspective, there is no condemnation of alcohol use. On the contrary, the drinking of wine is assumed to be part of ordinary life and is even commended for some central sacramental observances (Cook, 2004). But drunkenness, the use of alcohol in a manner that inflicts impairment and harm is considered as sinful and condemned. However, this is a complex issue. For example, during the Jewish holiday of Purim, Jews are obligated to drink until their judgmental abilities become impaired. The use of other psychoactive drugs is also considered a sin because of the risk of self-inflicted harm or injury to others.

For the Muslims, the Pentecostals, the Mormons, the Seven-Day Adventists, and some Buddhists, any ingestion of alcohol and certain other drugs is strictly prohibited, considered as a religious injunction, believing that alcoholism is the devil's work (Mariz, 1991).

Some religions promoted substance use too for a variety of reasons. Miller (1996) discussed religions which use hallucinogenic and other psychoactive substances in search of transcendence and divine contact, as practiced by some native Hawaiians and Polynesian religions. Some other religions are characterized as based on or inspired by drug use (Lyttle, 1988).

In one study arranging various religious groups across a fundamentalist-liberalist continuum, fundamentalist groups were more likely to consider alcohol and drug abuse to be "sins," whereas more liberal groups considered alcoholism and drug addiction as "illnesses" (Lorch and Hughes, 1985). One could then hypothesize that religious beliefs of people and society could affect individual attitudes toward substance use.

Religion and Spirituality as Protective Factors for Substance Abuse

The posited protective role of spirituality and religiousness is a well-known phenomenon that has been associated with substance use and misuse (Mohr and Huguley, 2004; Kendler et al., 2003; Booth and Martin, 2001). This phenomenon seems to be linked with acknowledgment of religious affiliation as well as the report of religious practices.

Alcohol and drug use-related problems are associated with a current lack of religious affiliation and involvement (Larson and Wilson, 1980; Hilton, 1991). A national study in the United States concluded that persons for whom religion was important were less likely to have drinking problems (Midanik and Clark, 1995). As noted in a study of Gorsuch, all religious groups have fewer alcohol misusers than are found in nonreligious groups, and religious groups with more antialcohol consumption norms produce fewer misusers (Gorsuch, 1995). A study of Khavari and Harmon (1982) about the relationship between the degree of professed religious beliefs and drug use highlighted that adults who view themselves as being "very religious" consumed less alcohol and used less psychoactive drugs when compared to subjects who consider themselves "not religious at all." Furthermore,
increased use of alcohol, tobacco, marijuana, hashish, and amphetamines was associated with the reported "not religious at all" (Khavari and Harmon, 1982).

Religious practices in the community were inversely related to substance use in the literature (Kendler et al., 2003; Booth, 1998). A study by Koenig, George, Meador, Blazer, and Ford, (1994) underlined that individuals who attended church at least weekly were one-third less likely to report alcohol abuse and dependence than those who attended church less frequently. Furthermore, those who prayed and read the bible several times a week were 42% less likely to have a diagnosis of an alcoholic disorder within the prior six months as compared to the rest of the sample (Koenig et al., 1994). Women who are partners of alcoholic men also report themselves to be substantially less religious in both attitude and behavior (Ichiyama et al., 1995).

The practice of transcendental meditation is associated with lower risk of substance use (Aron and Aron, 1980). Lower risk of alcohol use disorders has been associated with private practices of prayer and scripture reading (Koenig et al., 1994). More than a dozen studies have found that alcohol/drug abuse is associated with a lack of sense of meaning, on the Life Purpose Scale, relative to control samples (Crumbaugh and Maholick, 1969; Black, 1991).

In a study of over 2,000 female–female twins, Kendler et al. (2003) reported that current drinking and smoking as well as lifetime risk for alcoholism and nicotine dependence were inversely associated with personal devotion (such as frequency of praying and seeking spiritual comfort), fundamentalist Christian beliefs, and conservative religious affiliation.

It was reported, in a study assessing both spirituality and religiosity among opiate or cocaine users seeking treatment, that frequent time spending on religious/spiritual activities showed significantly better outcomes in terms of subsequent drug use and treatment retention (Heinz, Epstein, and Preston, 2007).

A paradoxical drinking pattern among members of religions that teach abstinence from alcohol was however reported (Skolnick, 1958). This pattern suggested that although most members of abstinence-promoting religions remained abstenent, the small percentage who did consume alcohol tended to consume large amounts and on frequent basis. Paradoxical alcohol use may result from punishing or abusive forms of religiousness (Booth, Blow, Cook, Bunn, and Fortney, 1992); in which alcoholics report experiencing a negativistic, punishing religious sentiment. A number of alcoholics consistently reported presentation and experience of judging, condemning, vindictive deity (Gorsuch, 1995). Religious-based social control using punishment (i.e., rigid "thou shall not"—focused religiosity) may not serve to reduce substance abuse but rather punctuate it (Gorsuch, 1995).

**Spirituality as Component of Treatment**

A substantial literature exists that examines various dimensions of spirituality with respect to the treatment of a wide range of mental disorders (Koenig, McCullough, and Larson, 2001). For example, Rebecca Propst (1980; Propst, Ostrom, Watkins, Dean, and Mashburn, 1992) found in controlled trials that incorporation of the client's spiritual themes into treatment can significantly increase the efficacy of cognitive therapy for depression (Propst, 1980; Propst et al., 1992).

In contrast, there has been relatively little attention given by researchers on the incorporation of spirituality in the treatment of addictions (Miller, 1999). This lack of attention represents a considerable gap given the posited possible protective roles of religion and spirituality with regard to addictive disorders and the prominence of such spirituality-oriented lay programs as 12-step programs (Arnold, Avants, Margolin, and Marcotte, 2002).
The 12-Step Programs. Except for the evaluation of the 12-step programs, which considers addiction as being a spiritual as well as a medical and a psychological disorder (Alcoholic Anonymous World Services, 1976), relatively few systematic evaluations have been reported which focused on the application of specific spiritually derived strategies in addiction treatments.

Project MATCH (1997) is the largest randomized trial of a spiritually based treatment. It compared a 12-step facilitation therapy (TSF) (Nowinski, Baker, and Carroll, 1992) with motivational enhancement therapy. The TSF treatment was specifically designed to engage clients actively in AA and to help them work through the first few steps of AA's spiritual program.

Clients assigned to TSF fared at least as well as those in the other treatment conditions, and on measures of complete abstinence showed significantly better outcomes. Across all treatment groups, both AA involvement and religious/spiritual involvement were found to be modestly and positively related to outcomes (Project MATCH Research Group, 1997).

In a self-help study among 310 dually diagnosed persons, many participants have credited 12-step affiliation to reconnecting them with a spiritual belief system discarded when they began using drugs; those beliefs in turn were credited with helping to provide the support and strength to remain abstinent (Laucht, 2000). A study compared personal and emotional modifications of inmates who were recovering addicts and who participated in one of two-year-long therapeutic intervention programs, one including social support and experiential spiritual program components (Narcotics Anonymous (NA) meetings and the 12-step course), the other including primarily social support (NA meetings only, without the 12-step program). Inmates participating in the 12-step program demonstrated a higher sense of coherence and meaning in life and a gradual reduction in the intensity of negative emotions (anxiety, depression, and hostility) than those participating in NA meetings without the 12-step program. The research findings demonstrate the importance of the 12-step program as part of a rehabilitation process for drug addicts (Chen, 2006).

Fiorentine and Hillhouse (2000) highlights in a study that the acceptance of 12-step ideology, particularly the strong agreement with the need for frequent, lifelong attendance at 12-step meetings, and the need to surrender to a "higher power" are significant predictors of weekly or more frequent attendance at 12-step meetings independent from other potentially mediating variables (Fiorentine and Hillhouse, 2000).

A study of Piderman, Schneekloth, Pankratz, Maloney, and Alchuler, (2007) highlighted an increased spiritual well-being (SWB), private religious practices (PRP), positive religious coping, abstinence self-efficacy (AASE), affiliation with AA (AAA), and their associations with alcoholics in treatment in 74 adults in a three-week outpatient addiction treatment program between their admission and discharge. Significant associations between the spiritual variables, SWB and AASE, as well as PRP and AAA were detected. Findings suggest that spiritual variables can change during treatment and lead authors to hypothesize that there may be connections between spiritual variables and variables associated with longer term recovery (Piderman et al., 2007).

Corrington (1989) found that among AA members, spirituality (as measured by Whiftield’s (1984) Spiritual Self-Assessment Scale) was associated with life satisfaction. This relationship was independent of the length of involvement in AA. AA attendance was often found to be modestly predictive of better treatment outcome (Emrick, Tonigan, Montgomery, and Little, 1993). In a study of Montgomery, Miller, and Tonigan (1995), it was found that drinking outcomes were unrelated to the extent to which clients attended AA after treatment (Montgomery et al., 1995). When it was measured with the extent to which clients had become involved in AA, however, a significant relationship emerged. Those
who were more involved in working program steps and in AA-recommended activities were more likely to be abstinent (Corrington, 1989). Spiritually Oriented Ambulatory Program. Piedmont (2004) evaluated a group of abstinent former drug users who had entered a spiritually oriented ambulatory program of eight weeks duration. Self-report data on symptoms, personality, and coping resources were obtained for 73 consecutive admissions (57 men and 16 women; ages 19–66 years) at intake and again from the 56 (47 men and 9 women) who completed treatment. Of those who completed the program, the ones who had higher pretreatment scores on spirituality had higher scores on well-being and less psychiatric symptom-related after completion (no indication of final drug-free status was given) (Piedmont, 2004). Meditation Programs and Mindfulness-Based Interventions. Meditation of various kinds has been found to be helpful in health promotion (Martin and Carlson, 1988) and has been applied in the prevention, treatment, and relapse prevention of addictive behaviors (Aron and Aron, 1980; Finney and Malony, 1985). One previous controlled trial, however, found no specific effect of meditation on alcohol consumption of “heavy drinkers” (Murphy, Pagano, and Marlatt, 1986).

Mindfulness, a form of meditation recently adapted for therapeutic purposes, is often related to spirituality given its roots in Buddhist tradition. Mindfulness is currently considered for the treatment of “substance abuse” (Bowen et al., 2006). Some studies highlight decreases in drug use-related problems through this technique but the lack of randomized design limits the ability to demonstrate the efficacy of mindfulness as a treatment for substance use disorder (SUD), independent of other variables (Bowen, Witkiewitz, Dillworth, and Marlatt, 2007). From a Buddhist perspective, mindfulness is seen as a necessary technique in the pursuit of spiritual goals. But mindfulness may also be viewed as a way of being present and open to one’s life experiences, unrelated to a spiritual path per se. This point of view seems to be confirmed in a study exploring through the Freiburg Mindfulness Inventory (Buchheld, Grossman, and Walach, 2002) and the Spiritual Assessment Scale (Howden, 1992) the relationship between mindfulness and spirituality. Indeed, this study highlights that spirituality and mindfulness may be separate constructs or, at least, two different ways of approaching experience.

Religious Recovery Programs. In the United States, Christian recovery programs have been offered by groups including the Salvation Army and Teen Challenge, among others. Walker, Tonigan, Miller, Corner, and Kahlich (1997) conducted the first double-blind randomized trial of intercessory prayer for alcoholics in treatment. No beneficial effect was observed. Clients who reported before treatment, that they were aware of someone already praying for them, also showed even higher levels of continued drinking at six-month follow-up. However, the use of prayer by clients themselves was associated with better outcomes. Geisler’s work shows that spiritual practices combined with psychosocial interventions, taking into account both individual and collective aspects of mental health, are effective aids to users in reducing their drug use (Geisler, 1978). A qualitative study on focus groups assessing addicted clients' perceiving need from a spirituality-focused intervention for the treatment of addiction and HIV-risk behavior highlighted the value of integrating spirituality-focused interventions into addiction treatment which may increase motivation for drug abstinence and HIV prevention (Margolin, Beitel, Schuman-Olivier, and Avants, 2006).

**Spirituality, Stress Perception, and Substance Use**

A study examining the role of spirituality in relation to stress and trauma symptoms among 393 women substance users who were in treatment highlighted that it did not mediate
the relationship between perceived stress, posttraumatic stress, alcohol and drug addiction severity. However, negative and significant associations were found between perceived stress, spirituality, and coping responses. Enhanced substance user treatments increasing spirituality and coping responses may be beneficial in helping women in substance abuse treatment to manage stress and posttraumatic stress symptoms (Arévalo, Prado, and Amaro, 2007).

What to Offer for People Not Spiritually or Religiously Oriented?

The 12-step program seems to be problematic and contraindicated for people who do not profess to be spiritually or religiously oriented (Ellis and Velten, 1992; Fletcher, 2001). For an individual to make a strong connection with a recovery group, he or she must connect with the philosophy of the recovery group. Individuals who have a higher level of religiosity can more readily connect with the philosophies of groups such as AA and NA and more easily find a sense of belonging in these recovery communities. For others who have low levels of religiosity, and especially for those who have a decisively secular or “scientific” worldview, it may be very difficult to fit in with spiritually based recovery programs. Individuals with this type of personal philosophy are more likely to feel that sense of belonging in secular support groups that do not use a spiritual approach and are more likely to continue participating in these secular groups (Galanter, 2006).

Spirituality as a Key Component of Recovery

Beyond specific interventions or coping resources, spirituality can help people to recover from various psychiatric conditions (Mohr et al., 2006). Although recovery can be considered as just maintained abstinence, we consider it in a broader sense. Indeed, recovery can be understood as a process whereby an abstinent person is moving toward a positive adaptation in life. This movement can take place with varying degrees of success, depending on the person’s own innate capacities and the circumstances in which they find themselves (Galanter, 2007). Those in recovery from addiction must learn to negotiate, adapt, and function, their way through life’s complex maze and demands of disappointments, obstacles, burdens, as well as facilitating bridges without the use of alcohol or drugs. They may or may not consume the recreational, socially approved substances of their culture and time periods: caffeine, nicotine, etc. They must re-establish relationships and reorder their use of time. Their commitment to abstinence, with its complex demand for life change, requires developing new adaptational and coping skills that could be spiritual. In this context, resolution of specific issues, considered as being important to the spiritual aspect of recovery from addiction could be considered. These include, among others: loss of sense of purpose due to excessive substance use, a feeling of inadequate social support because of one’s addiction, continued use of a substance while experiencing moral qualms over its consumption, and loss of self efficacy in refusing substances. Coleman, Kaplan, and Downing, (1986) described the “spiritual vacuum” of people addicted to heroin. They postulated that the sense of emptiness they observed was associated with early and bizarre loss, including frequent separations from parents and other family members. This experience of emptiness, which is sometimes associated with the sense of anomie, is not specific to substance users and was also described in other conditions such as borderline personality disorder and probably appears sometimes in a lower intensity in a wide range of people who have no psychiatric disorders. The sense of emptiness is however probably more distressing in
persons with substance use and particularly in those who report substance use in response to this phenomenon.

For a group of such people with few resources and important losses, the Higher Power fills the emptiness left by those losses and is a constant source of comfort, reassurance. The spiritual path appeared to provide a source of energy and sustenance that enabled the recovering person to confront the myriad tasks associated with “living life on life’s terms.” The relationship with the Higher Power provides a process for creating meaning in often incomprehensible situations too. The Higher Power, far from being an abstraction, is a daily presence in the individual’s life. The ability to talk to the Higher Power, through prayer and meditation, allowed the troubled individual an opportunity for reflection in times of trouble. Rather than acting to dull painful feelings or to sedate overwhelming memories, the recovering individual was in a position to conduct a discourse on these troubling matters, one that might lead to consolation (Coleman et al., 1986).

One method of understanding the etiology and recovery of addiction in spiritual terms is acquiring skills through participation in the aforementioned 12-step fellowship programs of AA or NA as well as many other mutual help-based processes (Gamblers Anonymous (GA), Overeaters Anonymous (OA), etc.) These 12-steps programs guide their members through recovery with 12 basic steps. The first step is the acknowledgment of one’s powerlessness over addiction. Subsequent steps focus on examining one’s character and developing a relationship with a Higher Power. The steps are designed to promote a spiritual awakening that prepares the recovering individual to carry the message to others and to practice the principles of the fellowship in all his/her affairs (McPeake, Kennedy, and Gordon, 1991). The growth of spirituality, as expected, through these programs, here has many functions. It provides containment, bounding the actions of the addicted person. The “giving over the will” to the Higher Power effectively limits the actions open to the individual. Alternatively described as the growth of a “conscience,” this bounding function is extremely important as a counterweight to the heedless and reckless thoughts and behaviors that characterized the addictive period. Booth and Martin (2001) described in their study that the spiritual awakening of the recovering individual allowed the patient to tap and find a new community. Religious communities can give social support and give moral influence preventing maladapted behaviors (Booth et al., 1998). Leaving the “addict” community, and entering other strata of the local environment, is critical to long-term sobriety. Such a process is accompanied by more profound cultural changes: communities that hold beliefs about the possibility and desirability of change, the moderation and restraint of behavior, the curbing of narcissism, and the importance of cooperation and mutual support could possibly have the same effect independently of religious or spiritual dimensions. The adoption of spiritual beliefs that are in tune with those of sober people in the milieu facilitates this transition. There have been a number of studies about substance user’s spiritual orientation whose findings reflect a positive relationship to recovery described in a five-year follow-up of recovering cocaine-dependent patients that the strength derived from religion and spirituality significantly distinguished between those who had a highly favorable outcome and those who did not (Flynn et al., 2003). Avants et al. (2001) found that a higher self-report rating on “spirituality or religious support” was an independent positive predictor of abstinence from illicit heroin and cocaine (Avants et al., 2001). Pardini, Plante, Sherman, and Stump, (2000) found in a study of 237 recovering substance users that higher levels of religious faith and spirituality predicted a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety (Pardini et al., 2000). Polcin and Zemore (2004) and Zemore and Kaskutas (2004) studied ambulatory patients who were predominantly drawn from AA meetings by applying a
multidimensional measurement of religiousness/spirituality, and they found that those AA members who had longer periods of sobriety reported a greater level of spirituality at the time of evaluation (Polcin and Zemore 2004; Zemore and Kaskutas, 2004). With respect to HIV risk-behavior research, Des Jarlais, Friedman, Hagan, Paone, and Vlahov (1997) found that over one-third of HIV-negative injection drug users indicated that “prayer” or “God’s help” was responsible for helping them avoid engaging in behaviors that could lead to HIV infection (Des Jarlais et al., 1997). A study of Avants et al. (2001) with inner-city HIV-positive injection drug users has shown that strength of perceived religious and spiritual support is an independent predictor of abstinence from illicit substances during methadone maintenance treatment, controlling for the influence of pretreatment variables (addiction and psychiatric severity, CD4 count, social support, and optimism), and during-treatment variables (methadone dose and attendance at counseling sessions) (Avants et al., 2001). Some studies analyzing recovery narratives from leaders of a peer-led, 12-step-based self-help group in a methadone treatment program highlights the importance of spiritually mediated role transformation in the recovery process. For these persons, their progression to a leadership role helping others with their recovery validated the spiritual transformation they regarded as underlying their own recovery process. Assumption of this new leadership/helper role marked a tangible sign that their deepened spirituality allowed them to assume a new, higher function in a struggle with the addiction that had plagued their lives. For these peer leaders, methadone was at the core of the group experience and an aid to spiritual transformation (Glickman, Galanter, Dermatis, and Dingle, 2006). Transformation and spiritual awakening, often in the form of embracing a higher power, have been identified as key elements in the experience of recovering addicts attending 12-step programs (Green, Fullilove, and Fullilove, 1998; Khantzian and Mack, 1994).

Retrospective narrations of recovery often include distinct and emotionally intense moments in the person’s life related to spiritual conversion experiences (Edwards, Duckitt, Oppenheimer, Sheehan, and Taylor, 1983). Such sudden and major personal transformations are well worth understanding, and may hold some keys to spiritual processes that can operate in life transformation (Miller and C’ de Baca, 1994). Miller (1998) made the hypothesis that the underlying processes are linked in some way to the consistent behavior changes that are observed following brief motivation-focused treatments (Miller, 1991; Bien, Miller, and Tonigan, 1993).

In contrast to these studies and reports, several papers about recovery, however, found no relationship between spiritual orientation and decreased drug use and abstinence (Murray, Goggin, and Malcarne, 2006).

**Patients and Staff Attitudes**

In the majority of studies, drug user patients view spirituality as essential to their recovery and value spiritual programming in their treatment more than some concrete items (Arnold et al., 2002). Despite the variability in how spirituality was conceptualized, it was found in a population of inner-city HIV-positive drug users that spirituality, as a source of strength/protection of self, and as a source of altruism/protection of others, was a very important part of therapeutic interventions for the majority of the participants (Arnold et al., 2002). In a study of Kaplan, Marks, Mertens, and Terry (1997), the inner-city drug users participating in the current study expressed an interest in being provided with an intervention that addresses spirituality. Findings from the questionnaire administration among the larger sample indicated that participants thought that addressing spirituality in addiction treatment would be helpful in their recovery, for reducing craving, for reducing
HIV risk behavior, for following medical recommendations, and particularly for increasing hopefulness. The vast majority expressed an interest in receiving a spirituality-focused intervention. There were no significant differences in perceived helpfulness of spirituality in recovery by HIV-serologic status (Kaplan et al., 1997).

The double-diagnosed patients rated spiritual orientation as more important to recovery than a job. They also rated AA meetings as more important than outpatient’s treatment. They also indicated that they wanted greater emphasis on spirituality and 12-step programs in their treatment. Resident of the therapeutic community indicated a preference for more of a spiritually oriented approach in their treatment. These findings support the view that some substance-abusing patients in treatment programs would prefer more activities associated with spiritual aspects of recovery than are provided. (Galanter, 2007).

Despite the possible roles which spirituality and religion can and do play drug user’s remission process and the interest revealed by significant numbers of patients, little attention, by and large, is given to the issue of drug use and spirituality among outpatients. The medical, and nursing staff, generally underestimate both the patients’ level of spirituality and the important emphasis of spiritual issues for them (Shafranske, 1996; Neelam and King, 1993; Hugulet, Mohr, Borras, Gillieron, and Brandt, 2006). Several hypotheses could be posited about this ongoing reality.

Care providers show little inclination to investigate this spiritual dimension with patients and rarely take note of it in the treatment strategies proposed despite the potential interest of religion and that the patients are not opposed to exploring this dimension.

Certain factors implicated can be mentioned: little religious affiliation among psychiatric caregivers documented by a study carried out among the psychiatrists in North America (Shafranske, 1996) and England (Neelam and King, 1993), a lack of knowledge, about religions, of the health professionals (Lukoff, Lu, and Turner, 1995; Shafranske, 1996), a tendency to perceive as being pathologic all thoughts or behavior of patients referring to a spiritual dimension (Crosley, 1995; Lukoff et al., 1995) or a fear of making the patient vulnerable by bringing the subject during a treatment session. A rivalry between religious and medical professions regarding the treatment of psychological suffering has also been reported (Roberts, 1997; Sims, 1999).

**Measurement of Spirituality in the Context of Addiction**

Spirituality seems to be a multidimensional concept (Larson et al., 1988; Cook, 2004). Numerous instruments referring to diverse aspects of this concept have been more or less well studied (Cook, 2004). Efforts to measure spirituality were however still limited to religiosity or religious involvement (Hilty, 1988; Richards and Folkman, 1997).

Moreover, religious beliefs and attitudes change across culture and differ for example between Europe and North America where most studies about religious questionnaires have been conducted (Fetzer Institute, 1999; Hill and Hood, 1999; Pargament, Smith, Koenig, and Perez, 1998; Pargament, Koenig, and Perez, 2000). This cross-cultural variability lead to consider that it will be difficult to find a questionnaire adapted for every kind of religious beliefs and practices (Wulff, 1997).

The development of an interview or a questionnaire adapted to a variety of spiritual and religious beliefs and practices and well validated in population with substance use disorders may help to improve our understanding of the possible role of spirituality in recovery process.

To this purpose, Galanter (2006) has recently developed a six-item Spirituality Self-Rating Scale designed to reflect a global measure of spiritual orientation to life in substance
users and controls (Galanter, 2006). In our opinion, this scale, which consists in the measure of an intrinsic orientation to spirituality (importance to spend time in private spiritual thought and meditation; intensity of living life according to religious beliefs; importance of prayers and spiritual thoughts of the person when she is alone in comparison to those said by her during services or spiritual gatherings; the importance of enjoyment when reading about her spirituality or religion; how much spirituality helps to keep life balanced and steady in the same ways as the person’s citizenship, friendships, and other memberships do; how much the person’s whole approach to life is based on spirituality), is likely to bring useful information to clinicians.

**Discussion and Conclusion**

For as long as history has been recorded, people have found spirituality to be a significant source of healing and an important source of meaning and sustenance. Not surprisingly, this review highlights the importance of the religious dimension and its potential implication on conception of illness, recovery, and treatment of addictive patients.

How can we approach beliefs and subjective attitudes regarding substance use related to religiousness? Four causal models were found in the literature.

The first one suggested that one’s personal religious experience may influence behavior (Gorsuch, 1995). An individual having some essential need filled by spirituality/religion will possibly experience a decreased need for and use of drugs. However, this model is flawed: we assume that because people who have religious affiliation are less likely to develop problems with substance misuse that the two are causally connected. It may be that other variable, unexplored, that caused the individual to find such affiliation positive and also protect against substance misuse and that the protection has nothing directly to do with the affiliation.

Gorsuch’s (1976) second model was based on the cognitive consistency model of psychology in which consistent exposure to church doctrines through participation in settings of worship constantly reminds one of ideals (Gorsuch, 1976).

Gorsuch (1976) also proposed an indirect role of the religion-substance use/abuse and use relationship: religious people constantly live in a social environment, thus forming a mutually supportive group. Group pressure provided reinforcement for a particular style of behavior—substance use or disuse—depending on the norms and values of that particular subgroup (Gorsuch, 1976).

Koenig et al. (1994) provided a fourth model in an effort to explain possible causality. Perhaps religion prevented the onset or persistence of alcoholism with doctrines that prohibited the use of alcohol through a supportive religious environment offering alternative cognitive and behavioral means of coping with painful emotions and feelings that may precipitate alcohol consumption and drug use (Koenig et al., 1994).

A further model could integrate the stages of development of addictions. Effectively, substance use begins usually by an initiation stage and shows progressively an evolution toward addiction. During the first stage, persons still have a possibility to control behavior, whereas this control tends to be lost at the stage of addiction. Furthermore, the initiation stage is widely subjective to cultural influences and representations. The last stage is out of this control (Tiffany, 1990). In the light of these considerations, the lower rate of substance use disorders in people involved in religious behaviors could be explained by a lower rate of initiation and maintenance of substance use during the first stage. One could hypothesize that the individuals who are in the addictive stage, the stage of addiction which occurs after the initiation stage and which is characterized by loss of control, could be harboring more
guilt feelings and thus be prone to feeling rejection, or could experience shame that could lead to the paradoxical effect of increase substance use. People may experiment shame rather than guilt or the opposite. This variation is probably highly influenced by cultural differences between guilt-based and shame-based societies and religions. The possible role of spirituality in treatment and recovery could be understood from a motivational perspective (Miller, 2003). Spiritual involvement could give sense to a behavioral change by giving more weight to alternative behaviors to drug use and may help to modify several coping strategies related to addiction.

In order to maximize patients' resources, clinicians should aim to evaluate the spiritual and religious dimension during both the diagnostic process as well as the therapy. It however seems that the clinician needs to be aware to use aspects of spirituality carefully and only in a sense acceptable for a given patient. Spiritual involvement may help patients who have an inclination toward a spiritual stature and may possibly be contraproducive with others.

Validated instruments or methods allowing one to clearly answer the question about how to effectively integrate a spiritual specificity for and with a person in a planned therapeutic process currently do not exist. Approaches such as the 12-steps developed in the West do not probably fulfill the diversity of the various spiritual needs. Future clinical developments could perhaps allow an open exploration of the personal spiritual needs and hence conceptualize the integration of these needs in the treatment under the condition of avoiding distortion in its usage.

An other avenue of development is to study the links between the wide range of instruments assessing spirituality (Cook, 2004) and to construct an instrument that investigates the multidimensional aspects of spirituality which could be also used in patients not religiously involved and to test treatment methods that are explicitly spiritually focused.

The place of spirituality in addiction and its importance for an important part of patients speaks in favor of specific training in this field for caregivers and policy makers. There is also a need for policies aiming to promote interventions, more sensitive to issues of spirituality, targeting an outcome, confounding factor, or component of treatments. Researches and consensus conference on assessment criteria of process involved in treatments as well as on outcomes in the field of spirituality and addiction may help in the understanding of issues related to this domain.

Further studies will have to overcome a possible publication bias in the literature on addiction and religion due to the fact that almost all the studies are from the western world and especially from the United States.

Research about factors and specific processes (whether spiritual or secular) or combinations of factors and processes that promote abstinence, as well as types, levels, and qualities of harm reduction and qualities of life satisfactions—even while using drugs—during the various phases of the development of addictive behaviors and in various cultural settings is essential. The findings, if generalizable, should ultimately be applied to both the traditional clinical settings as well as to the natural environments in which planned change—treatment—can and does take place.

Religion et addiction: quelles implications dans les soins?

De tout temps et dans toutes les cultures, les hommes ont consommé des substances et ce à diverses fins: comme remède médical, comme moyen d’établir un lien social ou comme moyen de communiquer avec d’autres dimensions. L’étiologie des addictions a
ainsi toujours été intimement liée à la dimension spirituelle et religieuse, certaines religions autorisant cette consommation, d’autres l’interdisant formellement.

Depuis une dizaine d’années, des chercheurs ont évalué le rôle de la spiritualité dans l’étiologie des addictions, son rôle protecteur ou précipitant à l’égard des consommations de substances, son possible rôle dans le traitement des addictions et comme faisant partie ou non du concept de rétablissement. Notre revue de littérature fait le point sur ces sujets touchant à la relation entre addiction, religion et traitement psychiatrique.

Mots-clés: addiction, rétablissement, religion, religieux, religiosité, spiritualité, bien-être spirituel.

**Religion y Adicción: que implicaciones en el tratamiento?**

En todos los tiempos y en todas las culturas, los hombres han consumido substancias y con diversas finalidades: como remedios medicos, para establecer una relation social o como medio de comunicar con otras dimensiones. La etiología de adicción liada siempre e intimamente a una diension espiritual y religiosa, ciertas religions autorizando este consumo, otras prohibiendo oficialmente.

Desde hace una decena de años, los científicos han evaluado el papel que juega la espiritualidad en la etiologia de addiction, su papel protector o precipitando cara al consumo de substancias, su posible papel en el tratamiento de adicción y como haciendo parte o no del concepto de restablecimiento. Nuestra revista literaria aclara ese punto sobre el tema de la relation entre adicción, religion y tratamiento psiquiátrico.

Palabras claves: adicción, restablecimiento, religion, religioso, religiosidad, espiritualidad, bien estar espiritual.

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Glossary

Religion: In this paper, we endorse a broad definition of religion including both spirituality (concerned with the transcendent, addressing the ultimate questions about life’s meaning) and religiousness (specific behavioral, social, doctrinal, and denominational characteristics).

Substance misuse: In this patient sample, we considered substance misuse, which involved either substance abuse (harmful use), substance dependence (dependent use) or both.

References


The Relationship Between Addiction and Religion and its Possible Implication for Care

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Why just the term religion is quoted in the title of the paper by Bonas and colleagues, and not the term spirituality, the latter being so frequently discussed.

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I think that the treatment programs for alcohol dependent people and illicit drug users that have developed during the last decades are historically based around are the issues of morality and immorality.

In fact “alcoholics” and “drug addicts,” who represent a heterogeneous population of people who adapt and function daily, immediately elicit moral blame that generates a separation between “them” and “us,” and activate processes of fear and segregation of “the other,” who is perceived as being a stigmatized and dehumanized object to place at a distance. The medical disciplines—that in turn draw upon tradition-bound processes of diagnostic objectification and classification—have contributed to such diffused perceptions.

The issue of immorality was turned upside down by means of a loving and compassionate understanding that has to be shared with “the other” as a person. This event was just possible in North America, in 1935, thanks to the experience and mission of Bill Wilson and his Alcoholic Anonymous (AA) fellows. Indeed AA was born from the failure of the consequences of using moral parameters, i.e., a sort of moving from Law to Spirit, using the words of Saint Paul. As a matter of fact, the modern treatment of alcoholism by social and health professionals begins with the initial co-operation with AA, in North America during the 1940s; such cooperation began the transformation of the concept of “vice” and “sin” into the concept of “illness.”

The proposition (quoted by our Authors in the section Religion and Spirituality) that spirit is freed from material needs, is typical of our western culture, which is based on the values of Ancient Greece. Another perspective, that is closer to the Judeo-Christian tradition, claims that “Spirit is life”; it is a blow that animates the body. You neither can anticipate it nor can you classify it, notwithstanding that spirit is needed for everyday life. It is the “body-spirit.” Moreover, it can actively change a dull and useless life into a life, which can be and is experienced as being fulfilled and open to self and others.

The paper quotes the description by Coleman about the “vacuum” experienced by drug addicts. This description has a psychopathology approach, that you can find in different authors during the last decades, e.g., the French psychoanalysts de Mijolla e Shentoub (1973).

However writers and clinicians like Christina Grof (1993) show us another corner of the problem, or other images representing the vacuum, i.e., the vacuum as a desert, as a dry land, as the night for the soul, within a therapeutic or healing process during one’s own life. Not to mention the Buddhist vacuum, that is one of the main experiences of awareness.

Such elements were also described in the 16th century by John of the Cross, who said that they are needed for a person to change from a too human person, that is too much taken by everyday needs, to a naked condition that is able to understand the complexity of life through a God that you cannot think of. The void is filled in with something, but if this something is a chemical substance, it does not attain an interactive relationship with “the other” as a changing person.

To come in touch with the Spirit through the vision of the “white light” in his hospital bed was necessary but was not sufficient for Bill W. In order to go beyond a closed and private experience and to make it into an available tool for humans, Bill W. had to also experience the relationship with the other, i.e., doctor Bob, and the alcoholics who followed.

Spiritual AA and 12-step Programs are not appropriate for everybody or for the same person at different times in their life cycle of change. However, there are spiritual alternatives. Some examples, which clinicians refer to, at least in my country, are the spontaneous conversion to other religions or religious sects or spiritual movements, like Buddhism, which parallels the remission or cessation of addiction.
Possibly professionals, whatever their discipline and treatment ideology, who are aware of the spiritual dimensions are more effective in treating addicted persons, whatever their goals (abstinence, harm-reduction, quality of life). Also failure, as a defeat of the ego, and of its associated power games, has to do with the spiritual dimension, like the experience of “hitting the bottom” or the Christian experience of Cross—Jesus who had to be in touch with his death and his hell, in order to resurrect. There are a few clinical anecdotes describing that just when a professional or a professional treatment team in an addiction treatment program come to honestly conclude that they were not able, any more, to sort out any kind of necessary therapeutic action for one of their clients, that that client started to improve, a therapeutic paradox.

Measuring spirit is an epistemological contradiction. Spirit blows where it likes, and (according to C. G. Jung) pertains to an archetypical, or acausal dimension that is the Self. Rationality is another dimension, based on causal criteria.

Within the dimension of spirituality, beliefs are more rooted than scientific demonstrations. The latter are able to assess the material part of spirituality, and the rites and behaviors that are especially visible in religion. Then, in the area of beliefs there is little place for demonstrations. The main criterion, I think, is the respect for the other’s opinion, as a fellow BEING, and to listen to, to hear his, her, their story, or narrative.

ABOUT THE AUTHOR

Allaman Allamani, M.D., (Italy) is a Psychiatrist, Family Therapist, and Researcher since 1993. He is the Coordinator of Centro Alcologico, Florence Health Agency. He is also author or coauthor of 140 articles, and editor or coeditor of 13 books. He is a member of the Editorial Board of Substance Use and Misuse and a faculty member of the Middle Eastern Summer Institute on Drug Use. From 1973 to 1993 he worked as a gastroenterologist clinician in the Gastroenterology Unit of Careggi Hospital in Florence. In the 1970s he cofounded the Tuscany section of the Italian Psychosomatic Society and the Centre of Interactional and Family Therapy in Prato, Italy; in the 1980s he also cofounded the Tuscan section of the Italian Society of Alcohology. In the same decade he contributed to a Regione Toscana project on Therapeutic Communication for helping professions together with Vera Maillard and others. Later on he started a comprehensive Alcohol Problem Treatment and Prevention program in Florence, also focused on eating problems, based on low access threshold, family and motivational approach, and cooperation with mutual-help groups. He developed the first community-action alcohol use intervention projects in Italy in the Florence area. He was the first nonalcoholic trustee of Italian Alcoholics Anonymous from 1997 to 2003. He is trustee of the Psychosomatics Training Institute, Florence.

References

Addiction and Spirituality in a Disenchanted World

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The review published in Substance Use and Misuse discusses a very relevant but often neglected dimension of the use and misuse of substances—spirituality. Such neglect seems to be a consequence of the paradoxes of the contemporary world, a world where different religious fundamentalisms live (and thrive) side by side with a prevailing materialism and deep disenchantment about any link between daily life and transcendence. Modern science freed us from what Carl Sagan called the “Demon-Haunted World” (Sagan, 1997), but at the price of severing the fruitful dialogue between science and spirituality. The very subtitle of Sagan’s book “Science as a Candle in the Dark” depicts the Illuminist endeavor, the tireless effort to free humanity from entrenched prejudices, and to bring light to a world plagued by the shadows of ignorance, the influence of religions, or any supernatural dimension that may compromise the concept of viewing man as the exclusive measure of all things. The Illuminist program succeeded in many fields, such as the establishment of democratic societies, the promotion and protection of human rights, and the respect for the multifarious and sometimes self-contradictory essence of human experience. But the Illuminist program failed miserably in many other fields, including the understanding and management of substance use and misuse.

The Illuminist program invested its energy in the naïve promise that the continuous progress of science and rationality would provide man and society with a firm basis to deal with our ethical and practical dilemmas. After each one of its failures, the answer has been monotonic: we need more of the same, i.e., more rationality and better science. Over time, all dilemmas would be solved or simply do not exist as such.

The persistent use and misuse of mind-altering substances by men and women living in the most different cultures and societies over time clearly documents that the pursuit of strict sobriety and clearness of mind is nothing but a point of view a fraction of society impose or try to impose upon other segments, such as in the Prohibition Era in the United States in the 1920s and 1930s. The Illuminist program faces a sheer contradiction in the way it deals with the so-called illicit substances. From one perspective, the illuminist program should guarantee the right of grownup, conscious individuals to consume whatever substance they want, to the point such consume does not harm others. From another valid and complementary perspective, society should promote and protect the health of the public and in this sense is entitled to prohibit the misuse of substances viewed as risky or harmful.

This contradiction becomes even more flagrant when the secular contemporary state is asked to legislate about substances used with the explicit purpose to foster the connection of believers with the realm of the sacred, as discussed by a Brazilian multidisciplinary team of experts (to which the author of this comment belonged) asked to pronounce themselves about the ritual use of Ayahuasca, a plant originally used for healing and divinatory purposes by traditional societies of the Amazon, but nowadays a core component of the booming religion of Santo Daime, an eco-religious creed born in the deep Amazon (MacRae, 1992),
that became a growing spiritual movement in Europe and the United States (see updated information at http://en.wikipedia.org/wiki/Santo_Daime). As happened in Brazil, the ritual use of Ayahuasca has faced court battles in different Western countries, so far favorable to Santo Daime believers (see information at the Wikipedia entry).

Much beyond the legal aspects, such disputes touch the sensitive point of the complex and unresolved relationship of the secular Illuminist societies and spirituality, the relationship of the profane and the sacred or, as discussed by Stephen Jay Gould (1999), the deep dialogue turned into monologue and intolerance between science and religion, the complementary dimensions of humanity, called by him “The Rocks of Ages.”

Exception made to movements such as Santo Daime, it would be silly to understand any use of mind-altering substances by Western-minded rational citizens in the context of the sacred, but on the other hand it would be also silly and harmful to deny spirituality as a core instance of people using and misusing substances or rather of any individual living the fullness of life, as mentioned by Gould. The quest for transcendence pervades the most different texts of writers who describe their own experiences with mind-altering substances. Our deep and complex challenge is to understand how such “paradis artificiels” (the “artificial paradises,” as originally coined by Charles Baudelaire after his experiences with opium and hashish; Baudelaire, 2006) may become the self-destructive episodes described by William Burroughs in his “Naked Lunch” (2004).

To deny spirituality as a key dimension of human life and a core component in the millennia long sought for mind-altering substances by each one of the civilizations that were born and perished under the sun (to paraphrase a treasure of spirituality, the Ecclesiastes) means to “sweep things under the carpet” of a self-confident Illuminist rationality, as pretentious as incapable to deal with the deepest challenges of modern world, such as social injustice, wars, environmental degradation, and last but not least, the harmful consequences of substance misuse.

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Francisco I. Bastos, M.D., Ph.D., is a senior researcher and Chairman of the Graduate Studies on Epidemiology at the Oswaldo Cruz Foundation (FIOCRUZ), Brazil. He is a physician who has extensive experience working on studies assessing populations at high-risk of HIV infection in Brazil, an area in which he is well published. He has been involved in the planning and management of multicentric projects, such as the WHO Multicity Project on HIV/AIDS and viral hepatitis among injection drug users and different protocols belonging to the National Institutes of Health, USA (NIH)-sponsored HIV Prevention Trials Network (HPTN) cooperative network. Dr. Bastos has been also involved in analyses aiming to assess the status and trends of the AIDS epidemic in Brazil.

References


Commentary: The Relationship Between Addiction and Religion . . .

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Among the many excellent points put forward by the authors, they note that spirituality and religion play relatively modest roles in drug user treatment other than those programs that purposely put religion at the center of their treatment regimen (e.g., Teen Challenge), or that make substantial use of spirituality in the context of their recovery program (e.g., the various 12-step initiatives). As the authors point out, spirituality—if not formal religious observance—is nonetheless an important aspect of many clients’ lives. In ignoring that point, the authors suggest that the great bulk of formal programs ignore an important aspect of prosocial functioning that might otherwise prove a significant support to maintaining abstinence. The question arises as to why this aspect of client functioning, with its obvious ties to supports for clients’ adoption of changed values and behaviors, is so little employed in drug user treatment. The authors suggest the likelihood that a bias exists such that drug treatment program staff minimize the utility of spirituality and religion for their own lives and thereby minimize its significance for the lives of others; and suggest as well that there is a long-standing tension between the secular treatment forms with which treatment professionals (and their research brethren) ally themselves and the spiritual treatment forms of the fellowship groups. Indeed, both tendencies may be grounded, in part, in the age-old tension between science and religion. Nonetheless, whatever the reservations specific to spiritual or religious involvement held by treatment programming, I would suggest those reservations are enmeshed in a more general disinclination of treatment professionals to examine and engage clients around a range of potential community supports—beyond an attention to family relations.

Thus, while there is a widespread recognition of the risk of relapse as clients exit treatment and re-enter communities that have, in the immediate past, proven supportive of the client’s drug use, little effort is made to explore and develop or strengthen aspects of that community that might help to insulate the individual from drug use, or conversely to identify the forces capable of leading the individual on a path back to drug use and to develop strategies for countering and/or avoiding those forces. For all the talk about a bio-psycho-social approach, the social is rightly shown as last if it enters the treatment picture at all. Thus, we can ask to what degree treatment concerns itself with exploring the client’s leisure time activities and linking the client to recreational, fraternal, or other social organizations that might be employed to support abstinent and prosocial behaviors.

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To what degree are existing friendship patterns and/or living arrangements investigated and, as appropriate, alternatives found in conjunction with the client? And, as a part of those efforts, to what degree is effort made to understand the individual’s interest in and prior involvement with religious organizations and, as appropriate in terms of the client’s expressed interests, to forge alliances with religious organizations that can prove supportive to changed, and prosocial, behaviors? In short, to what degree is effort made to enter and modify the client’s community to support the maintenance of meaningful behavior change?

It is recognized that there are real world constraints on counselors’ capacities to work with each client to explore his/her community and to enter that community in conjunction with the client to work with him/her to make changes that can provide supports to continuing abstinence. In far too many instances, counselors have little training or experience in working with the client to reorganize his/her community, and have little time for such activity. Large caseloads and frequent staff turnover are barely conducive to providing minimal counseling, let alone work to modify the client’s reference community. Nonetheless, without a conception of service delivery as an initiative extending beyond the four-walled treatment box, and as relating in some meaningful fashion to the client’s own corner of a world that has spawned and has maintained his/her substance use and misuse, we seem fated to make “chronic relapsing patient” a self-fulfilling prophecy.

ABOUT THE AUTHOR

Barry Brown has worked in the area of drug abuse for over 40 years as clinician, researcher, and research administrator and is the author of more than 100 articles. He has been a member of the SUM editorial board for the past 20 years. After retiring from the National Institute on Drug Abuse, where he directed its services research and community research programs, he has been working with Friends Research Institute on studies of both continuing care strategies for drug abuse clients and early engagement, and is an adjunct professor with the University of North Carolina at Wilmington.

Spirituality, Religion, and Recovery

Research is indicating that spirituality, if not religion, is an important component of recovery. I’m not sure where that leaves agnostics or atheists (although both Alcoholics anonymous and narcotics anonymous have specific literature relating to this issue and people possessing both belief systems are welcome there). A huge issue for court-ordered treatment in the United States is how to avoid violation of the First Amendment of the U.S. Constitution, which prohibits the establishment of religion. There is already a whole line of cases that say AA specifically cannot be ordered by a court, at least when “non-secular” alternatives such as Save our Sobriety or Rational Recovery are not given. Judges in the United States
must be very careful in scripting their sentences and other orders so they pass Constitutional muster. It’s very difficult for a judge, such as myself, who believes strongly that peer support groups are proven recovery tools to craft appropriate orders. Cases have also been sent back to the sentencing judge where the criminal defendant was placed in residential treatment with a Christian bent such as the Salvation Army. Just this past week I was teaching at the National Judicial College and part of our curriculum includes sending our participants to an AA meeting. A judge from Colorado came in the next morning and said they were asked to hold hands and recite The Lord’s Prayer at the end of the meeting. She said, “My inner Jew rebelled.”

ABOUT THE AUTHOR

Hon. Peggy Fulton Hora is a retired judge from the Superior Court of California and one of the founders of the drug treatment court movement in the United States. She trains, teaches, and lectures nationally and internationally on the subject of alcohol and other drugs in the justice system. She has been a faculty member of the Middle Eastern Summer Institute on Drug Use (MESIDU) in Israel. She is a member of the editorial board of Substance Use and Misuse.

References

Cox v. Miller 154 F.Supp. 2d 787 (S.D.N.Y. 2001)
Held statements made at an AA meeting are confidential religious communications; Reversed and Remanded, 154 F.Supp. 2nd 787.
Inouye v. Kema 504 F.3d 705 (9th Cir. 2007). Cannot require AA as condition of parole.
Addiction, Religion, Spirituality, Treatment

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Some research is indicating that spirituality, including religious beliefs and practices as
one expression, is an important component of recovery (e.g., Sussman & Ames, 2008). This
research creates debate regarding the options for recovery among agnostics or atheists
(Tonigan, Miller, & Schermer, 2002). One argument is that if one will not relinquish
control to a Higher Power of some kind, generally a Supreme Being, one will not be able
to quit substance use (Alcoholics Anonymous, 1976). In other words, to be a nonbeliever
purportedly may doom one to a life of drug problems. Alternatively, if one quits drug use
without reliance on a Supreme Being, a presumption that one will not be able to retain a
sense of life balance (soberety, as opposed to mere abstinence) may exist.

On the other hand, sole reliance on a Supreme Being orientation while in treatment
appears to violate basic ethical notions of freedom of speech, beliefs, and choice or, in
the United States, the separation of church and state (Trimpey, 1996). Anecdotally, many
persons have asserted that if they had had to endorse a Supreme Being, they would have been
doomed in their efforts for recovery (Christopher, 1988; Galla & Sussman, 1995; Hovarth,
1999; Peele & Brodsky, 1992; Trimpey, 1996). There is some evidence that reliance on
a Supreme Being is not central to recovery, although “spiritual” practices (or somehow
obtaining solidity/stability of one’s sense of self) may be quite helpful (Tonigan, et al.,
2002). There do appear to be a variety of “spirituality-related” beliefs and practices that
may be predictive of recovery success, many of which are not reliant on the existence of
a Supreme Being. However, there is often little explication regarding what “spirituality”
refers to (Sussman, Nezami, & Mishra, 1997). Rather, this term is often used in a way left
to be defined by the individual, and it often retains a mysterious veneer to it. It is difficult to
support or refute the influence of treatment organizations that promote spirituality without
an understanding of what is intended by their use of “spirituality.”

Even if one makes explicit certain statements or practices that are said to be spiritual
in content, what mediates the effects of these spirituality-based beliefs or practices on
recovery is generally not stated. That is, assuming a person meditates to receive support
from a Higher Power, prays, goes to church, engages in a number of other “religious”
activities, or, alternatively, states positive affirmations, meditates on a fixed object of self,
focusses attention, engages in service work, or “smells the roses,” the utility of these actions
is contingent on what they actually do for the person, how they translate into recovery
behavior.

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There are numerous potential mediators. These may vary within and across individuals over time. Subjective statements of attachment to Higher Powers or supernatural entities are types of spirituality related to a religious conceptualization. Three other mediators that do not appear to rely on a Supreme Being conception include (a) building a personal sense of morality (Sussman et al., 2005), (b) creating a stable positive attitude or conscientiousness (Sussman, et al., 1997), or (c) strengthening reliance on executive cognitive processes (Pribram, 1999). Regarding morality as a mediator, Sussman et al. (2005) found that a spirituality practices-and-beliefs measure that included items tapping prayer and meditation practices, religious/spiritual group participation, and reliance on a Higher Power predicted multiple types of drug use 1 year later among a sample of 501 at-risk teens from 19 alternative high schools. However, when statistically controlling for a measure of morality of drug use (which also predicted later drug use) the spirituality measure no longer predicted later drug use. Only the morality of drug use measure remained a significant predictor. The researchers inferred that it may have been the alteration of one’s associations of “guilt” or “right or wrong” with drug use that was more fundamental to changing behavior, rather than spiritual beliefs and practices per se. The spiritual practices may have provided the social learning setting within which to establish cognitive associations of immorality with drug use.

Spiritual beliefs or practices may also work to decrease drug misuse through eliciting statements of positive attitudes toward life or a tendency to help self and others (Hovarth, 1999; see the review by Sussman, et al., 1997), which may be antagonistic to self-seeking, negativistic behavior. In other words, taking an optimistic life perspective or being conscientious may mediate the effects of spiritual actions on drug use. Bogg and Roberts (2004) conducted a meta-analysis of 194 studies, finding that conscientiousness-related traits are uniformly negatively related to unhealthy behaviors including substance use. An attempt at operationalization of spirituality, based in part on a content analysis of current self-report measures, suggested that conscientiousness was a key constituent or mediator of the impact of spirituality on drug misuse (Sussman et al., 1997).

Mindfulness-related cognitive techniques might alternatively be referred to either as attentional-retraining-type strategies or spiritual practices (Cleveland & Arlys, 1992; Pribram, 1999; Sussman & Ames, 2008). The impact of meditation may be on strengthening the operation of executive cognitive function, which, in turn, would serve to strengthen inhibition of impulsive, substance-misuse-related behavior. In other words, spiritual beliefs or practices (coined as cognitive-therapy-related therapy techniques) may be mediated by effects on the quality of cognitive function.

Part of the parcel is the packaging. Whether mediated by morality-based attitudes, conscientious actions, or strengthening of cognitive function, religious-based or non-religious-based spiritual beliefs and actions may represent a healing process that may be very different from an initial Higher Power-type “cover story” and might be repackaged in a way that is more acceptable to people of different philosophical/religious beliefs. Indeed, 12-step programs have been reconceptualized to refer to understanding and support of others in the group or to spiritual resources rather than to a Supreme Being (e.g., Cleveland & Arlys, 1992). If people in recovery can identify with a healing process that will help them, it may not matter which route is taken. A healing route may be one they choose to label as religion, spirituality, or rational rewiring.

One other important observation should be explicated: Spiritual beliefs and practices are context dependent; that is, they derive meaning within socioenvironmental contexts. As such, it is even possible for spirituality to be employed as a means to promote drug use or misuse, rather than ameliorate drug use or misuse (Sussman et al., 2006). There exists a
drug-based-type spirituality; that is, one may use drugs to experience spirituality (Sussman et al., 2006). It is well known, for example, that one of the founders of Alcoholics Anonymous used the drug LSD (d-lysergic acid diethylamide) to try to achieve spiritual growth and healing (Dyck, 2006; Sussman et al., 2006). As another example, namely, Sussman et al. (2006), found a drug-use-specific spirituality measure (e.g., self-report items including “drug use can help you find your true self” and “drug use promotes personal growth and enlightenment”) was positively predictive of cigarette smoking and hallucinogen use 1 year later among a sample of 501 at-risk teens from 18 alternative high schools. Thus, the context within which spirituality operates may define or moderate the effects of related beliefs and practices on substance use.

In brief, spirituality “is” what spirituality “does.” It may be protective or facilitative of drug use, depending on what contexts and practices are associated with the term. Practices that direct one’s thoughts and behavior away from drug use, and perhaps provide one with a stable sense of a positive self, would seem to me to be most fundamental to recovery. These practices may be labeled as religious, transcendent, spiritual, mindful, moral, or conscientious or as cognitive reparation or cognitive coping. No matter how they are labeled, if the one being treated can identify with and make in-depth use of appropriate healing tools such as those mentioned in this dialogue, and if those who are treating can permit the flexibility to help channel the one being treated down a path that will work for the individual, great strides in substance abuse treatment will be made.

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References


**Spirituality and Religiosity in Context**

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Spiritual and religious factors are one component of a set of social processes that can protect individuals from substance misuse and contribute to the effectiveness of treatment and the maintenance of remission and recovery. These potential benefits are likely based on four active ingredients that are specified in social control, behavioral economics, social learning, and stress and coping theories (Moos 2007).

**Active Ingredients**

1. Consistent with social control theory, spiritual/religious involvement can build supportive bonds with family, friends, social networks, and other aspects of traditional

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society, and motivate individuals to engage in responsible behavior and refrain from substance misuse. These bonds provide goal direction and structure in the form of a shared belief system that enhances individuals’ immersion into a like-minded group and shapes their behavior toward socially acceptable goals.

2. Consistent with behavioral economic theory, spiritual/religious involvement engages individuals in rewarding social pursuits that tend to elevate mood and decrease anxiety. These activities typically protect individuals from exposure to substances and opportunities to use them, and thereby preclude or reduce the likelihood of substance misuse.

3. Consistent with social learning theory, membership in spiritual/religious groups increases the likelihood that an individual will identify with role models who engage in socially valued activities and shun substance misuse. These role models can motivate individuals to build a sense of purpose and responsibility, feel good by helping others in need, and participate in a social system that enhances their social standing and promotes new meaning in their life.

4. Finally, consistent with stress and coping theory, affiliation with spiritual/religious groups is likely to increase an individual’s self-confidence and coping skills. Individuals who profess stronger religious/spiritual beliefs tend to be more aware and accepting of their internal experiences, such as cravings and distress, rely more on adaptive coping responses, and develop better self-regulation skills (Carrico, Gifford, and Moos, 2007).

Limitations and Caveats

Just as with any powerful social influence, the potential benefits of spiritual/religious involvement must be considered with caution and placed in context.

Most important, spiritual/religious involvement must be freely chosen, not mandated. This bedrock civil liberties principle must hold sway in the face of potentially powerful pressures to subvert it.

Another point is that spiritual/religious influences reflect one—and only one—aspect of the broader social context that affects substance use and misuse. These influences are not a necessary or a sufficient component of substance use recovery. Other social context factors, including a diversity of influences from family members and social networks, are likely to be more salient for the majority of individuals.

In this regard, the influence of spiritual/religious factors is not unique; it is based on the same four sets of active ingredients that appear to underlie the effects of treatment, self-help groups, and other social contexts on the remission and recovery process (Moos, 2007). Secular family members and friends who strengthen social bonds and goal direction, promote engagement in activities that protect individuals from exposure to substance use, bolster abstinence-oriented norms and models, and build individuals’ self-efficacy and coping skills, raise the likelihood of stable remission.

Finally, spiritual/religious influences can have a detrimental or iatrogenic effect by demanding conformity to group norms and undermining an individual’s sound judgment and independence (Moos, 2005). Spiritual/religious groups can reward adherence to discredited ideals, alienate and socially isolate an individual, and even model and reward substance use.

To make fundamental advances in this value-laden and controversial area, we need to complement existing procedures that assess personal spiritual/religious preferences with measures of the emphasis on spirituality/religiosity in varied social contexts, such as treatment programs and families (for examples, see Lillis, Gifford, Humphreys, and Moos,
Joint consideration of personal and contextual factors should enhance our understanding of the benefits and risks of spiritual/religious factors in the development of and recovery from substance misuse.

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References


Tuned In, Turned Off

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Let us assume that—despite their broad and frequently conflated understanding of spirituality and religiosity—the authors have identified an empirical connection between spirituality/religiosity and the avoidance or overcoming of substance misuse or dependency. A number of questions arise.

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1 Although the authors discuss the ways in which religion may foster drug use, the bulk of their paper is concerned with religion's protective or recuperative use.
One concerns the nature of the causal connection: is it some objective Higher Power that benefits the potential or actual addict, or is it enough that a Higher Power is believed to effect such benefits—a kind of spiritual placebo effect? Or might it instead—as the authors also consider—not be either of the latter but the causal influence of the communal character of much spirituality: a religiously inspired social support system? Or might some or all (rather than just one) of these factors be operative? Given how broadly (and nondoctrinally) the authors cast spirituality and religiosity, the best that might be inferred from their review is that the value associated with spirituality/religiosity is based in function rather than in the truth of the underlying beliefs.

Perhaps it could not be otherwise. Social researchers must focus on causal connections rather than the truth of the underlying beliefs. Nevertheless, given the diversity of religious beliefs and spiritual experiences, and the exclusionary character of some of them, the most that can be said of the religiosity/religiosity to which the authors address themselves is that the religiosity/spirituality in question has a functional rather than truth value.

But if, then, we take it that there is at best some functional value to spirituality/religiosity, an important ethical question is generated concerning the legitimacy of either using or exploiting it for its functional value. There is, for example, probably some functional value to credible threats of penalization for using certain substances, but the legitimacy of such an approach might be questioned. We will need for example, to consider the appropriateness of using threats to deter the particular kind of substance use, the proportionality between the threats and the seriousness of the substance's use, the unintended costs of coercion, and so on. Somewhat similar questions might be asked of the exploitation of religiosity/spirituality. Admittedly, use of the latter need not involve threats, but advocating a purely functional approach to spirituality (which seems to be implied by the broad understanding adopted by the authors) surely comes close to employment of deception, since it is the functional rather than the truth value of belief that is critical. Deception arises because those who believe must believe the religious/spiritual views to have a truth value if they are to functionally benefit from them.

Maybe the ethical question can be met. Though truth is an important value, it is not all important. We are content to accept some social white lies: primum non nocere. Is there no case for placebos—whether chemical or spiritual? What legitimizes the use of a placebo is the fact that it lacks bad side effects and that no more beneficial alternatives to it are known to exist. If, indeed, it can be argued that religion/spirituality will serve to protect or return a person from some deleterious condition (addiction), that the religious/spiritual commitment will not have other deleterious effects, and that other alternatives to such commitment are not likely to be (in general or for that person?) more effective, that may serve to sustain the use of religion/spirituality in combating drug misuse.²

But the latter argument may be hard to sustain, at least in the broad sense advocated by the authors. Being religiously committed or spiritually inclined usually brings with it a range of understandings and responsibilities that extend far beyond those that will be causally associated with the avoidance of or emergence from drug dependence.³ Indeed, many faith-based programs are designed with a view to initiating a person into some specific religious tradition. And some of those traditions are likely to be socially and personally damaging. So, what we may also need to do, beyond determining whether religious/spiritual commitment ought to be used to address problems posed by drug use, is consider whether

²I leave aside here the important question of coercion. Even placebos need to be taken voluntarily. Whether there is something inherently coercive about prevention/treatment strategies involving religious or spiritual engagement also needs to be addressed.

³Twelve-step programs may be an exception to this, by requiring no more than belief in a power outside one, greater than one's own.
the cluster of beliefs that go with a particular form of religious understanding is—all things considered—better to have than not have. Do the benefits of a religious commitment—which may extend beyond those associated with drug use—outweigh the individual and social burdens that may also be associated with it? Despite their catholicity and social scientific concerns, the authors may not be able to escape the responsibility of choosing among religious or spiritual traditions.

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If We Spend $10 Billion on Faith-Based Interventions, Will They Work? A Comment on the Relationship Between Addiction and Religion and its Possible Implication for Care

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The Faith-Based Initiative¹ was introduced on January 29, 2001 (National Training and Technical Assistance Center [NTTAC], 2008), early in the first term of American President

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¹On January 29, 2001 the White House Office of Faith-Based and Community Initiatives was established by Executive Order 13199 with corresponding centers within the Departments of Justice,
George W. Bush, a self-confessed former excessive alcohol consumer who credits his return to, and continued sobriety to his born-again Christianity.

The faith-based initiative, as revised over the years by Congress, allows federal funding of religious-based social service and substance abuse programs; while not permitted to proselytize overtly, religious-based programs are, nevertheless, permitted to restrict hiring to coreligionists. Although criticized by some as breaching the strict separation of church and state enshrined in the US constitution and leading to discriminatory hiring (Americans United for Separation of Church and State, undated), the program is likely to extend beyond the Bush administration (Loven, 2008).

In the period 2003 to 2007 the total amount of federal funding for faith-based nonprofit programs totaled $10.4 billion (Executive Office Of The President Of The United States, undated).

In view of the enormous amount spent on faith-based interventions in the United States (as well as other countries such as Italy where the majority of social welfare programs are carried out by the Catholic Church), it seems entirely appropriate to have a review of the relationship between addiction and religion, especially as it regards faith-based intervention outcomes.

The author(s) in this paper, along with religion, included spirituality. Religion involves a belief system or dogma as to the nature of the deity, the relation between the deity and humans, defined practices and rituals of worship, a specialized religious intercessionary group (the priesthood), and a codified moral order that regulates the behavior of humans with one another, along with definitions of moral transgressions (sins) and their consequences (hell and damnation) as well as ways to achieve salvation (judeo-christian-islamic heaven) or enlightenment (nonrecurring reincarnation for Buddhists) by canceling out punishment through prayer, good deeds, including financial outlays for religious rites or devotional objects (statues, icons, churches, temples, schools, hospitals).

Spirituality, as embodied in the 12-step program of Alcoholics Anonymous and other self-help movements, is in many ways akin to a religion. It incorporates many aspects of what we now call “born-again” Christianity. Without actually recognizing a named deity, Alcoholics Anonymous follows most of the precepts of Christian religion: there is a dogma and a ritualized relationship between the alcoholic and the not-named deity: the alcoholic must acknowledge with humility a Higher Power to which he is subject and without which he is powerless. As Bill W., the founder of Alcoholics Anonymous put it in his own words “I humbly offered myself to God... to do with me as He would. I placed myself unreservedly under His care and direction. I admitted for the first time that of myself I was nothing; that without Him I was lost.” The nature of the relationship between humans is codified with consequences for transgressions clearly spelled out: “for if an alcoholic failed to perfect and enlarge his spiritual life through work and self-sacrifice for others, he could not survive the certain trials and low spots ahead. If he did not work, he would surely drink again, and if he drank, he would surely die” (Anonymous, 2007).

While Bill W.’s sentiments are very moving, it behooves the prudent policymaker to test the effect of religious or spiritual interventions on addiction intervention outcomes, and, as in all therapeutic interventions, to identify best practices and their cost effectiveness, so that their benefits (if any) can be made available to those who may find them useful. At the same time it must be recognized that such religion/spirituality-based interventions may NOT be suitable for many people, especially when the faith-based intervention is of a faith
that contradicts the patient/client’s own faith (or lack thereof). The patient/client in that case will just continue to game the system as when the indigent learn to sing a hymn so as to get fed at a Salvation Army soup kitchen, leading to continued cynicism and alienation inimical to recovery.

ABOUT THE AUTHOR

Manuela Adrian, M.Sc., Hyg. (USA-Canada), is a scientist, administrator, lecturer, public health researcher, and educator. Early in her career she was a policy analyst with the Canadian Ministry of State for Science and Technology (MOSST) where she investigated different models of research organization used in a number of countries in North America and Western Europe. More recently, she has been director of research at the Kansas Health Institute, head of the statistical research program at the Addiction Research Foundation of the province of Ontario in Canada, research economist/sociologist with Health and Welfare Canada. She is a consultant to the World Health Organization, (WHO), the Pan American Health Organization (PAHO). She has had appointments with universities in Canada (Guelph, Toronto, Carleton) and the United States (Florida International, Nova South Eastern, Kansas). She is a member of the editorial board of Substance Use and Misuse, and a faculty member of the Middle Eastern Summer Institute on Drug Use (MESIDU) in Israel, and the Middle Eastern—Mediterranean Summer Institute on Drug Use (MEMSIDU) in Italy. Her research interests include: addictions, psychoactive drugs, population health, health behaviors, epidemiology, special populations (women, youth, elderly, minorities), social costs, cost benefit/cost effectiveness, measuring quality of life (QALYs/DALYs), health care financing, health care management, needs-based planning, evaluation and outcome studies of health care and public health initiatives, estimates of market size, and postmarketing surveillance of pharmaceuticals. She uses quantitative methods including research design, applied statistics, analyses of large databases, ecological studies, multivariate techniques. She has over 200 professional publications, including 26 books and monographs, 15 book chapters, 34 articles (Social Science and Medicine; Medical Care; J. Applied Economics; J. Public Health Policy; American J. Health Promotion; American J. Drugs and Alcohol; Canadian Medical Association J.; Canadian J. Public Health; British J. Addictions; J. Studies on Alcohol; Drug Use and Misuse; International J. Addictions; American Statistician), newspaper articles, and video scripts. She is currently interested in community-based public education intervention through the use of print and television media for improved community governance.

References

Dialogue on the Relationship Between Addiction and Religion and its Possible Implications for Care

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This thoughtful and well-crafted article certainly sets the issues of religious faith and spiritual ideation in the context of contemporary investigative thought. It’s balanced and comprehensive approach is especially helpful when it comes time to discuss the implications of religion and spirituality in the treatment setting.

Reading it, I could not help but think of the concerns that Paul Tillich expressed in Theology of Culture (Tillich, 1964). In essence he said that the distinction between religion and spirituality was based on a misunderstanding of both. That religion is what points to ultimate concerns in all human creative activity.

“It (religion) is at home everywhere, namely in the depth of all functions of man’s spiritual life. Religion is the dimension of depth in all of them. Religion is the aspect of depth in the totality of the human spirit. What does the metaphor depth mean? It means that the religious aspect points to that which is ultimate, infinite, unconditional in man’s spiritual life. Religion in the largest and most basic sense of the word, is ultimate concern (p. 7).”

As such it is not distinct from the spiritual strivings of human beings but the ground on which those strivings rests. Perhaps it was this understanding that caused Dogen, father of Soto Zen Buddhism, in the 13th century to have carved on the gates of the monastery he founded a phrase, which loosely translated meant “Those not concerned with matters of life and death need not apply.”
There is, no doubt, another understanding of religion as an institutional structure or as personal piety. But this may not be what theologians mean when they use the word “religion.” Again as Tillich says,

“...why has mankind developed religion as a special sphere among others, in myth, cult, devotion, and ecclesiastical institutions? The answer is, because of the tragic estrangement of man’s spiritual life from its own ground and depth (p. 8).”

We behavioral scientists approach matters empirically, but this understanding may not be authentic or adequate when it comes to notions like religion or spirituality. Even if we engage those who are authentically spiritual and religious, what can they express about their experiences that we can possibly understand? I am not even sure that anything can be expressed about such experiences any more than one can adequately describe the taste of an orange to someone who has never eaten one. Even the best description is only a kind of metaphor or simile: “It kind of tastes like a grapefruit only sweeter.” Perhaps those interested in this area would do well to read more theology rather than behavioral science.

The article encourages clinicians to engage the spiritual and religious beliefs of those with whom they work. But even a cursory reading of spiritual teachings like Henri Nouwen seems to make it clear that the process of spiritual development follows a somewhat different paradigm than the one we tend to favor for emotional change. For example Nouwen, together with any number of spiritual writers classic and modern, maintain that the spiritual life begins not in community but in solitude. In solitude one comes to terms with one’s self and out of this encounter comes the desire to care both for one’s self and for others and it is out of this care that community arises. As Nouwen (1974) put it in Out of Solitude,

“It is in this solitude that we discover that being is more important than having, and that we are worth more than the results of our efforts. In solitude we discover that our life is not a possession to be defended but a gift to be shared. . . . In solitude we become aware that our worth is not the same as our usefulness. . . . To the degree that we have lost our dependencies on the world, whatever world means—father, mother, children, career, success, or rewards—we can form a community of faith in which there is little to defend but much to share (p. 19).”

The work that has begun in trying to understand the role of religion and/or spirituality in connection with substance misuse and any number of other human problems is of great value. But I suspect we could make more headway if we attended to those who have been thinking about these matters for a very long time.
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References


Science, Religion and the Challenges of Substance Abuse Treatment

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Social science approaches to knowledge and belief systems suggest that natural science, as we know it today, emerged out of the religious and magical traditions of the pre-enlightenment era (Yates, 1966; Thomas, 1971). Nonetheless many—perhaps most—scientists assume that science and religion are fundamentally at odds.¹ An anthropologically self-reflective and culturally relative perspective on both science and religion allows one to disengage from this zero-sum, competitive binary framework and to explore avenues for pragmatic rapprochement.

The field of biomedical substance abuse treatment is dominated by molecular neurobiology, one of the higher prestige, well-remunerated fields in both science and medicine. In the 1960s, to diminish the influence of morally and religiously based censure identifying substance abuse as an individual sin and a personal moral failure, scientists in the

¹The awarding of the 1.5 million dollar Templeton prize to natural scientists such as physicist Charles Townes for devising ways in which to “resolve” the tensions between science and religion demonstrate how this conflict is routinely framed.

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subdiscipline of substance use treatment redefined addiction as a “brain disease” (Dole and Nyswander 1967). This conceptualization was crucial to destigmatizing the field and to legitimizing the creation of methadone maintenance clinics for opiate addicts. It currently drives the bulk of ongoing private and public funding for laboratory-based research: that research is oriented toward magic bullet pharmacological interventions for the types of psychoactive substances most conducive to destructive patterns of consumption.2

Psychiatrists for the most part dominate the administration of treatment at clinical sites as well as research venues, medical education and training institutions. They adhere to the standard, liberal medical discourse known as the “bio-psycho-social model of disease” that predominates in public health and clinical therapeutics. In practice, however, model pays only lip service to sociocultural and economic contexts. Because of their theoretical and methodological training (and their material interests), psychiatrists tend to cast a psychologically individualizing and behavioral or neurobiological lens onto understanding the reasons for risky practices and for positive or negative health outcomes. They seek to maximize individual behavior change. This individualizing approach, of course, has been the subject of theoretical critiques from the social sciences and philosophy over the past several decades (see, especially Foucault, 1981). The interdisciplinary “science studies” field spanning the social sciences and humanities devotes itself to deconstructing the ways facts, truth, and, even to a certain extent what is popularly called “reality,” emerge out of social networks and webs of meaning-making (Latour, 1987). Influenced by the philosopher/historian Michel Foucault, many science studies scholars argue that the emergence of scientific disciplines represents a form of disciplinary power/knowledge that becomes the basis for shaping “subjectivities.” These are the socially structured senses of self that are popularly construed as expressions of individual willpower, agency, and force of personality. They manifest themselves at the level of individual action as choices, desires, values, and embodied self-presentation, but they are culturally and socially specific and follow broad, identifiable patterns and discursive logics that change across historical eras (Foucault, 1981).

The biomedical treatment field faces an internal credibility challenge to its claim to expertise and dominance over field of substance abuse treatment: evidence-based statistics document that most people fail treatment most of the time. Treatment advocates have responded relatively successfully by redefining relapse as a normal part of recovery and by requantifying every of sobriety as an objective measure of a successful outcome. Nevertheless, public funding for treatment is limited and the dominant political and law enforcement establishments remain skeptical of medicalized interventions to the problem of substance abuse. The hegemony of the biomedical approach is, in fact, very uneven. In practice, the biomedical clinical therapeutic approach remains inconsistent. Repression, moral sanction, and stigma predominate in many—treatment programs including some that are administered by devoted and effective clinical practitioners.

The biomedical approach, in its efforts to remove social stigma and to promote a brain disease model of addiction, imposes a lifelong, chronic illness on all its patients—even those who are fully adherent and who successfully stay away from drug use. In contrast, religion-based treatment ministries offer an instantaneous and complete cure. They also claim higher success rates and point to their large congregations of former addicts as proof. Through the concept of conversion and salvation, addicts can metamorphose from being sinners and victims of the devil to being the chosen children of God destined to lead their brethren to redemption. Most importantly, evangelical churches offer addicts an

2See anthropological critiques by Agar (1977) and Bourgois (2000).
immediately welcoming community that promises to rebuild their sense of meaning and self-worth. They substitute a new formal structure of personal discipline for the formerly precarious and often chaotic lifestyle of survival on the streets through petty crime and interpersonal hustling. It is not surprising, consequently, that so many vulnerable street addicts prefer evangelical, religious-based treatment services to the ones offered by biomedicine.

Faith-based treatment initiatives also generally resonate with deeply held, class-based, and culturally consistent systems of meaning and righteousness that predate addiction. Good examples in the United States are the prison-based ministries of the Nation of Islam (which recruits primarily African Americans) and Victory Outreach (which recruits primarily Chicanos and other Latinos) (cf. Rodríguez in press). Similarly, the white, middle-class phenomenon of recovering from addiction through Narcotics Anonymous by “surrendering to a higher power” has deep historical roots in US Protestant revivalism and Great Awakenings.

It is easy and unfair to throw stones at the biomedical treatment model of chronic brain disease and individualized psychological therapeutics. In fact, the field is faced with an impossible job. Historians and epidemiologists have demonstrated that there are large-scale, long-term patterns to substance abuse across history and that these are relatively clearly shaped by class inequalities and politically structured ways of imposing suffering on individuals (Golub et al., 1999; Courtwright, 2001; Agar, 2003; Bourgois, 2003; Bourgois and Schonberg, 2009). Arguably, ever since late 19th-century germ theory overthrew the “miasma theories” that had spawned state investments in sewage and drainage systems, the intervention paradigms of public health have shifted toward individual behavior change rather than infrastructural transformation of the risk environment (Tesh, 1988).

Contemporary biomedical science lacks the conceptual power to understand the relationship between individual agency and structural forces. It is not oriented toward comprehending how distinct patterns of “subjectivities” emerge during distinct historical eras. To be successful in the so-called “war on drugs,” treatment would have to be able to solve structural and historical problems for which it lacks a theoretical apparatus. Furthermore, the field has always been grossly underfunded in the United States, and its relative penury has been exacerbated by the consolidation of neoliberalism in the 1980s. Public subsidies for health have been slashed and the ideological emphasis on individual self-help and personal responsibility is hardening. Subsidized treatment on demand does not exist in the United States, for example, and the disjunction between short-term detox and long-term recovery programs has widened.

As a first step, biomedicine must recognize that addiction organizes the lives of substance abusers, enveloping them in a community of mutually dependent (even if dangerous and unstable) peers on the street who share the same priorities. Consequently, physical dependence and/or psychological cravings for a psychoactive substance, contrary to appearances, provides order and direction to lives that have often been disrupted by indigent poverty, intimate childhood violence, institutional abuse, and exploitation in the labor market. This is especially evident for homeless heroin injectors. When they wake up in the morning, they know exactly which foot to put in front of the other. Their needs and priorities are unambiguous: they must solve their most urgent physiological problem before worrying about anything else. Finding employment, acquiring food, obtaining shelter, appearing in court, applying for public assistance, or treating an abscess become inconsequential. Society’s opprobrium and personal public failure are the least of their worries. Similarly, childhood psychological wounds of abuse or abandonment have long since been subordinated to the demands of daily heroin consumption. Furthermore, most addicts
cannot survive as solo operators on the street. They are constantly seeking one another out to exchange tastes of heroin, sips of fortified wine, and loans of spare change. This gift giving envelops them in a web of mutual obligations and also establishes the boundaries and interpersonal hierarchies of their community. Sharing enables their precarious survival and allows for expressions of individual generosity, even if gifts often go hand in hand with betrayals (Bourgois 1998).

To be successful, biomedicine must learn to address the vacuum left in the lives of newly detoxed patients. Doctors are able to manage the short-term detox process with remarkable success. Unfortunately, few coherent, replicable follow-up programs exist for indigent addicts who urgently need to build supportive social networks from scratch and who must immediately find remunerative employment in order to survive. Furthermore, their new lives must be fulfilling and inspiring in order to keep them away from the urge to return to destructive patterns of drug use and violence that are so familiar to them (Bourgois and Schonberg 2009).

Evangelical religions, in contrast, have no problem transcending the theoretical and practical challenges of the structure-agency divide. They organize themselves around recreating sociability, establishing a sense of meaning, and imposing a protocol of individual discipline that enables individuals to commune ecstatically and collectively with an invisible omnipotent and omniscient being. The long-standing Protestant-derived American focus on “spirituality”—individual cognitive and emotional relations of faith with/belief in a higher power as the core of religion—may lead some analysts to miss the central arguments of sociocultural anthropology concerning the power of religion. A long tradition of French, Durkheimian sociology and British Malinowski ethnography has argued that religion is constituted by a set of social and conceptual techniques for organizing everyday life (Durkheim, 2001 [1912]; Malinowski 1978 [1935], 1984 [1948]; Evans-Pritchard 1985 [1965]). Indicators that strong “perceived religious and spiritual support” is a predictor of abstinence during treatment (Avants et al. 2001 cited in Borras et al., in print) may have more to do with this framework of culturally imposed discipline than it does with the “growth of conscience” or with “scales of spirituality.” Theories of a “human universal need for religion” (or for “spirituality”) miss the point that social embeddedness both produces and assuages “needs.” The “needs” of an addict are not universal: they are locally specific and historically and socially contextualized.

From a practical perspective, in the absence of a paradigm shift in public health and of a massive infusion of public funds for treatment, we must explore nonpolemically and pragmatically what forms of faith-based therapeutics work for whom and when and how we need to articulate them more productively with biomedical technologies. The current zero-sum competition between science and evangelical religion is a waste of time. At the same time, evangelical treatment cannot be embraced blindly. It is deeply steeped in ideologies of gender and sexuality which many people consider unjust, repressive, and intolerant. Furthermore, reliance on low-cost, “faith-based” treatment modalities often facilitates the retreat of state investment in desperately needed health services for street-based substance abusers (Hansen 2004; Hansen, Alegría et al., 2004; Hansen 2005). Fundamentally, the biggest problem faced by treatment is not science versus religion. It is the rising hegemony of the punitive, US-led global war on drugs. Most heroin detox treatment does not take place in clinics or under medical or faith-based supervision. It occurs in a purposefully brutal and coercive setting, on the cold concrete floors of precinct holding cells and county jails. It is generally accompanied by the jeers, kicks, and curses of guards and hostile inmates. Vulnerable populations of addicts are not evenly distributed across the social spectrum nor are spiritual or biomedical treatment protocols universal. We need to talk directly about
who, precisely is addicted, where, and when, and for what reasons, if we want to promote long-term abstinence from destructive patterns of drug use.

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References


A Few Thoughts on Addiction and Religion

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The authors have written a very useful paper that brings together a broad base of empirical research studies and alternative theories related to this topic. The paper broaches a number of important issues that would benefit from more extended discussion in the future. The paper rightly notes that correlations found between (low) religiosity and substance misuse may not indicate a causal connection and that instead other variables, associated with each and “unexplored,” may explain such correlations. One such possible confounding variable, hoary but far from easily dismissed, is a general attitude of nonconformity, rebelliousness, or rejection of authority. In the United States, as examples, this seems applicable in explaining substance misuse among those immersed in the jazz culture of 1900–1940 (Peretti, 1994), the Beat Generation during the late 1940s–1950s and the Sixties Counterculture in the 1960s (Wikipedia, 2010). This explanation is not entirely dependent on specific subcultural influences, but is also applicable on the personal level or for small reference groups, as demonstrated by the evidence in support of Problem Behavior Theory (Jessor and Jessor, 1977). Studies reporting correlations between religiosity and substance misuse rarely collect the type of data that would allow tests for such confounders, which is itself a symptom

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of failing to comprehend the whole person and how specific behaviors fit into the overall “picture” of his/her life.

The paper discusses the incongruity of many patients apparently being amenable to a spiritual dimension in their treatment versus the general disinterest of treatment professionals to pursue this topic (although certainly change is in the air). My thought is that referring patients to 12-step groups, which have a spiritual (but not religious) orientation, has been the primary method by which professionals have responded to the issue. But as the authors note, the 12-step program may not meet the full diversity of spiritual needs that exist today. Clearly the treatment community needs some help with all this. I have noted previously that the 12-step program is built on a particular Christian-Calvinist conception of the healing process (Magura, 2007). This remains appealing and useful for many, but there are a multitude of religious and spiritual traditions in Western and non-Western societies that might be drawn upon to assist patients, depending on their own backgrounds and preferences.

If professionals are to assist patients in building a spiritual element into their recoveries, they first need to learn something about the healing paradigms of at least the major religious and spiritual traditions (Mijares, 2003). They can then inquire concerning their patients’ interest in pursuing a spiritual dimension in treatment, which may be based on a patient’s background and beliefs, or a tradition that the patient may have heard about and would like to learn more about. This does not imply that the therapist needs to take the role of a shaman who guides the patient through the healing process and administers the prescribed rites. As in 12-step, depending on the religious or spiritual tradition at issue, much might be practiced individually, given the right materials. If the patient has a strong interest, referrals for advanced religious and spiritual guidance on healing would be indicated. One would envision collaboration between the principal therapist and the spiritual advisor in most instances, although in some cases transfer of the patient might be the logical course. Clearly a suitable local network for such referrals would need to be established, also taking into account cost and convenience. This would take some effort, to be sure, but could yield large dividends in terms of improved treatment outcomes.

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The Science of Spirituality and Addiction: What is Being Measured? What Does it Mean?

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What is the relationship between addiction and religion as posited by Borras et al. (2010) in this issue? What is meant by the “science of spirituality”? There has been a great deal of writing and research that has recently focused on the scientific measurement and explanation of spiritual, religious, and related concepts and phenomena (Hagerty, 2009). First, there was the God gene (Hamer 2004), then the God spot (in the brain), and now a God chemical (neurotransmitter for religiosity). The popularity of these ideas is evident by the cover of Time magazine, October 25, 2004, which focused on the purported God gene “discovery.” That a human construct about a higher being named God is being condensed in a gene or molecule shows just how nonsensical positivism and reductionism can be sometimes. There is even a Web site, Science of Spirituality (www.sos.org), that sounds like a clearinghouse for this type of thinking and research results; but in fact, it focuses mostly on meditation.

The “Science of Spirituality”

On the basis of research involving brain-scan studies on various types of people, Web-based surveys of people’s religious and spiritual experiences, and analyses of adult drawings of God, Newberg and Waldman (2009) have concluded, in a popular mass-market book, that something called God changes a person’s brain for the better, leading to spiritual well-being. The God molecule research attempts to evaluate a person’s belief in God and religion and to
correlate that with regions in the brain and the neurotransmitters that function there. Certain areas of the brain “light up” (become active) when people think about God or ponder moral or religious problems. It thus is concluded that God and religion are “hardwired” into the human brain.

Does this represent the classic error in thinking, *post hoc ergo propter hoc* (“after this, therefore because of it”)?

What these researchers actually are accessing in these studies are the parts of the brain that, when active, correlate with emotion, mood, and memory. Does this equate emotion, mood, and other feelings and sensations with a higher being (whether or not called God), spirituality or mystical/transcendent states of being (entering one of the many realms of consciousness), or human-constructed social organizations called religions?

Leaving aside the many philosophical and other arguments that arise when contemplating the “science of spirituality,” studying religion or spirituality or related concepts from a scientific perspective means using the basic tenets of science. Two of the most important principles of scientific inquiry are defining the concept and determining how to measure it.

**What is Being Measured?**

Phrases used in operationalizing and measuring these concepts include self-transcendence, mystical-type experiences, personal meaning, spiritual significance, and a myriad of related terms with various meanings. A brief review of the article by Borras et al. (2010) identified over 60 terms, words, phrases, and items (see Table 1) that they used to describe how to measure religion in terms of its relationship to addiction, another ambiguous term with a variety of meanings.

It is amazing how researchers mix and interchange spirituality (transcendence) with the concept of a higher being (a god) with religion (a social organization) and other related terms. While in some instances and contexts, they can be interrelated (but never the same thing), in other situations and for many people, they can be wholly distinct and not even connected. This above-mentioned Dialogue article interchanges spirituality, religion, religiosity, spiritual well-being, and other terms throughout, which is both confusing and conceptually problematic. Below are some examples from the article:

Religion, in its broad definition including both spirituality (being concerned with transcendence or addressing the ultimate questions about life’s meaning) and religiousness (specific behavioral, social, doctrinal and denominational characteristics).

Religion is defined in part as religiousness. How can a term be used to define itself?

Spirituality is multi-dimensional, complex, dynamic, bounded (culture, time, place, etc.) and includes at least behavior (religious and spiritual practices), belief (deity, interrelatedness of living beings, soul or spirit and life beyond material existence, etc) lifestyle and experience (mystical and convictional experiences, serenity and oneness).

While the definition of religion given in the first quote stated that it includes spirituality, thus suggesting that spirituality is a component of religion, here it is reversed; spirituality includes religious behavior. Spirituality also includes spiritual practices. Again, the term is used in part to define itself.
<table>
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<th>Conceptual dimensions or measures described in “The Relationship between Addiction and Religion” (Borra et al. 2010).</th>
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Religion can be defined by its three grand characteristics: the beliefs, religious practice, religious sentiments where the faith and the union in the same community of those who share the same faith. For this reason, religion has been easier of the two to define and measure in operational terms.

Has it? Is what is being stated here clear and understandable? Religion is defined as religious practice (religion) and religious sentiments (religion). What does “the faith...of those who share the same faith” mean? Can the definition of “drug” therefore be a substance with drug action (or acts like a drug), or something that drug users take, or a chemical that is called or referred to as a drug?

If researchers want to study the role of religion, spirituality, or whatever in drug use, they need clear definitions and “operationalized” or measurable concepts. If they want to progress these ideas, they need to be more lucid, more distinct, more rhetorically and conceptual sound than what is being described at this point in this body of research.

The recent Johns Hopkins studies (Griffiths 2006, 2008) on psilocybin and spirituality show the lengths to which these nebulous concepts can be measured. The researchers used a number of scales and questionnaires in the initial and follow-up studies. These included
the following, along with a number of other scales and questions: (1) a measure of behavior and mood (used by the monitor of the subjects) that consists of 20 dimensions, such as sleepiness, yawning, tearing/crying, restlessness, nausea, peace/harmony, and joy/intense happiness; (2) a 72-item yes/no questionnaire to assess altered states of consciousness; (3) the Addiction Research Center inventory that consists of 49 questions (relating the psilocybin experience to other drug experiences); (4) a states of consciousness questionnaire with 100 items (43 items measure mystical experiences, while the other 57 items are distractors); (5) a mysticism scale with 32 items; (6) a persisting effects questionnaire with 89 items; (7) a 24-item personal transcendence scale. They also asked the subjects the following three items/questions: How personally meaningful was the experience? Indicate the degree to which the experience was spiritually significant to you. Do you believe that the experience and your contemplation of that experience have led to change in your current sense of personal well-being or life satisfaction?

That is over 350 scale items and questions (not counting the distractors) that attempt to measure some dimension(s) of spiritual significance and personal meaning with regard to what the subjects experienced after taking psilocybin.

By the way, the stated purpose of these studies was to examine the acute and long-term psychological effects of psilocybin (a rather long conceptual leap from psychological effects to spirituality).

What Does It Mean?

The authors of this Dialogue article do acknowledge that spirituality is a multidimensional concept and mention four causal models that relate substance use to religiousness (though, again, it is religion per se, not belief or spirituality). They also acknowledge the great variability in how religion and spirituality are conceptualized, and that has been the point of this commentary. They most importantly state the need to study and confirm (reliability and validity, two other precepts of scientific inquiry) the links between the various instruments that have been developed to measure spirituality, even the various concepts or measures that have been operationalized as surrogate variables.

There is no doubt, listening to drug users and those trying to resolve their drug use problems, that for some, spirituality or something related like religion can help them interpret, describe, and understand their experiences and guide them toward improved well-being. But a key question, given the muddle of fuzzy conceptual thinking in this area, is this: What exactly are the important predictors of “mystical-type” drug experiences or of a greater probability of successfully achieving a drug-free existence after being dependent on a drug? Perhaps instead of religion or spirituality, the more important factors are belief, past experiences and expectancies, social support, and other facets of user set and setting (Frank & Frank, 1993; Zinberg 1986). These variables have been studied extensively in the past, and they have been found to be essential in influencing the types of drug-taking experiences that users perceive, interpret, and describe.

It thus may be difficult to untangle the interrelationships between “secular” factors such as user set, setting, and support and those that are defined in “spiritual” terms as far as helping those with addictions is concerned. While researchers will continue to struggle with methods and approaches to measurement, clinicians may already have some ideas about how to help certain patients who feel or believe that a spiritual component in their treatment program would be beneficial.
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References


The Role and Function of Faith-Based Organizations in the Delivery of Effective Substance User Treatment Services

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Background

Between 1996 and 2000, President Clinton signed into law several pieces of legislation that have been classified under the term, Charitable Choice. These laws apply to four Federal programs: (1) Temporary Assistance to Needy Families (TANF), (2) the Community Services Block Grant, (3) programs for substance abuse and mental health, and (4) the Welfare-to-Work program. Under these laws, the rights and responsibilities of faith-based organizations receiving federal funds are specified. Faith-based organizations cannot be excluded from competition for these funds and, if funded, may continue to carry out their religious missions and environments including maintaining their religious criteria for hiring employees. Along with these rights, faith-based organizations that receive federal funds must serve all eligible (nonreligious criteria) participants and are restricted from using such funds to support religious activities including worship, proselytizing, and religious instruction. Federal funds provided through the Community Services Block Grant and for substance abuse and mental health programs must maintain a separate accounting system for the federal funds that are received.

In January 2001, President Bush established the Office of Faith-Based and Community Initiatives within the White House. The principal functions of this office are to: develop, lead, and coordinate the Administration’s agenda for faith-based and other community programs and initiatives, ensure that the Administration’s policy decisions and programs are consistent with the President’s goals, integrate the relevant policy and agenda across the Federal Government, coordinate public education activities to support faith-based and community nonprofit initiatives, encourage private charitable giving to these programs, bring ideas to the President for assisting and strengthening these programs, provide policy and legal education to policy makers at all levels of government, showcase innovative grassroots programs, address barriers to these programs’ efforts to solve social problems, monitor the implementation of the President’s agenda affecting these programs, and ensure that the efforts of these programs meet high standards of excellence and accountability.

At the same time, Centers for Faith-Based and Community Initiatives were formed in eight cabinet departments and two Federal programs. These Centers were charged to conduct an audit of “...existing barriers to the participation of faith-based and other community organizations in the delivery of social services by the department, including but not limited to regulations, rules, orders, procurement, and other internal policies and practices, and outreach activities that either facially discriminate against or otherwise discourage or disadvantage the participation of faith-based and other community organizations in Federal programs” (White House, 2001, p. 1). The Centers’ report specified 15 barriers to the full participation of faith-based organizations in seeking federal support. These barriers are as follows:

1. A pervasive suspicion about faith-based organizations—i.e., that collaboration with religious organizations is legally suspect.
2. Faith-based organizations are excluded from funding—i.e., some Federal programs explicitly ban religious organizations from applying for funds.
3. Excessive restrictions on religious activities—i.e., some agencies have rules on how religious organizations can spend government grants that go beyond Constitutional requirements.
4. Inappropriate expansion of religious restrictions to new programs—i.e., carrying over old interpretations of funding laws to newer initiatives.
5. Denial of faith-based organizations' established right to take religion into account in employment decisions—this is probably the most contentious aspect of the Charitable Choice laws, protected both in Title VII of the Civil Rights Act of 1964 and again in the Equal Employment Opportunity Act of 1972 and supported in the US Supreme Court's 1987 ruling, Corporation of the Presiding Bishop v. Amos, 483, U.S., 327.


7. Limited accessibility of Federal grant information.

8. Heavy weight of regulations and other requirements.

9. Having additional requirements to meet before application for support.

10. Questionable favoritism for faith-based organizations in some cases such as the Center for Substance Abuse Prevention's announcement to expand the capacity of minority communities for substance abuse and HIV prevention programs limiting eligibility to faith-based organizations and to youth-serving organizations in collaboration with faith-based groups raises constitutional questions and barriers for secular programs.

11. Improper bias in favor of previous grantees.

12. Inappropriate requirement to apply in collaboration with likely competitors.

13. Requiring formal 501(c)(3) status without statutory authority.


On January 2, 2005, a headline from the Associated Press stated that more than $1 billion was given in 2003 to organizations considered "faith-based." Close examination of the list and verification with several of the organizations mentioned revealed that many are entirely secular (Smith et al., 2001). Clearly, much more refined investigations need to be completed to have a better idea of the extent to which "faith-based" organizations are receiving Federal funds.

Health Services Outcomes and "Faith"

The expansion of government funding to include faith-based organizations with the passage of Charitable Choice laws has stimulated interest in the relationship between "faith" and social and health services and the outcomes of these services. Prior to subsequent to 2000, studies have explored this relationship in the health area. For instance, several researchers have found that there is a positive association between religious involvement and/or spirituality and positive physical and mental health outcomes (DeHaven, Hunter, Wilder, Walton, and Berry, 2004; Pardini, Plante, Sherman, and Stump, 2000; Powell, Shahabi, and Thoresen, 2003; Thoresen, 1999). What processes or mechanisms take place that explain these relationships are open to further social and biological research. (Borg et al., 2003; Miller and Thoresen, 2003; Seeman, Dublin, and Seeman, 2003).

Substance Abuse and "Faith"

In the field of substance use, there is a smaller literature exploring the relationship between faith, religiosity, spirituality, and substance use. The balance of this literature focuses on these factors as protectors against the initiation or continuation of substance use (Harris, Thoresen, McCullough, and Larson, 1999; Amey, Albrecht, and Miller, 1996; Lester, 1987; Gibbons, Wylie, Echterling, and French, 1986; Kendler, Gardner, and Prescott, 1997;
Examination of these factors in the context of prevention or treatment interventions has received much less attention. Alcoholics Anonymous, Narcotics Anonymous, and other related 12-step programs received the most attention, and while, the evidence of effectiveness is positive, as Tonigan et al. (1996) point out, these programs are not homogeneous entities and should not be treated as if they are. Other types of research address the relationship between faith and/or religiosity and outcomes from treatment. For example, Pardini et al. (2000), in their study of 236 clients recovering from substance use found that those having religious faith and spirituality had more positive mental health outcomes. They suggest that these beliefs reinforce optimism, social support, and coping with stress, therefore reducing feelings of anxiety.

In the report, So Help Me God: Substance Abuse, Religion and Spirituality, the National Center on Addiction and Substance Abuse of Columbia University (2001) examined the relationship between God, religion, spirituality, and substance use prevention, treatment, and recovery. Their two-year study included analyses of existing databases such as the National Household Survey on Drug Abuse and their own surveys of teens and their parents, a literature review, and the administration of surveys with presidents of schools of theology and seminaries and clergy regarding their perceptions of the extent of the substance use problem and the availability of training on the problem. Their findings support the findings from other studies about the protective nature of religious involvement for adolescents and adults. In addition, they found that although clergy recognize the significance of substance use, most did not complete any formal training and only about one-quarter of presidents of schools of theology or seminaries reported that such training was required in preparing for the ministry.

The lack of understanding about the link between “faith” and substance use particularly in the prevention and treatment processes warrants study. Untangling the complexities of defining and measuring the dimensions of “faith” from the delivery of services including who delivers what to whom, where, and under what conditions are very challenging.

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References


