Section 2
Chapter
16

Treatment: context and content

# Spiritual and religious issues in treatment

Spiritual and religious issues are now important in all areas of healthcare. This is because of a growing research literature concerned with their influence upon health, their importance as factors to be considered in treatment, and also their influence upon outcome in a wide range of areas of mental and physical health (Koenig, 1998). It is also because of their importance in understanding the whole person, the meaning and purpose that they find in life, their values and relationships, and thus relevance also to ethical considerations. However, if this is true in most (if not all) areas of healthcare, it is especially true in working with people with so called 'addictive' disorders, not least those with drinking problems.

This particular relevance of spiritual and religious issues in the treatment of drinking problems arises for a number of reasons, which will be considered here in turn. These are concerned with history, religion and the nature of drinking problems. We can then turn to a consideration of how spiritual and religious issues might be addressed in treatment, and what influence we should expect that they might have on outcomes. However, before we can consider any of these matters, we must first consider more carefully exactly what spirituality and religion are.

## Definitions

*Spirituality* is a word with a relatively short history (Cook, 2004). Whilst it has its origins in the Christian tradition, it has come to be applied not only to all faith traditions, but also to an aspect of human nature which is generally considered to be universal. Those who are atheist or agnostic, according to this understanding, also experience a spiritual dimension to their lives just as much as those from the world's various faith traditions. Just as there are biological, psychological and social dimensions to being human, so there is a spiritual dimension. In this sense, spirituality is a part of holistic care, of recognizing the totality of what it is to be human.

Beyond this, however, spirituality is a controversial term. For some it is simply not scientific and therefore outside the purview of the medical and social sciences. However, the major controversy is not so much that it is *ultra vires*, as that it is capable of diverse and varied definition, even to the point of self-contradiction. This has led to suggestions that the term either be abandoned completely or else that it should be redefined, using alternative terminology, on a multidimensional basis.

Before we adopt this nihilistic perspective, however, it must also be asserted that whatever some may think, this term is still widely used, not least in the field of addictive disorders. It may also be argued that the diverse definitions are not entirely unrelated, and that some underlying coherence of the term is still affirmed by many clinicians and researchers, not to mention members of mutual-help groups such as Alcoholics Anonymous and members of faith communities. In practice, it is therefore a de facto subject of conversation in this field, which simply does not go away.

What are the various definitions of spirituality? Whilst they are indeed varied, it would seem that (at least within the field of substance misuse) they comprise some combination of the following 13 conceptual components (Cook, 2004):

- relatedness
- transcendence
- humanity
- core/force/soul
- meaning/purpose
- authenticity/truth
- values
- non-materiality
- (non-) religiousness
- wholeness
- self-knowledge
- creativity
- consciousness.

Of these, *relatedness* and *transcendence* are much the most frequently encountered in relation to substance misuse. Thus, for example, a common working definition is of spirituality as relationship with self, others and the wider universe (where the wider universe might variously be understood as 'truth', 'God' or some other 'Higher Power'). The greatest polarization is associated with *(non-) religiousness*, where some writers argue that spirituality and religion are almost diametrically opposed, whereas others cannot conceive of spirituality as divorced from their religious beliefs. The approach adopted here is that all human beings are spiritual, whereas not all are religious. It is therefore possible to be 'spiritual but not religious', but not 'religious but not spiritual'.

It will by now be apparent that a simple, universally acceptable, definition of spirituality is (at least for present purposes) elusive. However, the following definition has been proposed following a study of a large number of papers in this field, and has been adopted as the basis for other work on spirituality and mental health.

> Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values (Cook, 2004, pp. 548–549).

In contrast to all of this, the word *religion* has a very long history, and calls to abandon this term altogether are relatively infrequent. However, it is no less elusive of a clear and universally agreed definition (Bowker, 1999, pp. xv–xxiv). Generally, definitions of the term are concerned with social structures, ritual, tradition, belief and practice. It might therefore be easy to contrast spirituality as individual and subjective with religion as socially defined. Whilst this has some merit, it undoubtedly fails to recognize the social concerns of spirituality (as relatedness, for example) and the psychology of (individual) religious experiences.

Religious belief is a matter of tradition – the handing down from one generation to the next of practices and beliefs. An understanding of those practices and beliefs, according to

the world's major faith traditions, is therefore not unimportant in clinical practice. However, in reality, many individuals and local communities adopt elements of various faith traditions and popular beliefs do not always marry exactly with the orthodoxy of the tradition at large. It is always important, therefore, in clinical work to understand what each individual believes and not to make assumptions on the basis of religious or denominational 'labels'.

## History

Up until the late eighteenth century, drinking problems (then known as 'chronic inebriety') were largely understood within Europe and North America as being a matter of morality. This was not necessarily the popularly understood moral model that is now so often denounced (i.e. that such people are morally bad in a category apart from other people). It rather reflected a Judeo-Christian understanding of drunkenness as being amongst a range of sins, to which all human beings were more or less subject, all of which were primarily spiritual/religious concerns rather than medical ones. All of this changed in the nineteenth century, under a progressive medicalization of the concept of inebriety.

The nineteenth-century temperance movement understood inebriety as a 'disease of the will', a disease caused by alcohol. However, in the twentieth century, with the repeal of Prohibition in the USA, and the waning of the temperance movement in Europe and North America, a new disease model arose. Associated particularly with the work of Alcoholics Anonymous (AA), this disease model identified certain individuals, 'alcoholics', as suffering from a disease which made them unable to control their drinking. Other people could drink safely and in moderation. Alcoholics could not do this – but this was due to an as yet incompletely understood disease, not any moral failing. This disease model has attracted critics, and it stands alongside hugely influential, and often competing, psychological and scientific models of addiction. But the generally acknowledged effectiveness of AA continues to affirm its credibility, especially in the eyes of those many people who have been helped by it.

The philosophy and experience of AA has subsequently been greatly influential in regard to the treatment of drinking problems around the world (see Chapter 15). It is explicitly not aligned with any particular religious tradition, and is open to atheists and agnostics as well as to members of all the world's major faith traditions. However, AA drew in its early days on the spirituality that its founders identified in the work of Carl Jung and William James and, most especially, the spirituality of the Oxford Group. The Oxford Group, a Christian movement founded by an American Lutheran minister, Frank Buchman, was at the peak of its success in the 1930s. It emphasized confession and repentance of sins, and a life of dependence upon God.

The spirituality of AA, now effectively a 'secular'[iii] spirituality, is at the heart of the help that AA offers to people who struggle with their drinking. It is defined, most importantly, by the philosophy of the '12 steps' of AA – the steps taken by the founders in their own recovery from alcoholism. The nature of this spirituality will be considered further, below.

[iii] Alcoholics Anonymous has been described as a secular spirituality, alongside other secular forms of spirituality, such as sport, aestheticism and psychotherapy (Kurtz, 1996). However, this is not to neglect the important observation that many of its members continue to understand their own spirituality within the framework of traditional religious practice. It might therefore be thought of as a pluralist spirituality, as much as (if not more than) a secular one.

However, what must be noted here is that it has been so very widely influential. It is AA, more than anything else, which has placed spirituality firmly on the contemporary addictions treatment map.

## Religion

In Europe and North America, the Temperance movement did more than simply change attitudes to drinking and drunkenness. It spawned a variety of projects aimed at reclaiming the drunkard or, as we would now say, offering treatment for drinking problems. Many of these projects found inspiration and motivation in the Christian tradition. Perhaps most famously, the Salvation Army devoted itself (amongst other concerns) to helping those whose lives had been destroyed by alcohol, but it was not alone. Alongside the secular spirituality that emerged from AA, various Christian groups in Europe and North America continued to concern themselves with rescuing those whose lives were ruined by alcohol, and they did so in explicitly Christian ways. Today, there continue to be numerous projects around the world that offer rehabilitation from addiction within a Christian framework.

For Christianity, concern for those whose lives have been shackled by bonds of addiction has been a part of a broader tradition of concern with social and spiritual bonds from which people need to be set free. Elsewhere in the world, and increasingly also in the West, treatment programmes are integrated with, inspired by and motivated by other faith traditions, including Islam, Buddhism and Native American religion (Abdel-Mawgoud, Fateem & Al-Sharif, 1995; Barrett, 1997; Garrett & Carroll, 2000). These traditions each find their own distinctive point of contact with problems related to alcohol and other drugs.

Buddhism recognizes that all human beings have a tendency to attachment to things, which causes suffering. What might otherwise be identified as 'addiction' is but one manifestation of this, but it is a problem which afflicts us all. Treatments founded on basic tenets of Buddhism, and which are not dissimilar to forms of cognitive behavioural therapy, thus lend themselves readily to the treatment of alcohol dependence (Marlatt & Kristeller, 1999).

In Islam, alcohol use is forbidden on the basis of texts in the Quran, which point out that its use has an adverse impact on relationship with God. The response of this tradition to drinking problems has thus been much more akin to that of the Temperance movement, and prevention (in the form of injunction to total abstinence) is emphasized rather than treatment. However, treatment programmes for other forms of addiction, which incorporate Islamic spiritual practices, have been reported in the scientific and medical literature (Abdel-Mawgoud, Fateem & Al-Sharif, 1995) .

Native American religion is important because of the extremely high rates of alcohol-related problems that Native American peoples have experienced since beverage alcohol was first introduced by European settlers. Whilst this might still leave its importance limited to North America, it also provides an example of the way in which spirituality and religious practices of a faith tradition may be woven into the fabric of treatment programmes based upon the 12 steps of AA or other models. Native American religion understands spiritual reality as more 'real' than the visible order of the world, but addiction represents a closing down of connection with this reality. Treatment is therefore about reconnecting to this reality, and various treatment programmes now integrate traditional Native American practices such as talking circles, sweat lodges, tribal music, pow wows and peyote meetings in support of recovery from alcohol dependence.

Treatment programmes based explicitly upon other faith traditions are relatively unusual in Western countries. However, there is evidence to suggest that similar principles

apply in working with individual members of other faith communities. Thus, for example, Morjaria and Orford found that South Asian men in the UK undergoing counselling for drinking problems experienced a reaffirmation of existing beliefs (Hindu or Sikh) during recovery. This contrasted with members of AA who underwent a 'conversion' experience (Morjaria & Orford, 2002). However, both groups found a deeper sense of connectedness with God, and it is this spiritual dynamic of recovery, understood within the particular spiritual or religious tradition of the individual concerned, which seems to be of general importance in the treatment of drinking problems (and other forms of substance misuse).

## The nature of drinking problems

As we have seen in the earlier chapters of this book, drinking problems can take many forms. They may be expressed as drinking which is potentially harmful, but has not yet caused actual harm, or else as actual harm of various kinds: biological, psychological and social. To this we might now add spiritual harm – the harm that inappropriate or excessive drinking may cause to faith, morality, values, self-worth and relationships with self, others and a transcendent order, in a variety of ways. It is not so much this spiritual harm, however, that defines drinking problems as an especially spiritual concern. Rather, it is the nature of the problem itself.

The problem itself, we have seen, is also concerned with biological, psychological and social factors. It is not well understood either from a purely individual perspective or from a purely population perspective. It is, rather, about the whole experience of individuals living in community. This whole experience concerns the pressures that come to bear upon people to drink more or to drink less. The individual thus becomes a focal point for decisions which balance harm against good, suffering against pleasure, the present moment against the longer term or self against others.

Many of these decisions are made unconsciously or rapidly and without much thought. No one deliberately chooses to become dependent upon alcohol. Thus, the adolescent who succumbs to peer pressure and drinks to the point of reckless irresponsibility does not set out to cause harm. However, through a series of decisions over a period of time they develop a relationship with alcohol which profoundly affects their relationships with others. Perhaps, at some point, an experience of the reality of this dynamic will provoke a change of course. We know that many young people do 'mature out' of a period of irresponsible or excessive consumption and go on to become moderate drinkers as adults. However, others do not.

At some point, some drinkers find that they are dependent. Alcohol dependence, as we have also seen earlier in this book, is a bio-psycho-social syndrome characterized, amongst other things, by a subjective compulsion to continue (or to reinstate) alcohol consumption. This compulsion characteristically takes the form of a division within the self, or a division of the will, which leads to an internal experience of struggle or conflict (Cook, 2006, pp. 127–170). Thus, those who provide treatment for people with drinking problems have frequently encountered stories of repeatedly failed resolutions to stop drinking. At one level the alcohol dependent person knows that they need to stop. At another level, the desire (or craving) to continue seems to be stronger still.

This inner division of the self has important points of resonance with the world's major faith traditions. We considered briefly, earlier in this chapter, the way in which Christianity, Buddhism, Islam and Native American religion understand this kind of problem. However, it is a fundamentally spiritual problem, concerned with relationships with self, others and a transcendent order of things. It is a disorder of relationship that leads to denial of those things

which are most deeply valued, and which provide meaning and purpose in life. It is this inner division of the self that leads to the tragedy of the alcohol dependent person who loses the job that they loved, the lover that they cherished or the integrity that they took pride in. The choices that the dependence syndrome presents, and the disorders of relationships that it establishes, are a fundamentally spiritual problem.

## Spirituality and religion in the treatment of drinking problems

There is much clinical wisdom in the published literature on spirituality in the treatment of drinking problems, but there is also much which is vague, confusing or unhelpful. Unfortunately, the research literature on spirituality in treatment is only just beginning to develop the evidence base, and so much of what must be done will still rely upon conjecture, tradition or intuition. Leaving aside conjecture and intuition for a moment, what does tradition tell us?

The best-established tradition, in terms of an explicit relationship of spirituality and drinking problems, is to be found in the philosophy and practice of AA. Different commentators each offer their own analysis of the 12 steps (see Chapter 15). However, given here our working definition of spirituality, and our understanding of the spiritual nature of addiction, a few comments may be made concerning their perspective upon the spirituality of relationship: with alcohol, with a Higher Power, with self and with others.

The steps clearly begin with a recognition of powerlessness (Step 1). Powerlessness (specifically over alcohol, but with the result that whole lives become unmanageable) leads on to identification of the need for belief in a 'Higher Power' (Step 2). In Steps 3, 5, 6 and 11, this Higher Power is unambiguously identified as 'God', but the emphasis is on the individual member defining their Higher Power in the way that best works for them. For example, it is suggested that the Higher Power could be AA itself. What matters is the recognition that there is a higher power than self and that it is in this power that help can be found.

Steps 4–9 outline a process of change which impacts profoundly upon relationships with self, God and others. The process begins with the self – and specifically with a self-reflective moral account. This account needs neither to be excessively self-punitive (as though the individual were worse than others) or self-righteous (as though the individual were better than others). It is rather about regaining moral perspective and this requires honesty with one's self about one's self. The process continues with sharing this account with God (or the Higher Power) and then working it out in relationship with others, with God's help. Most members of AA will require a sponsor, or other person, to help them with this process. It is both a 'one-off' process of putting right the wrongs that have arisen as a result of alcohol dependence and also an ongoing process of living in reordered relationship with self, God and others. Steps 10–12 are concerned with the ongoing process.

The word 'spirituality' does not appear in the 12 steps at all. Only Step 12 refers to a 'spiritual awakening', and only Step 11 refers to what might normally be expected as spiritual matters – prayer and meditation. The spirituality of the 12 steps is practical, relational and (largely) implicit. For most members of AA, the help of another person (usually a 'sponsor') in working through the steps is essential. For some, the embedding of the work of the early stages of the programme within a residential community, often with medical and counselling support, is also helpful. The 12-step programme is, by definition, not something that can be done alone. It involves a very practical approach to relationship with God and other human beings, as well as a radical revision of relationship with self.

The world's major faith traditions have not left texts that are as explicitly applied to the spiritual process of recovery from alcohol dependence as have the founders of AA. However, as we noted above, there are various examples of how recovery from drinking problems may be pursued within programmes structured according to the beliefs and practices of different faith traditions. Within some of these traditions there is much latitude for interpretation. Thus, for example, within Christianity differences of approach may be identified between more liberal and more conservative traditions. Typically, the latter are likely to define a sharper boundary with secular practice (although this is not always or necessarily the case). For example, Teen Challenge provides an example of an approach within which the concept of addiction is understood as more or less coterminous with the theological concept of sin. In this paradigm, recovery from addiction is more or less identical with the process of conversion and Christian growth which is expected in this tradition of all Christians. Less conservative Christians, in contrast, might be expected to rely on medical and other secular treatments, or else on a programme such as that of AA which is not explicitly linked to any particular faith or denomination.

Harold Koenig, writing about the relationship between religious organizations and the delivery of mental health services, identifies five categories of faith-based organizations (Koenig, 2005):

A Local churches, synagogues, mosques, etc., that provide services
B Networking and advocacy organizations
C Groups that provide largely secular services for religious reasons
D Trained counsellors that utilize a mixture of secular and religious methods
E Groups and counsellors that provide largely faith-based therapies.

Examples of each of these categories could probably be identified in respect of projects and individuals working with people with drinking problems, but the nature and range of provision varies from country to country. For example, in the UK, the Salvation Army might be identified as working under each of these headings – although probably more under A and C than the others. Christian charities with an evangelical tradition providing residential rehabilitation might most frequently be found under E.

For some Christians, the choice between secular and religious approaches is a difficult one. Anxieties about compromising Christian belief have been expressed in movements that have sought to re-express the 12 steps in more explicitly Christian terms (e.g. Overcomers Outreach). On the other hand, other Christians have written firsthand accounts of how AA does not require any compromise of faith and in fact can be helpful both to the process of recovery and to growth in faith (K, 2002) .

It is also possible to integrate spiritual approaches within completely secular treatment programmes, such as those provided by the National Health Service in the UK (Jackson & Cook, 2005). This is not simply a question of the provision of chaplaincy services, which are a part of all healthcare provision within the UK, but rather a matter of recognizing the spiritual needs of all health service users, and recognizing spirituality as a component of all truly comprehensive assessments and treatment programmes.

## Working with the individual

What does all of this mean when working with an individual person with drinking problems?

The first, and most important, lesson is that spirituality and faith are matters which can be discussed in the counselling room or clinic. It takes only a few seconds to ask one or two simple

questions about whether someone has any spiritual or religious beliefs that are important to them. After making it clear in this way that such things can be discussed, it usually becomes clear whether the conversation needs to be taken further and, if so, in which direction.

The second conclusion to this chapter is that the context of a faith community, and a spiritual or religious belief system, can be important in planning treatment. This might be at a very explicit level of referral to a faith-based organization offering services for people with drinking problems, or it might be a matter of allaying fears that AA is either 'too religious' or else not a suitable place for a Christian, Muslim or Jew, etc. Or, it might be at a much more implicit level of acknowledging that there are spiritual aspects to all treatment programmes and to most (if not all) kinds of drinking problems.

Thirdly, it is clearly important for health professionals to do their homework. We cannot all be experts on comparative religion, and those who come to us for help do not expect this. They are, after all, the experts on what they believe – which may in any case not be exactly according to what the orthodoxy of their tradition would expect. However, when working in a given locality it is important to know what is available. Where are the nearest AA groups, or residential programmes using a 12-step approach? Are there any faith-based organizations locally working in this field? Where might someone with a strong sense of belonging to a particular faith tradition most feel at home? How might questions about the compatibility of (say) the Christian faith and AA be handled?

Finally, there is a need for professional and spiritual integrity. Sometimes it will be easier working with someone from a different faith tradition or spiritual perspective than one's own – sometimes it will be more difficult. However, the relationship between helping professional and client should never be misused as a place for proselytizing, whether to a particular tradition or to a position of agnosticism or unbelief. Only in exceptional circumstances (for example, when working with those who have survived involvement with cults) is it appropriate to engage someone in questioning the validity of the tradition to which they have belonged. Even then, it may be very important (where appropriate) to involve family or members of a healthy faith community in the process of recovery.

Integrity also involves recognition that all human beings are spiritual beings. Exploration of a client's spirituality implies that one has explored one's own spirituality and is not afraid to grapple with the same kinds of questions that they are grappling with. In fact, spirituality is a great antidote for the so called 'moral model'. Spirituality reminds us that we are all spiritual beings, struggling within ourselves over various desires and motives that draw us in different directions. People afflicted with drinking problems are not morally weak – they are simply human. Those of us who work with them will best be able to help them when we have recognized this common humanity within ourselves as well.

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