

Addiction Psychiatry

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Addiction psychiatry presents its own particular ethical challenges and opportunities in relation to matters of spirituality and religion. This is, in part, due to the huge influence of Alcoholics Anonymous and its spiritual approach to recovery. However, there is a long history of religious support for recovery from addiction, which long predates AA, and faith based organisations continue to play an important part worldwide in offering rehabilitation and treatment (Cook, 2009). Perhaps even more importantly, it is in the nature of addictive disorders that they raise important ethical issues both for those who are directly affected and also for wider society (Cook, 2006).

In this chapter, two cases will be presented which illustrate just some of the ethical issues arising in relation to spirituality and religion in the course of clinical practice in addiction psychiatry. Both cases were encountered during the course of delivering a service for people with addictive disorders in the National Health Service in England. This cultural and political context is important, both because of the nature of statutory services as compared with services offered in other contexts, and also because of the largely secular nature of UK society (notwithstanding the complex constitutional relationship between church and state). Many UK citizens continue to consider themselves broadly “Christian”, or even identify as belonging to the Church of England, even though they do not regularly attend any place of worship or engage in other religious practices. Others explicitly identify with particular faith traditions (Christian or other) and yet others identify as agnostic or atheist. Many now say that they are “spiritual but not religious”. In this context, the place of spirituality/religion in current clinical practice is controversial and must be handled with care and sensitivity (Cook, 2013b, 2013a).¹

Twelve Step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are widely available in the UK and have long provided a spiritual approach to recovery that is utilised both in the community and in many residential rehabilitation programmes. They have been less widely accepted in the National Health Service, although many NHS addictions services do encourage patients to attend local groups, and some invite closer contact. Similarly, there is a complex relationship between NHS services and faith based organisations working in this field. Generally speaking, referral for Christian or other religious approaches to rehabilitation has been the exception rather than the rule. Mindfulness Based Relapse Prevention has been something of an exception – having been effectively detached from its Buddhist roots and now offered more widely in mental health services, including some addictions services (Mason-John and Groves, 2013).

There is thus something of a disconnection, at least within the UK, between spiritual and religious approaches to treatment and recovery, and medical/secular approaches. Both of the following cases illustrate some of the problems that this disconnect might occasion.

Case 1

¹ It is also not entirely clear that the protective benefit of spirituality – as opposed to religion – in relation to substance misuse operates in the same way in UK society as in North America (King, Marston, McManus, Brugha, Meltzer and Bebbington, 2013).

W was a 40 year old man when he first presented to Addiction Services with an opiate addiction (opiate dependence syndrome – F11.2²). He gave a history of having been a very nervous child and his mother would give him kaolin and morphine to settle his anxiety. Otherwise he described an uneventful childhood and upbringing and after school went straight into factory work as an apprentice.

In his early 20s, there was a re-emergence of anxiety with features of panic disorder (F41.0). He sought medical attention but found treatment with anti-depressant therapy unhelpful and was unable to engage in psychological therapies. He started to drink heavily to manage his symptoms and within a year fulfilled the criteria for alcohol dependence syndrome (F10.2).

At this point, W was living alone. His parents were both dead and he was socially isolated. He lost his job following a period of poor attendance and his drinking increased as a result. On the verge of losing his home, he returned to his GP who prescribed a medically assisted alcohol detoxification and suggested he attend Alcoholics Anonymous. W was initially reluctant, particularly given his vulnerability to anxiety in social situations. However, a sponsor was found and after a few AA meetings, he embraced the concept and remained abstinent from alcohol for the rest of his life.

He returned to work and AA remained the focus of his life, attending meetings at least twice weekly and becoming a sponsor for others.

In his late 30s, W noted increasing anxiety. To avoid drinking alcohol, he started to buy kaolin and morphine (available over the counter) and, as in his childhood, it alleviated his symptoms. Over time, his consumption escalated and local pharmacists started to question the amount he was buying and he had to travel further afield to get it. He started to experience symptoms of opiate withdrawal when he was unable to obtain it.

W then returned to his GP, who referred him to specialist addictions services with a diagnosis of opiate dependence syndrome. He was seen and assessed and his treatment plan included switching to a long acting opiate (methadone) with a view to opiate detoxification once the underlying anxiety had been adequately treated.

W disclosed the situation to his AA sponsor. His sponsor felt that opiate substitution therapy was not commensurate with AA principles and felt that abstinence was the only way forward. W felt guilty about his perceived lack of adherence to AA principles. This was discussed with his addiction team who suggested opiate detoxification from methadone with transfer to a Twelve Step Residential Rehabilitation Facility.

W continued to report guilt and shame at his use of substances to manage his emotions and was unsure about Residential Rehabilitation but could see no other way forward at the time. He was detoxified from methadone and admitted to the facility as

² Diagnostic categories are taken, throughout, from the International Classification of Diseases (World Health Organization, 1992)

a priority. Within 2 days of admission, he was found dead in his room having hanged himself from the curtain rail.

Discussion

W found the spirituality of AA supportive of recovery for many years. Unfortunately, despite his in depth knowledge of the 12 Steps, and his active involvement with his local AA group, when he relapsed his spiritual beliefs contributed to a sense of guilt and failure which were further reinforced in the course of conversation with his sponsor. A conflict of approaches by his sponsor and his medical team further increased the tension surrounding management of his relapse. Eventually, despite progress that should have been a source of encouragement to him, he committed suicide.

For W, social isolation was relieved primarily by his involvement in the Twelve Step community. The concerns expressed by his sponsor thus contributed not only to a sense of spiritual failure but also isolated him from the community that had provide social support so reliably for almost a decade. Whilst some members of AA would also have belonged to a faith community that would have provided additional support, W did not have this resource to fall back on. It is probably true to say that for many in the UK a “spiritual but not religious” approach to life is very individualistic. Whilst providing coping resources associated with meaning and purpose in life, and a sense of relationship with a transcendent order or Higher Power, it does not necessarily have the social networks and supports associated with traditional religious communities.

The role of the sponsor was crucial for W. At its origins, AA had good relationships with medical professionals such as Dr Silkworth and Dr Carl Jung (Kurtz, 1991). However, in the UK today it operates largely independently of medical services. Closer liaison between the sponsor and the medical team in this instance could well have allowed development of a treatment plan which incorporated both the strengths of AA and those of the medical team, and might have avoided the perceived conflict between those seeking to help W which further contributed to his sense of tension and guilt. However, such liaison is not easily established and in some cases is not welcomed by AA sponsors. In the present cases, the medical professionals were very sympathetic to W’s spirituality, and supportive of it. However, some atheist doctors find a professional and ethical conflict in recommending or supporting a spiritual approach to treatment with which they cannot personally agree.

W did not reveal his suicidal thoughts to the professionals concerned prior to his eventual suicide. Mental health chaplains report that questions about what will happen after death by suicide is one of the most frequently presented questions in their work with patients (Cook, 2014). However, many other patients are unaware of the way in which chaplains now work across traditional religious boundaries, and also provide support to those with no formal religious affiliation. Being independent of religious institutions, yet affiliated to them, and independent of the medical team, yet employed by medical services, chaplains occupy a uniquely independent role which allows them to discuss such matters with patients in a way that is not open to other professionals.

Case 2

Ms M was a 38 year old woman in treatment with the Addiction Service. She had a history of heroin use and a diagnosis of opiate dependence syndrome on a clinically supervised maintenance regime (methadone) (F11.22). She described an aversive upbringing and had been exposed to domestic violence between her parents. Her history suggested that her father was probably alcohol dependent. She had spent some time within the care system as had her two brothers.

Throughout her teenage years, she had contact with Child and Adolescent Mental Health Services (CAMHS) as a result of episodes of self-harm. She gave a long history of substance use including solvents and ecstasy in early adolescence moving on to cocaine and heroin use in late adolescent and she first entered into treatment at the age of 22. She did not use alcohol, blaming this for her difficult upbringing and the violence within her parent's relationship.

At the age of 28, Ms. M. began a relationship with a man who misused drugs and alcohol. She became pregnant unexpectedly but saw this as an opportunity to turn her life around and give her child the family life that she wanted. Children's Services were involved through the pregnancy because of her history of drug use. Ms. M. did well in treatment during the pregnancy and initially following the birth of her baby. However, over time, the relationship with her partner deteriorated with episodes of domestic violence and she eventually relapsed into heroin use.

By the time her daughter was 3 years old, Children's Services had intervened and the child was placed in foster care and subsequently adopted. Ms. M. had no contact with her daughter other than through a mail drop with the exchange of gifts and cards at birthdays and Christmas. She struggled with thoughts of being a "not good enough mother", repeating the mistakes of her own parents and abandoning her child.

Ms. M. continued in treatment. Her recovery was punctuated by periods of crisis with self-harm and sometimes suicidal intent always worst when she was misusing substances. However, her motivating and protective factor throughout was her daughter and the hope that they would resume contact once the child was aged 16.

When the child was 9 years old, she ran out into the path of a car whilst in the care of her adoptive mother and was killed. There was a significant delay before Ms. M was informed of the death as the social worker felt that she was not stable enough to receive the news and may attempt suicide.

Ms. M did react catastrophically and, although she was successfully supported through this period of time, she was unable to come to terms with her guilt at giving up her child to a mother who had, in her mind, had allowed the child to die. She felt unable to grieve and this was compounded by her having played no part in either the planning or attending of the funeral (the ceremony had been held before she had been informed of the death). She said that there would have been some consolation if there had been organ donation, the meaning for her in the sense of life after death, but this had not happened.

Discussion

M appears to have been nominally a Christian but not an active member of any church community or congregation. Her spirituality did not appear to play a major part in her life but certain implicit religious beliefs came to the fore when her child was so tragically killed. The funeral provided both an important rite of passage and an opportunity to deal with grief and mourning which were unhelpfully denied to M. At such times, even in a post-Christian context such as that provided in the UK at present, religious ceremonies continue to provide spiritual meaning and support. In this case, an important source of meaning and purpose might also have been provided had possibilities for organ donation been properly explored. M found in this domain some way of understanding “life after death” which could have been a source of significant comfort and hope.

M did not have any of the resources of either a traditionally religious kind, or based on the principles of the Twelve Steps, to help her deal with her sense of guilt and failure as a mother. Guilt, and the need to forgive and be forgiven, are issues which frequently (perhaps even universally) need to be addressed during the course of recovery from addiction. Within a purely medical context, therapeutic and psychological approaches to addressing these issues can be helpful but are not as universally recognised as within the Twelve Step Programme and most religious approaches to assisting recovery.

Whilst the social worker in this case was clearly operating out of a well-intentioned concern to avoid the distress of her client, it was clear that the pain of grief could not ultimately be avoided and that delaying breaking the news was likely to store up additional problems rather than resolve existing ones. Closer liaison between social and medical services, and particularly more careful planning of how to support M through her receipt of the news of the death of her child and her subsequent grief, might have avoided the eventual tragic outcome.

Conclusions

The foregoing cases illustrate just some of the ethical issues that arise when working in addiction psychiatry in the UK. We are aware that other contexts, cultures and subcultures present different, and differently emphasised, concerns. For example, within the context of a strongly religious culture, such as that found in many Islamic countries, there are opportunities for greater integration between treatment and religious belief and practice (Ali, 2014, Abdel-Mawgoud et al., 1995) and there is probably also greater uniformity (rather than plurality) of belief within the population served. However, we do feel that these different contexts offer mainly differently emphasised ethical issues, rather than a completely different set of issues. In particular, we identify the following as amongst the more important ethical considerations.

Firstly, professional and patient may or may not share spiritual and religious perspectives. Nothing can be taken for granted here, and identification with a shared single faith tradition (eg Islam or Christianity) may conceal greater differences than between a doctor and patient of different traditions. It is therefore important that the

professional should have the clinical skills, and ethical awareness, to explore sensitively, and to affirm in a patient centred fashion, the beliefs, belonging and practices of their patient. Generally speaking, these may offer hugely positive coping resources. Even where they do not, it is important that the clinician properly understand the conflicts or tensions that a patient may perceive as a result of their faith perspective. A treatment professional should not hesitate to offer a spiritual/religious treatment option that may be of benefit to their patient, even if they do not personally subscribe to, or agree with, the spirituality or religious tradition concerned.

Secondly, medical and spiritual/religious approaches to treatment generally need present no conflict with each other. However, in some cases they do, and especially so where a medical goal of harm reduction accepts that abstinence may not be possible in the short term (or even at all) (Inciardi and Harrison, 2000). Where conflicts are perceived, they can often be negotiated and misunderstandings clarified. It is important (as in Case 1, above) that possible tensions should not be left unresolved to the detriment of treatment, and that patients/clients should be supported in managing them. This may need much patience on the part of the treatment professional.

Thirdly, there are often, expressed or unexpressed, feelings of guilt on the part of the person receiving treatment, arising from the physical, psychological and social harm that has been inflicted as a result of addictive behaviour. Substance misuse may also have been a way of coping (maladaptively) with unresolved guilt or anger at real or perceived offences, inflicted or sustained. At the heart of the phenomenon of addiction is a struggle within the self which is an inherently spiritual issue. Many such considerations are explicitly addressed within a Twelve Step approach to treatment, but are not always identified as important within medical treatment programmes. In Case 2, above, more specific attention to the sense of guilt that M carried as a mother might have gone a long way towards preventing the eventual unhappy outcome.

Fourthly, there are some specific issues regarding Twelve Step treatment programmes that can lead to ethical concerns. These are helpfully summarised by Wendy Dossett (Dossett, 2013) and they include the potential dangers of emphasising powerlessness over addiction (especially for women), as well as particular concerns regarding the Judeo-Christian religious emphasis, and the stigma associated with self-identification as an “addict” or “alcoholic”. Each of these concerns is associated with valid counter-arguments, but they may also impinge differently upon different people. Thus, for example, an emphasis on powerlessness for a woman who has been repeatedly abused may be profoundly unhelpful and may be a good reason for considering alternative approaches to recovery, or at least additional support and counselling aimed at addressing the particular dilemmas involved in accepting powerlessness over addiction at the same time as not accepting powerlessness in relationships with men.

Perhaps the most important ethical consideration of all is simply that the need for treatment should be acknowledged and that treatment should be available equally for all. Patchy geographical availability of treatment (Drummond et al., 2005), and the stigma that prevents access to treatment, or labels people as undeserving of treatment, are (or should be) important considerations in treatment service planning and in relation to any attempt to inform professional and public attitudes.

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