

Mental Health – Substance Use

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Chapter 13: Spirituality, mental health-substance use

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Introduction

Spirituality is an increasingly important topic in healthcare. A growing evidence base suggests that spirituality and religion are protective factors which reduce the risk of a wide range of physical and mental disorders. They also influence use of medical services and outcome following treatment. Furthermore, service users wish spirituality and religion to be taken into account in the planning and delivery of the care that they receive(1-3). It would therefore seem that there is a good prima facie case for making spiritual care routinely available as a component of healthcare provision.

However, spirituality and religion are also proving to be controversial topics in healthcare. In the UK in 2009, a nurse was suspended (albeit later reinstated) for offering to pray for a sick patient.¹ In 2008, in the journal *Psychiatric Bulletin*, heated correspondence followed an editorial in which it was suggested that spirituality and religion should be taken into account in the assessment and treatment of mental disorder.(4-7) It would therefore seem that spiritual care is a subject of disagreement amongst healthcare professionals.

Within the wider world of healthcare, and alongside specialities such as palliative care, mental health and substance misuse are amongst those fields in which spirituality and religion have attracted particular attention. This should not be surprising, for they are concerned with some of the most deeply held human beliefs and values. At a purely psychological level we might therefore expect that disorders of affect, cognition and behaviour might have some impact upon spiritual and religious belief, and conversely that such beliefs would be likely to have an impact upon the expression of psychiatric disorder.

What, then, is the nature of the inter-relationships between spirituality, religion, mental disorder and substance misuse, and how might these relationships influence assessment, treatment and service provision? Before attempting to provide some answers to these questions, it is necessary to consider the nature and concept of spirituality.

Spirituality

Spirituality is a difficult term to define.(8, 9) It is undoubtedly capable of diverse and, at times, mutually contradictory definitions. Thus, for example, in the minds of some it is intimately related to the concept of religion, whereas for others it is the very antithesis of religion. However, generally speaking, it tends to assume a more individual, subjective and personal quality than does religion. Whereas it is self evident that not all people are religious, it is arguable that all human beings are spiritual. It is therefore possible to be spiritual, but not religious. Some people would argue that it is also possible to be religious but not spiritual, and still others would argue that they are neither spiritual nor religious. However, if spirituality is concerned with relationships, with deeply held values and beliefs, and with meaning and purpose in life, it is difficult to see how it is possible for a person not to be spiritual unless they have nothing and no-one that matters to them.

There are many definitions of spirituality, and this is not the place to assess their relative merits. However, the following is offered as an example of a more inclusive approach:

¹ <http://www.dailymail.co.uk/news/article-1133423/Nurse-faces-sack-offering-pray-sick-patient.html>
<http://www.timesonline.co.uk/tol/comment/faith/article5675452.ece>

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.(8)

In passing, it is important to note that religion is also a difficult concept to define, but that it is usually understood in terms of socially shared beliefs, behaviours, traditions and experiences. In research terms, it is easier to measure as it involves easily observable functions (often referred to as “religiosity”) such as attendance at religious services or involvement in personal religious devotions, or self-identified affiliation to a particular community or faith tradition. However, it also has its subjective aspects and it is difficult to see how religion can be completely devoid of spirituality unless certain negative patterns (eg discrepancies of moral behaviour) are redefined (usually according to someone else’s values) as being a lack of spirituality rather than as a negative manifestation of a particular form of spirituality.

Both spirituality and religion are important in the healthcare context. It is therefore important to be able to enquire about both in a clinically sensitive fashion. When a patient or relative or carer identifies themselves as belonging to a particular faith tradition, assumptions should not be made about what that might mean. The significance and expression of this self-identified religious belonging needs further exploration in order to understand exactly what it means to *this* person, rather than to any notion of orthodoxy or to members of that religion in general. Similarly, self-identification as “not spiritual” or “not religious” still leaves important scope for enquiry about relationships, value, purpose and meaning in life.

Mental Health

Mental health is also notoriously difficult to define. The World Health Organization Definition of mental health does not include any explicit reference to spirituality:

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community²

However, health and “well-being” are concepts which invite reflection upon spiritual as well as physical, social and psychological aspects of what it means to be a flourishing human being. Because spirituality is concerned with such issues as relationship, value, meaning and purpose it is also very difficult (if not impossible) to separate from the kinds of issues that arise when thought, mood, perception or behaviour are disordered as a result of mental illness. Spiritual issues therefore, not surprisingly, arise in most clinical areas of psychiatric practice.(10)

² http://www.who.int/features/factfiles/mental_health/en/index.html

Statistically, religious involvement is associated with a greater sense of well-being, more positive mood states, greater satisfaction with life, better psychological coping and better mental health (see review by Koenig(11), pp43-81). However, in a minority of studies it is associated with worse mental health, and in some cases it is associated with negative emotional traits (*Ibid*, pp70-81). There are also clearly forms of “pathological spirituality”, such as those associated with some cults, which are especially associated with psychiatric morbidity.(12)

In the case of major psychiatric disorders, such as schizophrenia or bipolar affective disorder, the evidence of a protective effect of spirituality or religion is largely lacking. However, there is also a dearth of research in this area, and therefore little is known with confidence about the nature of the relationship.(11, 13) Furthermore, the relationship between psychosis and spirituality is a complex one, within which mental and spiritual experiences become closely intertwined. The need for sensitive and compassionate spiritual care of those who suffer from such disorders is great.(14)

Koenig identifies ten ways in which religious beliefs or practices may improve mental health, which might reasonably also be understood to apply to spirituality(9, 11). They may:

1. promote a positive worldview
2. help to make sense of difficult situations
3. give purpose and meaning
4. discourage maladaptive coping
5. enhance social support
6. promote “other-directedness”
7. help to release the need for control
8. provide and encourage forgiveness
9. encourage thankfulness
10. provide hope

Spirituality and religiosity may also be incorporated into treatment. Options include specifically religious approaches to psychotherapy, and utilisation of the social support available in faith communities. However, Koenig also warns of the dangers and limitations of such approaches. Mental health professionals often have little training or competency in such work, and discrepancies between the spiritual or religious worldview of clinician and patient can lead to ethical problems or complexities of transference and counter-transference.(11)

Substance use

The relationship between religion and substance use is well demonstrated by research, especially amongst groups of young people. Numerous studies have shown that affiliation with a faith community is a protective factor which reduces the likelihood of use of illicit substances or excessive use of socially sanctioned substances such as alcohol or nicotine.(15) There are various possible mechanisms by which this protective effect may operate:

1. Moral teaching provided within faith communities may operate directly to discourage substance use (and/or excessive substance use).

2. Belonging to a peer group which does not use substances (and/or does not use them excessively) may provide a form of modelling which encourages conforming behaviour amongst those who wish to belong to the group.
3. The social support provided by a faith community may enable alternative coping mechanisms which reduce the need to use substances as a means of coping with stress.
4. The better mental health, or more positive mood, enabled by membership of a faith community may reduce the need for use of substances as a coping mechanism.

It might be imagined that the chances of being offered drugs (especially illicit drugs) are less for those who belong to faith communities. However, although there is some evidence for this, the magnitude of difference is small and does not appear to explain the difference in prevalence of substance use/misuse.(16)

By way of example, one study of 7666 church affiliated young people in the UK in 1995 showed that 23% of those aged between 12 and 16 years had been offered illicit drugs, but only 10% had tried them. (Comparable figures for those aged 17 to 30 years were 46% and 23%).(16) Church attendance, agreement with a statement of Christian belief, and personal spiritual practices (bible reading and prayer) were associated with a lesser likelihood of having tried drugs (and also of having smoked cigarettes or drunk alcohol). However, church attendance appeared to be a more important factor in the younger group and personal spiritual practices were more important amongst the older young people, perhaps reflecting a shift during adolescence towards personal spirituality as a more important protective influence.(17)

Substance misuse and dependence

Our understanding of the relationship between spirituality and substance misuse (including especially substance dependence) has been influenced by various historical factors concerned with the relationship between religion and excessive alcohol consumption (or in the case of Islam, any alcohol consumption). During the 20th Century it has also been profoundly influenced by the emergence of Alcoholics Anonymous (AA) and its sister organisations as a significant resource in support of recovery.(18, 19) Arguably, there is an intrinsic relationship between substance dependence and spirituality, in that the former is inherently a spiritual problem by virtue of the way in which it impacts upon relationships, values and purpose in life. However, the influence of AA and other “Twelve Step” programmes, which affirm a spiritual rather than religious approach to recovery, has been enormous and this has probably done most to draw attention to the need to address the spiritual dimension of problems associated with substance misuse and dependence.

The principles adopted by AA are summarised in the so called “Twelve Steps”, which were drawn up by the founders of AA based on their experience of recovery from alcoholism:(20)

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

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

The spirituality enshrined in these principles draws on the Christian tradition, but is importantly modified through a psychological and medical perspective influenced by William James, a pioneer in the study of the psychology of religion.⁽¹⁵⁾ James' influence is particularly evident in the reference to "God as we understood Him", and in the stripping out of any traditional religious, theological or doctrinal formulations. The emphasis is rather upon the recognition of one's own "powerlessness", a turning towards a transcendent source of help, and the recognition of a moral frame of reference. It is also important to note that Step 12 provides an emphasis on helping others. This is not "self-help", but rather "mutual-help".

This mutual-help programme for alcoholics has since been applied to those addicted to other drugs, as well as to a variety of non-substance based patterns of behaviour which might also be considered forms of addiction, such as gambling, sexual behaviour, and eating disorders.³ It has also influenced professionally led treatment programmes for addictive disorder.^(21, 22)

Other approaches to the treatment of substance dependence within which spirituality has been emphasised have included a variety of religiously based programmes, within which a programme of recovery is devised which includes prayer, study of scripture, meditation or other religious devotions. Obviously such programmes are primarily, but not exclusively, of interest to those who enter treatment with an affiliation to (or at least a sympathy for) a particular religious tradition. It is also possible to introduce spirituality as a component of a comprehensive treatment approach in a broad way, so as to address the needs of those who come from any of the world's major faith traditions or none of them.⁽²³⁾ What would seem to be important is the recognition of the spiritual needs of people recovering from substance dependence, and a sensitivity to providing an accessible way to address these needs during the course of treatment. That might be provided by involvement in a twelve step programme, or through chaplaincy support, or through an explicitly religious ethos.

³ Words such as "alcoholism" and "addiction" are those which would be preferred by members of these groups, and hence are used here without prejudice to more commonly employed medical terminology such as "substance misuse" and "substance dependence".

However, the research evidence that is beginning to emerge from this field does suggest that it is beneficial to good outcomes to address the spiritual needs of such people in some way.(15)

Mental Health-Substance Use (Dual Diagnosis)

We know, then, that spirituality exerts a protective effect against both mental disorders and substance use disorders. In each case, there are multiple possible mechanisms. However, spirituality is also probably best understood as a multi-dimensional concept.(24) Which aspects of spirituality exert the protective effect in each case? At present little empirical evidence exists upon which to base an answer to this question, but there is reason to believe that different aspects of spirituality may reduce the risk of mental disorders and substance use disorders respectively.

Kendler(25) and his colleagues, in a study of 2621 twins on the Virginia twin registry, found it impossible to separate spirituality from religiosity in their factor analysis. However, they found that different dimensions of religiosity were associated with reduced risk of mental disorders (depression, anxiety disorders, and bulimia) and substance use disorders (nicotine dependence, alcohol dependence, drug abuse or dependence). Two dimensions of religiosity, specifically social religiosity and thankfulness, were associated with reduced risk of both mental disorders and substance use disorders. Four dimensions of religiosity (general religiosity, belief in a God involved in human affairs, forgiveness, and belief in a judgmental God) were associated with reduced risk of substance use disorders (and adult antisocial behaviour) only. Only one dimension of religiosity, an attitude of “unvengefulness”, was predictive of reduced risk for mental disorders only.

Given the benefits in treatment of both psychiatric and substance use disorders, we would expect also that spirituality would have benefits in the treatment of patients with dual diagnoses. Research is beginning to provide evidence in support of this expectation.

In a study in Washington DC of 27 women with histories of physical or sexual abuse and co-occurring mental health disorders and substance use disorders, spirituality was identified by participants as an important influence sustaining recovery(26). In another study, patients with dual diagnosis (having both substance abuse and at least one other psychiatric disorder) at a specialist unit in New York reported that they viewed spirituality as “essential to their recovery”. Nursing staff in the same unit, whilst being similarly spiritually orientated as the patients, underestimated the extent to which patients considered this to be an important factor in their treatment.(27) Medical students at the same unit were significantly less spiritually orientated and did not consider spirituality to be an important factor in treatment of this patient group.(28)

There is research evidence to support the contention that paying attention to spiritual factors in treatment improves substance related outcomes for dually diagnosed patients.(29) In a study of homeless veterans with dual diagnosis, Benda found that spiritual well-being was one of a number of “transforming experiences” which reduced readmission rates.(30) There also appears to be particular evidence of the benefits of religious coping amongst women trauma survivors with dual diagnosis.(31) However, even if it is usually a beneficial factor, spirituality (or at least religiosity) is a variable which can work both ways.

In a study of 115 patients with non-affective psychotic illness in Switzerland(32, 33) (amongst which 23% had comorbidity of substance abuse and 63% of nicotine dependence) religious involvement was significantly inversely correlated to substance use and substance abuse. Religious coping was found to reduce substance use in 14% and to increase it in 3%. Similarly in this group, religion lessened psychotic and other symptoms in 54% (but increased such symptoms in 10%), increased social integration in 28% (but increased social isolation in 3%), reduced the risk of suicide attempts in 33% (but increased the risk in 10%) and improved adherence to psychiatric treatment in 16% (but resulted in opposition to such treatment in 15%). Whilst the overall benefits of religious involvement and religious coping are therefore evident, it is important to recognise that the relationship can work both ways. Sometimes, religiosity (and presumably also spirituality) may make things worse.

Twelve Step groups have been established which are particularly orientated towards the needs of people with co-occurring mental health disorders and substance use disorders. There is some research evidence that attendance at these groups is associated with better adherence to medication, lower symptom severity at one year follow-up, and reduced likelihood of readmission during the same follow-up period.(34, 35)

Good Practice

The need to undertake an assessment of spiritual need should not now be controversial. Not only does evidence suggest that spirituality is relevant to healthcare outcomes, but service users indicate that they wish their spiritual needs to be addressed in treatment. A spiritual needs assessment is simply good practice, and an example of such good practice is commended in the Department of Health guide *Religion or Belief* (pp33-34)(36). There are many ways in which such assessments may be undertaken(37), and they do not need to be time consuming. For example, Puchalski and Roma(38) have suggested a system based on four short screening questions, using the acronym “FICA”:

- What is your **F**aith tradition?
- How **I**mportant is your faith to you?
- What is your **C**hurch or community of faith?
- How do your religious and spiritual beliefs **A**pply to your health?
- How might we **A**ddress your spiritual needs?

Clearly, such assessment should be conducted professionally and within an ethical framework which does not allow proselytising or discrimination. The American Psychiatric Association have published guidelines within which the undertaking of a spiritual and religious assessment is understood as a part of the maintaining of respect for patients’ beliefs, and within which the imposing of psychiatrists beliefs upon patients (whether those beliefs be religious, antireligious or ideologic) is explicitly proscribed.(39)

Summary

Spirituality and religiosity are important factors to be considered in understanding the aetiology and proper treatment of both mental and substance use disorders. Where such disorders co-occur there is double reason to take these factors seriously. Good practice should, at least, involve a proper assessment of spiritual needs. There is also evidence to suggest that incorporation of spirituality into treatment is associated with good outcomes. This need not mean that treatment programmes must be explicitly religious, although some are. Professional treatment programmes and mutual help groups incorporating a secular or pluralist approach to spirituality, such as that espoused by AA and its sister organisations, are also effective.

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