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Religiosity in the Recovery of Alcohol Counselors

by

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Abstract

The hypothesis of this study is that traditional religious beliefs and practices do help people to recover and remain "clean and sober". The recovery stories of six recovering alcohol and drug counselors were examined to elucidate the spiritual dimensions of each individual's recovery program and explore the nexus of religiosity to substance abuse recovery in adults. Previous studies had reported that, in general, higher levels of reported spiritual well-being, religiosity, and religious activity were correlated with lower levels of drug use, tobacco smoking, alcohol use, and gambling (Trinkoff, Zhou, Storr & Soeken, 2000; Hodge, Andereck, Montoya & Harry, 2001). The hypothesis of this research specifically aimed at explicating the role of religiosity in the recovery of these six Substance Abuse Treatment Program (SATP) counselor supervisors.

All six subjects are recovering addicts. In their daily encounter with other recovery focused clients, these facilitators of change typically encountered a variety of patients with different faiths and/or religious denominations, to include atheists and agnostics (Tonigan, Miller & Schermer, 2002). Some of the healing elements present in a Twelve Step recovery program (i.e., AA spirituality) were compared and contrasted to the healing elements generally found within Christian spirituality to negate the reported belief by some AA adherents that "religion", in and of itself, will fail in recovery.

This author contends that addressing a "Higher Power" as God (or as "Our Father in Heaven") is basically the same as relying upon basic Christian spirituality, at least, as it is understood in common parlance and as practiced in substance abuse recovery efforts.

The conclusions of the study were as follows:

1. All study participants principally used AA Spirituality to achieve sobriety.
2. All subjects relied on religious/spiritual beliefs and practices related, in some way, to the Judeo-Christian tradition as a principal means of maintaining sobriety.
3. All subjects were exposed early to Judeo-Christian religion, at least by their mothers, and
4. Two of the six recovery counselors relied heavily on traditional religiosity.

Of special note, all study participants were military veterans who had not only used a variety of legal or illegal substances at some time in their past, but had also completed treatment and had remained sober for some years prior to participating in this study. All participants also had been brought up within some kind of Christian-based faith.

The study concluded by finding that traditional religious beliefs and practices did not play a significant role in the recovery of, at least, four out of six participants. The fifth participant did utilize traditional religious beliefs plus attendance at Twelve Step program to recover; for the sixth subject, religious beliefs and practices played only a partial role in recovery from addiction. This study specifically found that the spirituality of Twelve Step programs greatly helped two of six participants go back to their faith tradition while, on the opposite pole, two of the remaining four study participants turned entirely away from their earlier religious beliefs and practices.

In summary, Alcoholics Anonymous' spirituality played the more significant role in recovery for these six adults. Albeit limited in scope, this study disproved the hypothesis that religious beliefs and practices alone (or primarily) help people recover from their addictions.

The results of this study support the hypothesis that religious beliefs and practices along with AA spirituality can help addicts and alcoholics recover and maintain sobriety thereby contributing to the current body of literature that has found a correlation between substance dependency and dependency upon some form of belief in a Higher Power, either traditional or non-traditional. In supporting an overall positive relationship between spirituality and recovery, these findings also suggest that newer SATP paradigms should more proactively try to link personal religious practices to personal recovery.

And finally, while religion may be characterized as a social institution with specific and perhaps rigid beliefs, practices, and rituals shared by a group of people, a person's own spirituality is typically based on individual experiences without specific (and/or institutionally bound) parameters. If addiction is considered a spiritual disorder (a theory recognized by treatment programs, but often neglected by empirical research) and if clients' own unique belief systems are influenced by religion and/or personal spirituality, then recent developments in positive psychology and the integration of spirituality and personal psychology may make "courage and hope", for example, not just pseudo-psychological constructs, but the primary factors in any spiritually-based, treatment recovery model (Blagen & Yang, 2009).

The challenge for the future is to create an effective integration of the patients' belief systems into their personal health care treatment. It is important to understand that many beliefs, whether in traditional Christian practice or not, can provide the answers needed in any individual's quest for the "courage and hope" necessary to attain full and personal recovery.

1 consequences unless adequately treated. Substances ingested can cause structural and
2 functional changes within the brain itself. Although the initial decision to abuse
3 substances may be voluntary, overuse can lead to compulsion, poor social judgment and
4 decision making with resultant impairment in behavioral self-control. Annually 100,000
5 deaths are attributed to alcohol misuse at a cost of \$166 billion in the USA alone. It is the
6 third leading cause of preventable deaths after smoking and obesity (Pagano, Graham,
7 Frost-Pineda, & Gold, 2005, p.475). Lillian B. Yeomans, an M.D. and recovering drug
8 addict, stated that she thought that she was toying with the drug, but, as time passed, she
9 made a startling discovery that the drug was toying with her (Yeomans, 1984, p.4).

10 According to a 1999 National Household Survey on Drug Abuse, 3.6 million
11 Americans, or, 1.6 percent of the total population, aged 12 and older, were, at one time or
12 another, dependent on illicit drugs while 8.2 million Americans, or 3.7 percent of the
13 population, were dependent on alcohol. Of particular note, 1.5 million people were
14 dependent on both. Overall, an estimated 10.3 million people were dependent on either
15 alcohol or illicit drugs, which is 4.7 percent of the population" (Ringwald, 2002, p.9).
16 Over 700,000 people in the United States receive alcohol treatment, either in inpatient or
17 outpatient settings, on any given day (Fuller, Hiller-Sturmhofel, 1999, p.69). Repeated
18 substance abuse creates a dependent craving for it and individuals often go to any extent
19 to seek, obtain and use it, even if their seeking involves lying, hiding, stealing, cheating,
20 breaking the law and/or committing crimes, to include murder. "Alcoholism is common,
21 serious, and expensive to both those afflicted and society at large" (Pagano et al., 2005,
22 p.473). As a result of substance dependence or abuse, those who misuse alcohol often go
23 on to have problems with family and friends, the legal system, and/or financial

1 difficulties. The psychological pain that occurs as a result of the above behaviors
2 hopefully motivates alcoholics to seek help, for example, through self-help programs like
3 Alcoholics Anonymous and Narcotics Anonymous. What is unique about alcoholism
4 treatment is that the person has the capacity to surrender totally by participating in a
5 Substance Abuse Treatment Program (SATP) and to simultaneously develop an improved
6 spiritual life which can then be maintained through Alcoholics Anonymous (AA)
7 fellowship. For example, when everything else failed, the founders of AA, William
8 Griffith Wilson, a New York stockbroker, and Dr. Robert Holbrook Smith, a surgeon,
9 developed a spiritually based treatment recovery program based on their belief that this
10 was the best way to change alcoholics' lives and reunite them with society and their loved
11 ones.

12 "Most or more than 11,000 treatment programs in the country introduce their
13 clients to some form of spirituality, usually based on the Twelve Steps Program of AA or
14 Narcotics Anonymous (NA), or dozens of similar fellowships" (Ringwald, 2002, p. 4).
15 The Twelve Step program found in Alcoholics Anonymous specifically promotes
16 spirituality as an integral path towards sobriety. Over the years, millions have recovered
17 from addiction by following this spiritually based program. Today, spirituality, as
18 defined by AA, is considered a key component in any alcoholism treatment and recovery
19 program.

20 Before speaking about AA spirituality specifically, it is important to understand
21 how spirituality is defined since it is a commonly misunderstood term in contemporary
22 English usage. "Today bookstores, church and secular alike, literally teem with books on
23 spirituality" (Rolheiser, 1999, p. 5), yet the precise meaning of the word remains elusive.

1 Growing up in the nineteen sixties and seventies, few people, if any, differentiated
2 "spirituality" from religion. All spiritual practices were considered religious, and vice
3 versa. If one was considered spiritual, one was regarded as religious and the converse was
4 also true. Spirituality emerged as distinct from religion over a long period of time and
5 only after people began to separate the state from religion and God. Today, for some, it
6 no longer necessarily involves any particular religious notion of God as Supreme Being,
7 but rather it has become related to the more general notion of personal spirituality known
8 in AA as one's "Higher Power".

9 Spirituality can both positively and negatively affect one's overall health and
10 quality of life. The word "spiritual" itself, a derivative of the Latin word "spiritus", can
11 mean anything that is related to the "spirit of life". Spirituality has been used in a general
12 sense to refer to that which gives meaning and purpose in life, or more specifically to the
13 practice of a philosophy, religion, or a way of life. Finally, the English words "inspire,"
14 (to breathe in) and "expire," (to breathe out) also come from the same Latin root and in
15 that sense spirituality becomes a symbol for breath (i.e., breathing), or the force in every
16 person that gives life, energy and power.

17 Both traditional Christian spirituality and AA spirituality attempt to answer basic
18 existential questions; they prompt troubled individuals to find new meaning and purpose
19 in life. Once aware of physical and mental limitations, man tends to look outside himself
20 and searches for the capacity to transcend self (Macquarrie, 1992, p.47). Christian
21 spirituality embraces specific religious and spiritual experiences, feelings, thoughts and
22 beliefs about one's relationship to God as a way to transcend oneself (Sperry, 2002, p.5).
23 AA Spirituality differs from traditional religiosity in that it does not profess a common

1 creed nor practice a common worship. There is no membership enrollment; no dues are
2 to be paid. There is no church hierarchy and no specific rites and rituals to be followed;
3 no institutional structures are maintained.

4 Advocates describe AA as a spiritual program for the living versus a theory about
5 life. The basic elements of AA spirituality, summarized in the Twelve Step program are:
6 acceptance of powerlessness over alcohol; dependence and guidance from a Higher
7 Power as they understand it; taking a personal moral inventory; confessing and making
8 amends for past wrongs; praying; living by spiritual precepts; and carrying the message
9 to other alcoholics (Alcoholics Anonymous, 2001, p. 59-60). It is a day-to-day roadmap
10 towards healing and recovery from alcoholism, a journey from brokenness to wholeness
11 and a rediscovery of themselves as worthy citizens with meaningful lives and productive
12 members of society. Recovering addicts are taught to differentiate between AA
13 spirituality and narcissism, that is, from thinking that they, not God, are the center of their
14 universe. When one worships his own self (e.g., his body) due to narcissism, or self-
15 centeredness, AA says the relationship to God, or a Higher Power, is broken – the
16 alcoholic is worshiping a false idol. Also, when the alcoholic abuses his own body (e.g.,
17 through alcohol or drug use), he likewise loses the image and likeness of God. Like the
18 biblical Israelites who wandered in the desert, alcoholics may question the treatment
19 approach of AA and its spirituality - they may have doubts, anxiety and skepticism about
20 the program. But fundamentally they know that unless they stop their abuse, they can
21 never reach sobriety (i.e., the Promised Land). They become acutely aware of the need
22 for inner spirituality.

1 Like AA, Christian spirituality also emphasizes an inner struggle. St. Paul, for
2 example, spoke about the struggle in every person between the desires of the flesh and
3 the fruit of the spirit. He wrote "the fruit of the spirit (Holy Spirit) is love, joy, peace,
4 patience, kindness, generosity, faithfulness, gentleness and self control" (Gal 5:22).
5 Concepts such as love, faith in a Higher Power (or God), hope, service, worship, prayer,
6 meditation, spiritual readings, honesty, humility, patience, forgiveness, unselfishness, and
7 fellowship gatherings are common to both AA and Christian based ideas of spirituality.
8 Their mutual goal is to transform its believers so as to live meaningful lives and become
9 one with their communities.

10 Christian communities have a common creed, dogma, theology, tradition and
11 common worship within its congregations. For Christians, Christ is center of everything:
12 their meaning, their hope, their self-understanding, their theologies and their spiritualities
13 (Rolheiser, 1999). "What happens in Congregations is theological. People of faith,
14 gathered in congregations, work every day to make sense of their lives, to devise ways of
15 relating to the divine powers that lie within and beyond them" (Ammermann, Carroll,
16 Dudley, Eiesland, McKinney, Schreiter, Thumma, & Warner, 1998, p. 9). In AA
17 communities (and treatment programs), alcoholics also similarly gather, share their
18 stories and search for what makes sense in their lives. AA strives for spiritual progress,
19 not spiritual perfection. It is not a religious program, but it is a spiritual one in which it is
20 clearly stated that it is "the 'God' of one's understanding" rather than any specific,
21 preconceived version of a specific supreme being that can make the difference. In AA, as
22 opposed to Christian spirituality, the Higher Power can be anything greater than oneself
23 (e.g., nature).

1 The hypothesis of this study is that traditional religious beliefs and practices do
2 help people to recover and remain sober. Through one-on-one interviews, the impressions
3 and recovery stories of six recovering alcohol and drug counselors will be examined to
4 explore the spiritual dimensions of individual recovery programs. Are the healing
5 elements present in a Twelve-Step recovery program due exclusively to AA spirituality?
6 If there are healing elements common to both Christianity and AA spirituality, why do
7 some in AA say that religion, in and of itself, will not lead to recovery? How is it possible
8 that the healing elements in Christianity work with its own followers, but not with
9 substance abusers? In some places AA meetings start with a prayer: “*God, grant me the*
10 *serenity to accept the things I cannot change, courage to change the things I can and the*
11 *wisdom to know the difference*”, and concludes with the Lord's Prayer. Addressing a
12 Higher Power as "God" or as "Our Father in Heaven", it seems to me, is the same as
13 "Christian" spirituality.

14 This study contends that Christian spirituality is present in Alcoholics
15 Anonymous spirituality, though adherents to AA philosophy say otherwise. Studies have
16 been conducted to examine the nexus of religiosity and substance use/abuse among
17 adults. Expressions of religiosity, such as church attendance, for example, have decreased
18 marijuana use among incarcerated men. In general, studies have found that the higher
19 level of reported spiritual well-being and religiosity, the lower the level of drug use
20 (Staton, Webster, Hiller, Rostosky, Leukefeld, 2003). Individuals with high levels of
21 spirituality and even low levels of religious activity had generally recorded the lower
22 levels of tobacco smoking, alcohol use, and gambling (Trinkoff, Zhou, Storr & Soeken,
23 2000; Hodge, Cardenas & Montoya, 2001).

1 The hypothesis of this research paper specifically concerns the role of religiosity
2 in the recovery of Substance Abuse Treatment Program (SATP) counselors/supervisors.
3 All six are recovering addicts. In their daily encounter with SATP patients, they typically
4 encounter a variety of people of different faiths and religious denominations, even
5 atheists and agnostics. This study will explore the spirituality that they followed to
6 recover and abstain from substance abuse. Was AA Spirituality exclusively beneficial to
7 them? What role did personal religiosity (religious beliefs and practices) play in their
8 recovery/sobriety? What do they consider the spiritual source, or basis, of their
9 recovery? What sustains them to remain sober and lead productive lives?

10

11

12

Chapter Two

13 Review of the Non-empirical Literature

14 Alcoholics Anonymous, Rational Recovery and Celebrate Recovery are three of
15 the main approaches for treating substance abuse/dependence. Rational Recovery is a
16 non spiritual approach to sobriety with an emphasis on personal effort. Celebrate
17 Recovery is just the opposite - a total faith based approach. AA combines both, but is
18 known primarily as a spiritually based recovery program. "Alcoholics Anonymous (AA)
19 is widely accepted as the model for alcoholism treatment" (Brown, Whitney, Schneider &
20 Vega, 2006, p. 654).

21 "Alcoholics Anonymous is a voluntary worldwide fellowship of men and women
22 who meet together to attain and remain in sobriety. The only requirement is the desire to
23 stop drinking. There are no dues or fees for membership" (Alcohol Anonymous, 2001).

1 AA is both a fellowship and a rehabilitation program. Fellowship provides mutual
2 support and a place where those seeking recovery can freely share thoughts and feelings.
3 The Twelve Step program is viewed as primarily responsible for the eventual
4 rehabilitation and recovery of AA alcoholics.

5 AA is not a medical treatment or a therapy for a biological entity. It is a spiritual
6 program for recovery from alcoholism and a fellowship of alcoholics living out the
7 program (Swora, 2001, p. 1). The members are encouraged to interpret the world, their
8 lives, and their affliction in sacred terms (Swora, 2004, p. 1). As stated above, the Twelve
9 Steps are the backbone of AA; these steps are a guide for living and a way of life. AA's
10 model of alcoholism puts forward that it is an incurable and progressive disease of the
11 body, mind and spirit.

12 Kurtz Ernest, in his review of Alcoholics Anonymous' history and development,
13 distinguished between "AA program" and "AA fellowship". The "program" was
14 described by way of the basic texts of AA (e.g., *Alcoholics Anonymous, the Twelve Steps*
15 *and the Twelve Traditions*) which, even after revisions, basically remained the same step-
16 by-step agenda. The "fellowship" part, on the other hand, referred to the particular
17 experiences each person had when he, or she, attended AA meetings and became
18 involved with other AA members. Each Twelve Step fellowship, therefore, can vary
19 greatly (Brigham, 2003, p.45).

20 The essence of Alcoholics Anonymous is sharing and by its very nature could not
21 have been founded by only one person. According to AA (1980), Bill Wilson and Dr.
22 Bob Smith are considered to be its cofounders. "Bill W" born November 26, 1895,
23 enlisted into the U.S Army and ingested his first drink. By the time he got out of the

1 service, "he had a sinister new companion -alcohol" (AA, 1984, p. 62). Studying for a
2 law career, he was too drunk to pass the final examinations. He later became successful
3 as a security analyst, but continued drinking. In 1929 the Stock Market fell and his
4 fortune and dreams were lost. Bill W was admitted to Towns Hospital, New York, well
5 known in its day for physical and mental rehabilitation of alcoholics. There, Bill W's
6 physician, Dr. William Silkworth (1937) formulated a theory that: (a) alcoholism was an
7 allergy of the body, (b) chronic alcoholics could never use alcohol safely, (c) once it
8 becomes habitual, they cannot break it alone and (d) alcoholics lose their self confidence
9 and their reliance upon other things and other humans (AA, 1984, p.102).

10 With the help of this doctor, Bill W. learned that being an alcoholic is not
11 necessarily due to a lack of will power, or a moral defect; it was a legitimate (organic)
12 illness, a theory unique at a time when alcoholism was considered mysterious and
13 shameful. Dr. Silkworth convinced Bill W. that alcoholism was an obsession of the mind
14 that compels people to drink and an allergy of the body that condemns them to madness
15 or death (AA, 1957, p. 102). Bill W. learned that it could not be defeated by will power
16 alone. Other physicians who treated alcoholism as a disease wrote that the effects of
17 spirits on the mind and body were physically toxic, morally destructive and obviously
18 addictive. Once addicted, drinkers experienced uncontrollable, overwhelming and
19 irresistible desires for more drink - what today is referred as to 'loss of control'. Total
20 abstinence was the cure and a "sober house" for treatment was often recommended
21 (Levine, 1984, p. 111).

22 Following Bill W.'s treatment, a friend of his, when offered drink, exclaimed,
23 "I've got religion" (AA, 1984, p. 111) and went on to talk about an "Oxford Group"

1 which was "more of a spiritual than a religious movement" (AA, 1984, p. 113).
2 Explaining to Bill W. that honesty with self, others and God was the essence of this
3 Group, he influenced Bill W to examine and practice their principles. Another fellow
4 alcoholic who received treatment from psychiatrist Carl Jung told him that "the only
5 thing that could now help free (alcoholics) from addition was a "spiritual awakening"
6 (AA, 1984, p. 114) and went on to suggest that Bill W. ally himself with others in a
7 religious movement similar to the that advocated by the Oxford Group.

8 The Oxford Group was a popular nondenominational evangelical movement in
9 Europe in the 1920's and 30's started by Dr. Frank Buchman, a Lutheran minister
10 unhappy with the church and who developed a non-denominational a way of life, based
11 on New Testament texts, but focused on changing lives and helping others to find a more
12 fulfilling and exciting life in service to God and others. Members sought "spiritual
13 regeneration by surrendering to God through rigorous self examination, confessing their
14 character defects to another and making restitution for harm done to others and giving
15 without expecting anything in return" (AA, 1980, p.54).

16 At the core of the program were four absolutes or standards; these were absolute
17 honesty, absolute purity, absolute unselfishness and absolute love. In addition to these
18 four absolutes the Group also forwarded three assumptions (we assume that God Speaks,
19 we assume that God has a plan for us, and He reveals His plan for us if we listen and
20 follow His directions), five C's (Confidence, Confession, Conviction, Conversion and
21 Continuance) and five procedures (give in to God, listen to God's directions, check God's
22 guidance, sharing for witness, and sharing for confession (AA, 1980, p.54).

1 The Oxford Group became the basis for the Twelve Steps and much of Alcoholics
2 Anonymous literature. Admission of personal defeat, surrender to God (or a Higher
3 Power), making personal inventory, confession of one's sins to another , making
4 restitution to those one has harmed, and helping others are all common elements to both
5 Oxford Group and AA.

6 Due to continued alcohol use and consequent depression, Bill W. desperately
7 cried out, "I will do anything; anything at all (to achieve sobriety)... if there be a God, let
8 him show Himself" (AA, 1984, p. 120-121). Dramatically, Bill W. reported, "my room
9 blazed with an indescribably white light. I was seized with an ecstasy beyond description.
10 Every joy I had known was pale by comparison. The light, the ecstasy – I was conscious
11 of nothing else for a time" (ibid). A spiritual awakening had taken place at the age of
12 thirty-nine and he never again doubted the existence of God; he never drank again (Ibid).
13 Bill later found that there were three common factors present in the case histories of
14 recovered alcoholics: all had met utter defeat in some vital area of life and all human
15 resources had failed them; each of the individuals acknowledged his own defeat as utter
16 and absolute; and all had come to appeal to a Higher Power (AA, 1984, p. 124).

17 Bill W. came to believe that spirituality could transform people so that they could
18 do, feel and believe that which they could not experience prior to their illness even when
19 those who were transformed had been initially seen to be hopeless. The insight for Bill
20 W. was that alcoholics were people without hope but that since spiritual experiences
21 worked for other hopeless people, it could and should work for alcoholics.

22 Dr. Bob, the other cofounder of AA and was born August 8, 1879. He was a
23 premedical student who had missed many classes due to drinking and blackouts. After

1 receiving his medical degree at the age of thirty-one, he worked at an Akron hospital
2 when his alcoholism became apparent. By this time, he had added sedatives to quiet the
3 morning jitters. His wife persuaded him to attend Oxford Group meetings through which
4 he met Bill W. Four years later when the AA "big book" was published, Dr. Bob,
5 reflecting about the first meeting noted, "Bill was a man speaking my own language"
6 (AA, 1980, p. 68).

7 Bill W.'s personal belief system was based on the Judeo-Christian concept of
8 God. He wrote that when he saw others attempt to solve their problems by a simple
9 reliance upon the spirit of the universe, they failed. Their ideas did not work and
10 consequently it became clear to him that "the God idea" worked (AA, 1980, p. 52). He
11 said that they had to have God's help to succeed and their purpose should be to organize
12 themselves to be of maximum service to God and the people around them (AA, 1980, p.
13 102). Prior to 1948, Dr. Bob believed that sobriety depended solely on the Bible. Later
14 their studies and efforts crystallized to form the Twelve Steps.

15 Dr. Bob Smith said that he and Bill W. used both the Bible and the precepts of the
16 Oxford Group. Dr. Bob, himself, was very pro Christian faith. If someone asked him a
17 question about the program, his usual response was "we follow what is in the Good
18 Book", referring to Bible. The Akron Alcoholics Anonymous Group, in fact, emphasized
19 Bible meetings with prayer, and other get-togethers called old fashioned prayer meetings,
20 where scripture was regularly read. Dr. Bob called meetings of the early AA movement
21 "Christian Fellowships" (AA, 1980).

22 As previously noted, early active members of AA were primarily Oxford
23 members. Bill W. and Dr. Bob were healed from alcoholism through the Oxford Group

1 and not, so much, by the influence of early AA spirituality. The Big Book and the Twelve
2 Step tradition actually came into existence after, and as a result of, their recovery from
3 alcoholism. Bill W. always had close associations with the clergy while he was drinking
4 and during the formation of AA. It was through the clergy that the historical meeting
5 between Bill W. and Dr. Bob came into being. Many esteemed ministers endorsed AA
6 helping to give it much needed legitimacy. But members of AA were not partisans of
7 any particular form of organized religion. To AA participants, religion meant an
8 experience they personally knew and which saved them from their slavery of addiction.
9 Some AA members eventually did not even like organized religion, its authority and its
10 doctrines. They refused to rely on theology, per se; however, they did share how they
11 were helpless, how they believed in a Higher Power, greater than themselves, and how
12 they could find the resources through other alcoholics to help them recover (AA, 1980).

13 When Bill W. presented his Twelve Steps to AA members themselves, they
14 foresaw early that dogmatic religiosity would discourage, or drive away, alcoholics for
15 whom the program was meant to help. As a result of feedback, Bill W. toned down the
16 religious language in order to be more inclusive of the needs of atheist and agnostic
17 members of Alcoholics Anonymous. By doing so, AA members were led to talk about:
18 (a) spirituality, not religion, (b) sobriety, not salvation, (c) wrongdoing, not sin, (d)
19 admitting defects, not confessing sins, (e) strength and hope, not resurrection, and (f)
20 carrying the message, not the faith. The eventual absence of direct religious reference
21 within AA did not take away from its Christian base and some of its early adherents.
22 They wrote convincingly that AA at its heart was still a Christian Fellowship: "to deny
23 this point is to repudiate the very conviction on which AA was founded that God could

1 and would help if He were sought. He can. He will. He does. And He is avail- able to
2 every drunk or addict who wants to seek and obey Him" (Dick, 2009, p. 4). Whatever the
3 claims of Alcoholics Anonymous, at present, may be, it was clearly then based in, and
4 reflective of, Judeo-Christian beliefs and practices. Early Akron AA meetings are the
5 proof that there was a direct connection between AA Spirituality and Judeo-Christian
6 beliefs and practices at AA's inception.

7 **Review of the Empirical Literature**

8 There has been little collaboration between religious and health care professionals
9 in their approach to the physical and mental well-being of their clients until the second
10 half of the twentieth century. Clergy and health care professionals worked in virtual
11 isolation and without the benefit of mutually shared empirical studies. Each tried to
12 prove the other false in terms of claiming what the "truth" is. Health care professionals
13 viewed religion/spirituality as unimportant and irrelevant to the health of their patients.
14 Consequently, they underestimated the role religion/spirituality played in the lives of
15 their patients. Only 26.1% of medical students believed in a God who can be reached by
16 prayer compared to 75.6% of their patients (Goldfarb, Galanter, McDowell, Lifshutz &
17 Dermatis, 1996, p. 555).

18 In a study which assessed the recollections of the medical and nursing staff at
19 Duke University Medical Center regarding their referral pattern to chaplains who dealt
20 with spiritual issues, physicians were found to make 51% whereas the nurses made 86%,
21 over a six month period (Galek, Flannelly, Koenig & Fogg, 2007, p. 364). This may be
22 due to the fact that nurses have a longer history of affirming the importance of
23 religion/spirituality in their patients. This study also found that physicians' self-ratings of

1 religiousness and spirituality were substantially lower than that of other health
2 professionals.

3 In 2003, over a three-year period studying 480 inpatients at Memorial Sloan-
4 Kettering Cancer Center at New York, nurses made 112 (24.9%) referrals to chaplains
5 compared to 4 (0.09%) by physicians. Nurses overwhelmingly made the majority of staff
6 referrals to chaplains; physicians' referrals to chaplains and clergy were rare (Flannelly,
7 Weaver & Handzo, 2003, p.763). Physicians' indifference to the spiritual needs of their
8 patients may have been due to many reasons. First, the physicians were unaware of the
9 reasons why time and energy should be spent dealing with the spiritual issues with their
10 patients. Possibly due to insufficient training in religious/ spiritual issues, they were
11 unaware of a faith communities' role in the early disease detection of diseases (e.g.,
12 AIDS/HIV) and the role clergy play in providing needed support, care, and
13 encouragement towards recovery. Second, physicians often lack the time to discuss
14 complex personal issues. They often complained that unending and/or senseless paper
15 work (e.g., insurance forms/fees) left little time to discuss spiritual issues. Third, they
16 felt comfortable discussing religious and faith issues with their patients, considering
17 religious/spiritual issues a private matter. Fourth, they were concerned about
18 overstepping the boundaries of religious leaders who were better trained to deal with such
19 issues (Koenig, 2004, P. 1197). Finally, physicians were often troubled by patient belief
20 systems that they felt could possibly undermine patients care and the doctor/patient
21 relationship (e.g., religious prohibitions to blood transfusion by Seventh Day Adventists).

22 Dr. Harold G. Koenig, who wrote and published many articles and books on
23 Mental Health, Geriatrics and Religion, discussed how he saw his medical colleagues

1 react when he gave lectures on Religion and Health. His sense was: "why are you talking
2 about this? This is something we don't talk about; we're doctors. Religion is an area that
3 clergy deal with. This is really not relevant to what we do. And maybe you're a little
4 weird and strange for even talking about it" (Aten & Schenck, 2007, p. 185).

5 From the Judeo-Christian perspective, all healing comes from God; He is the source
6 of all healing. Therefore all who work for the physical and mental well being of their
7 patients are actively participating in the healing ministry of God. They are called to serve
8 the sick, a noble profession for all physicians and clinicians--" to cure sometimes, relieve
9 often and comfort always (D'souza & Kuruvilla, 2006, p. 4).

10 **Relationship between Psychologists and Religion**

11 The word "psychology" is derived from two Greek words, "psyche" and "logos";
12 psyche means soul and logos mean study. Since the soul is the spiritual component of a
13 person, psychology therefore may refer to the study of human spirituality and/or religion.
14 However, most psychologists chose psychology to focus on human behavior, not religion.
15 Psychology, as a profession, has made a concerted effort to establish itself as a "hard
16 science" distinct from "the soft science of religion" and "this rejection by psychologists to
17 the study of religion has led a long history of antagonism between psychology and
18 religion"(Hyman & Handal, 2006, p. 265).

19 According to Gallup polls in 1985, compared to 40 to 75% of the general public
20 who view themselves as religious or spiritual, only 20-35% of mental health
21 professionals view themselves similarly. Over 50% of psychologists and psychiatrists
22 describe themselves as atheists or agnostics, as compared to 15% of the general public
23 (Hyman & Handal, 2006).

1 In a study among mental health professionals and religious leaders at Somerset,
2 UK, two-thirds of the staff (63%) had never made a referral to a chaplain and 28% have
3 made a referral occasionally, while 5% have "often" made such a referral. While nearly
4 half of the mental health professionals (49%) had "suggested" their clients see a priest or
5 rabbi at least once, some of them (17%) had done this more regularly whereas 45% had
6 never even considered it. Conversely, among religious leaders, 73% had referred their
7 clients to mental health professionals more than four times as much; seven per cent (7%)
8 never made such referrals. Over 60% of religious leaders have made referrals to a general
9 physician or a counselor; 30% made referrals to mental health professionals (Foskett,
10 Marriott & Wilson-Rudd, 2004, p.14-16).

11 This modern, yet strained, relationship between psychology and religion has been
12 due to many reasons: First, psychologists were convinced that only objective observation
13 can produce accurate information. Science is based on facts which can be verified, and
14 religion is based on faith which is subjective. They argued that only science, not religion,
15 could offer accurate knowledge. Second, only by repudiating religion they could claim
16 psychology as independent and scientific. They challenged methodologies used by
17 religious/spiritual professionals in dealing with sick souls as non-scientific. Third, their
18 lack of knowledge of religious faith, or their downright hostility toward historical
19 religious institutions, resulted in rejecting religion. Fourth, Psychology in America was
20 influenced by a positivistic philosophy which undermined the basic value of religion.
21 Interestingly this same trend towards an empirical or evidence-based practice of
22 medicine, also led to tension within the field of medicine itself between the surgical field,

1 and the more cognitive fields, like internal medicine. Finally many religious professionals
2 also viewed psychology with suspicion and mistrust (Haque, 2001, p.243).

3 Before 1980's clergy were doing most of the religious counseling. Some of the
4 reasons why clergy made few referrals to the clinical professionals are the following:
5 First, clergy were not well educated in psychotherapy, and may have limited knowledge
6 of, and lack of confidence and competence in, detecting mental illness in the parishioners
7 they see. Second, due to their numerous roles and services, they often simply lacked time
8 to make such referrals and/or follow up with them. Third, also due to time constraints,
9 they might not be able to meet with clients as often as the clients needed when mental
10 health issues coexisted with spiritual concerns (Worthington & Aten, 2009, p.125).

11 For the most part, clergy did not make referrals when the problems they were
12 dealing with primarily involved moral or religious issues. Lastly, of note, African-
13 American pastors felt the role of the church, particularly in the African-American
14 churches in the United States, was to specifically help emotionally troubled parishioners.

15 Of note there has been more cooperation and collaboration between religious and
16 health care professionals in medical and mental health areas since the end of last century.
17 Many theologically conservative clients sought religiously based psychotherapists (e.g.,
18 American Association of Christian Counselors; AACC) since the 1980's. Other
19 counselors now explicitly label themselves as Jewish, Muslim, Buddhist, or Hindu or
20 Catholic psychotherapists. Additionally, over the last two decades, an increasing number
21 of psychotherapists have declared that they conduct religiously accommodating therapy
22 from particular theological stances. Despite these changes, however, religious issues tend

1 to be addressed only if the clients bring them up in counseling; psychotherapists usually
2 conduct psychotherapy as secular therapy (Worthington & Aten, 2009, p.125).

3 Both disciplines, therefore, have begun to look towards education and training as
4 the best way to bridge the gap between the two professions. The fact that both are willing
5 to acknowledge the advancement of empirical studies, from one another, and, in relation
6 to each other, to recognize the useful and practical application in their respective fields is
7 a positive sign.

8 Recent evidence has shown that religious beliefs and practices are common in the
9 United States, especially among older adults. According to Gallup (2008), 78% people
10 believed in God compared 81% in 2004. In 2008, 61% respondents were church or
11 synagogue members compared to 64% in 2004 while 30% people attended church or
12 synagogue worship in 2008 compared to 35% in 2004. Lastly, 54% of people responded
13 that religion was important in their life in 2008 compared to 59% in 2004. This most
14 recent Gallup poll, therefore, clearly shows that the majority of people in the United
15 States still believe in God.

16 In 2003, the Joint Commission on Accreditation of Healthcare organizations
17 (JCAHO), the largest and most influential accrediting body in the United States for
18 hospital organizations, revised its accreditation standards to require all health care
19 facilities to spiritually assess patients in hospitals, home care organizations, long- term
20 care facilities and addiction centers. All the health care facilities where they treat
21 inpatients are expected to follow these guidelines (Cadge, Freese, & Christakis, 2008).

22 Aimed at providing holistic treatment care plans, it requires medical practitioners
23 to conduct an initial, brief spiritual assessment based on three areas: (a) denominational

1 faith tradition, (b) significant spiritual beliefs and (c) important spiritual practices.
2 Similarly, a panel of the American Colleges of physicians formulated 4 questions that
3 they asked their ill to seriously ill patients. They are: (a) Is faith (religion, spirituality)
4 important to you?, (b) Has faith been important to you at other times in your life?, (c) Do
5 you have someone to talk religious matters, and (d) Would you like to explore religious
6 or spiritual matters with someone? (D'souza, Kuruvilla, 2006, p. 411).

7 Finally, the Association of American Medical Colleges Medical School Learning
8 Objectives for Medical Student Education (1998, p. 4) project stated that physicians
9 "'must seek to understand the meaning of the patients' stories in the contexts of the
10 patients' beliefs, and family and cultural values. They must avoid being judgmental when
11 the patients' beliefs and values conflict with their own"(Association of American Medical
12 colleges.1998, p.4)

13 Psychiatrists generally seem to have a more positive attitude toward the effect of
14 religion/ spirituality on health, although they also recognize that religion/spirituality
15 sometimes causes negative effects that lead to increased suffering (Curlin, Odell, Chin,
16 Lantos, Koenig & Meador, 2007, p. 1825). One study even found that psychiatry and
17 religion can offer alternative explanations for many of life's deepest and most mysterious
18 phenomena and suggested that psychiatrists may be more open to interacting with
19 patients about religion/spirituality in clinical encounter than their non-psychiatric
20 physician counterparts. Many recent developments are showing that the antagonism
21 between psychiatry and religion is waning.

22

23

1 **Relationship between Religiosity and General Well-being**

2 There is a growing body of literature establishing a relationship between
3 religiosity and general well being. Religion/religiosity provides a sense of coherence, a
4 set of meanings that allow people to make sense out of what is happening in their daily
5 lives. This sense of coherence allows people to place events in a context that is bigger
6 than the immediate, thereby reducing the stress and strain that so often accompany daily
7 and/or occurrences. When any particular life is viewed as but a small part of a greater
8 scheme, events in it are less likely to lead to stress, and to stress-related illness (Perry,
9 1998, p. 129).

10 A study of 337 Duke University Medical Center patients in North Carolina who
11 sought admission for general medicine, cardiology, and neurology services, found that
12 90% reported using religion to some degree to cope, and more than 40% indicated that it
13 was the most important factor that kept them going (Koenig, 2004, p. 1194). Many other
14 studies have likewise found the role of religion to be helpful in treating diseases like
15 arthritis, diabetics, kidney disease, cancer, heart disease, lung disease, chronic pain severe
16 or terminal illness.

17 Religion is a protective factor among people against unwelcome human behavior
18 in society. This belief may be held very strongly in religious circles. The strongest
19 association found between church attendance and good mental health was among the
20 Mormons (Church of Latter-Day Saints) in Utah. It was hypothesized that this may have
21 been the result of good adherence to the relatively strict health and lifestyle expectations
22 found in this sect, which acted as an overall regulative (positive health) function of the

1 religion. Religion sets code of behavior for its followers to adhere and practice them in
2 their lives (Merrill & Salazar, 2002, p. 30).

3 It appears that, even for Jews living in religious settlements, support from one's
4 religious community is quite distinct from one's general social support and this can help
5 to achieve better psychological well-being among a religious Jewish population (Lazar &
6 Bjorck, 2008, p. 416). Religious beliefs and participation was found to be important
7 among older adults, in general, among rural older adults (rather than younger), females
8 rather than males, African-Americans more so than Caucasians. Belief in religious
9 intervention is found to be strongest among female African-Americans who live in rural
10 areas or smaller communities during an illness (Mitchell & Weatherly, 2000, p. 46).
11 Religiosity was also found to be significantly and positively co-related to happiness, and
12 physical and mental health. Religiosity was negatively correlated to anxiety and
13 depression (Abdel-Khalek, 2007, p. 579).

14 In older patients with chronic diseases in intermediate care, attendance at religious
15 services was associated with positive health perceptions, less severe illness, and fewer
16 pack/years smoked. Intrinsic religious activities were associated with less severe
17 depression and lower likelihood of living alone (Johannes, Koenig, Baldwin, Connolly,
18 2008, p.739). Practice of religion and spirituality played a major role in medical patients
19 in Germany and was of more help in coping with their illness than in comparison with
20 non-religious patients (Bussing, Ostermann & Matthiessen, 2005, p. 336).

21 Higher levels of religious attendance were associated with lower risk of
22 depressive illness among U. S. born and immigrant Latinos. The immigrant group
23 engaged in significantly higher levels of worship services than their Us-born

1 counterparts. Participation in a faith community was an empowering source for those
2 from socio-economically disadvantaged backgrounds (Aranda, 2008, p.17). Religion was
3 an important source of positive coping in highly religious psychiatric inpatients in a
4 Protestant hospital in Central Netherlands (Pieper, 2004, p.357).

5 Religious worship frequency was associated with lower rates of mood, anxiety
6 and substance disorders while people to whom spiritual values were important were much
7 less likely to have a current alcohol dependence disorder. High worship frequency is
8 associated with significantly lower alcohol and drug dependence and religious groups
9 who support abstinence had lower levels of substance abuse among its members (Baez,
10 Bowen, Jones & Koru-Sengul, 2006, p. 660). This last result was even found true among
11 college students in a university setting. There was a positive relationship between college
12 student's increased participation in physical activity,(e.g., exercise or work), lower levels
13 of tobacco use and lower levels of alcohol intake when there were higher levels of self
14 reported spirituality (Nelms, Hutchins, Hutchins & Parsley, 2007, p. 262-263).

15 **Religion & Substance Abuse**

16 Religion and religiosity (church involvement) has played a significant role, both
17 positively and negatively, in the lives of people throughout the centuries. It embraces
18 every facet of human life, to include, physical, mental, spiritual and emotional well being.
19 Since religion embraces every sphere of human life, it has been described by many as the
20 very fabric of American life, in providing meaning, support and social affiliation for
21 people; places of worship are visible in most every community. There is now a growing
22 body of scientific literature to suggest that there is a relationship between religiosity and
23 recovery from addiction. When addicts assimilate and integrate within a believing

1 community, they report feeling a sense of warmth, affection and support from the rest of
2 the community. It empowers them to restore their personal and social identity; it enables
3 them to restore self dignity and self confidence. One of the more obvious benefits of
4 belonging to a church fellowship, where members freely express themselves, is to be
5 affirmed without being judged. The fellowship assures that they are not alone in their
6 journey of faith and social communion (Chaney, 2008, p. 3).

7 Science and religion coexisted in Western civilization since Classical Greek
8 times. The relationship was marked by peaceful coexistence and even cooperation.
9 Studies of the natural world, human behavior (aka psychology) and theology were part of
10 one body of knowledge. St. Thomas Aquinas (1225-1274) wrote about the essential
11 unity of scientific and theological reasoning and their combined effect in gaining
12 knowledge of human thinking. However, things began to change with the work of
13 Francis Bacon (1561-1626) who recommended separating science from religion as he
14 believed it hindered the advancement of learning. "Bacon is well-known for advocating
15 separation between science and theology..... He drew a distinction between fact and
16 value and left morality in the realm of religion rather than science" (Nelson, 2006).

17 Beginning around 1800, Auguste Comte's approach to science and religion was
18 also anti-religious, historically shaped by centuries of state-church repression and
19 religious intolerance. Bacon's theories and Newton's explanations of natural phenomena
20 mold current beliefs in progress through science from a strict natural view of the world.
21 In the nineteenth century scholars, like John Stewart Mill and Sigmund Freud, believed
22 that "the positive view of science offered a way of setting up psychology as a 'true
23 science" distinct from both philosophy and religion". Freud believed that religious beliefs

1 were untrustworthy and not to be accepted; scientific work was the only road which led
2 to knowledge of the reality outside of us. Thus the divergence away from religion
3 towards the scientific process of observation and testing was given a strong impetus in all
4 of the behavioral sciences (Nelson, 2206).

5 Many of the major figures in early modern psychology like William James, John
6 Dewey, J. B. Watson, G. Stanley Hall, B.F. Skinner, Sigmund Freud, Carl Jung, Karen
7 Horney, Erich Fromm, Jean Piaget, Carl Rogers and Abraham Maslow were raised in a
8 Judeo- Christian faith tradition. They later turned away from these faith traditions and,
9 in their writings, made it clear that they saw that their work in the field of psychology as
10 sound science and a more superior alternative to traditional Judeo-Christian faith beliefs.
11 As a consequence, thereafter, scant attention was paid to religion even in introductory
12 psychology textbooks (Johnson, 1997).

13 Larson and his colleagues surveyed 2,348 articles in four leading psychiatric
14 journals between 1978 and 1982 and found that only 59 papers contained a quantitative
15 measure of religion; only three treated religion as a primary focus of study. They
16 concluded that, on the whole, religion had a minimalist place in psychiatric theories of
17 behavior. They also found that, "although American psychiatry has distanced itself from
18 Freudian theory as a major theoretical resource, it still relies significantly on Freud's
19 theory of religion as basically a form of obsessive-compulsive neurosis" (Browning,
20 2008).

21 In 2007 Delaney, Miller and Bisono conducted a survey of the religiosity and
22 spirituality of 258 members of the American Psychological Association (APA) and
23 compared it to a 1985 sample of psychologists surveyed on the same dimensions.

1 Psychologists surveyed in 2007 were no less, or more, religious than those surveyed two
2 decades before. Psychologists were also five times more likely than the public to deny a
3 belief in God, and of those people that reported having ever believed in God, 25% of
4 psychologists, compared to 4% of the public, reported they no longer do. Psychologists
5 were also found to be much less religious than the clients they serve and today are more
6 likely to describe themselves as "spiritual, but not religious". Of note, most of them
7 reported that they view the religiosity of their clients positively and of all those surveyed,
8 the majority still believed that there existed a positive correlation between religiosity and
9 overall good mental health.

10 Post and Wadfe (2009) found graduate students in clinical psychology, counselor
11 education, counseling psychology, marriage and family therapy, and psychiatry receive
12 minimal education and training in working with clients from diverse religious/spiritual
13 backgrounds. In a survey of APA accredited doctoral programs, only 17 percent
14 reportedly addressed religion/spirituality systematically through course work, supervision
15 or research (Jones, 2007). He found that teaching the integration of psychology and
16 Christian faith traditions in therapeutic modalities was addressed primarily in the one-on-
17 one, supervisor-to-supervisee relationship. Within all U.S. post-graduate study programs,
18 the increasing numbers of women and ethnic minorities continues to bring new and
19 improved perspective on issues of religion and spirituality (Maton, 2001).

20 While spirituality and religion does appear to have become of greater importance
21 to a growing number of community psychologists, they are not prepared as of yet to
22 extend an unqualified endorsement of spirituality and religion as integral in the complete
23 understanding of community based issues. Clinical and counseling psychologists have

1 had to become increasingly sensitive to religious and spiritual issues in the therapeutic
2 context. One reason is the baby boom generation's well publicized search for meaning
3 and personal significance, with a primary focus on the issues of religious socialization of
4 their children, which emerged in the 1990's. Secondly, faith based organizations are now
5 seen as increasingly important components within the human service safety net. Thirdly,
6 veterans sent to other parts of the world during diverse military deployments has resulted
7 in enhanced contact with peoples of different faith traditions, both positively and not.
8 In summary, spiritual and religious concerns have once again become increasingly linked
9 to positive healthcare, alternative health care and the overall well being of the public.
10 Positive and negative media coverage on religion and spirituality has also dramatically
11 increased from the 1990's to the present. (Maton, 2001)

12 There are a number of studies about the relationship between religion and substance
13 use among adolescents and college students. Religion, in general, has functioned as a
14 protective effect against alcohol and drug use among adolescents and college students.
15 But religion must be something more than just belonging to a church and participating in
16 religious services and practices. Through an individuals' faith and practice of religion, it
17 should become a part of the internal personal control structure that militates against
18 deviance from, or proneness to, unconventional immoral and unhealthful behavior. It is
19 an indicator of internal values and beliefs beyond the level of social religiosity-
20 conformity. Studies have found, in general, that aspects of religion, such as worship
21 attendance, religious salience, prayer, religious beliefs and membership in religious
22 groups that teach and/or preach against the use/misuse of substances are inversely

1 correlated to rates of alcohol consumption, binge drinking and alcohol dependency
2 (Menagi, Harrell, June, 2008).

3 A study among 151 female undergraduate students, who attended a four year
4 college located in a small urban center in North Central U.S., was highly suggestive that
5 religion impacted their use of alcohol. Female college students high in intrinsic religious
6 orientation (e.g., through their parents, religious authority figures and religiously active
7 peers) reported much lower alcohol use plus they perceived the effects of any alcohol use
8 more pessimistically. The study found that the quest for purpose and meaning in life,
9 along with religious beliefs, personal values, faith and relationship with God were the
10 most active working mechanisms against substance misuse and abuse (VonDras, Schmitt,
11 Marx, 2007).

12 Religious measures also were found to be significantly and inversely related to
13 adolescent substance use among 1273 middle school and 812 high school participants in
14 a study conducted in a New York City metropolitan area. Of the middle school students,
15 13% were in sixth grade, 45% were in seventh grade, and 42% were in eighth grade; the
16 sample overall was composed of 12% Africa-American, 32% Hispanic, 21% Asian-
17 American, 27% Caucasian, and 8% "other ethnicity" with 49% of the participants
18 female. About 58% of these middle school students reported they belonged to religious
19 organizations and 40% reported that they attended religious services on, at least, a
20 monthly basis. In the high school sample, 53% were in ninth grade, 37% were in the
21 tenth grade, and 10% were 11th grade. This sample was composed of 10% African-
22 American, \$2% Hispanic, 14% Asian-American, 28% Caucasian, and 6% of other
23 ethnicity with 51% female students. Among these high school students, 57% reported

1 that they belonged to religious organizations and 35% reported that they attended
2 religious services monthly or more often. This study found that religious measures were
3 significantly inversely related to overall adolescent substance use; participation in
4 religious organizations appeared to correlate highly to rejection of deviant behavior
5 among both groups. It concluded by recommending that future youth programs should be
6 designed for adolescents who are at high risk for substance use with these factors in
7 mind. Community resources should take note of, and include the religious institutions
8 and affiliations that are attended by the young people and which are readily available at
9 the community agents' disposal (Walker, Ainette, Wills, & Mendoza, 2007).

10 A survey among 241 nursing students enrolled in their first year of nursing at
11 Seventh-Day-Adventist colleges and universities found that those who had a strong
12 commitment to their religion, and had internalized their own religious norms against
13 substance use were significantly less likely to use any substances whatsoever. Again,
14 since religiousness seemed to be a protective influence, it was recommended in this study
15 to make that an integral part of any substance intervention program where opportunities
16 for religious activities are present (i.e., in faith-based programs) (Gnadt, 2006).

17 Another study explored the role of religion in explaining heavy poly-drug use and
18 other HIV-related risk behaviors among a tri-ethnic sample of 600 males and females
19 who were active heroin injectors. These subjects were recruited from the streets of
20 Miami-Dade County in Florida. The participants had injected heroin at least weekly for
21 the last six months prior to the survey and had not been in any drug treatment during that
22 time. Religious intentionality was significantly but inversely associated with the reuse of
23 needles/syringes. Those who reported that beliefs of their religious group strongly

1 influenced their behavior were less likely to reuse needles/syringes when compared to
2 those who said such beliefs have no influence on their behavior. Of special note, the
3 majority of heroin injectors reported that: a) they are religious and b) they participated in
4 one or more worship services in the past year (Weiss, Chitwood, Sanchez, 2008).

5 A study consisted of 221 students, recruited through an introductory psychology
6 course human participation in research pool, found that lower rates of alcohol use were
7 reported among those students who internalized a sense of religious identity. The students
8 who viewed religion as important and who had integrated it into their lives had overall
9 lower rates of alcohol use, supporting previous findings that religiousness is related to
10 lower rates of alcohol use among college aged students (Menagi, Harrell, June, 2008).

11 In 2007, a survey was conducted among the Australian Salvation Army residential
12 rehabilitation service with 77 male taking part. The purpose of the study was to examine
13 the relationship of spirituality, religiosity and self-efficacy to drug and/or alcohol
14 cravings. The sample included participants who ranged in age from 19 to 74. More than
15 57% reported a diagnosis of a mental disorder and 78% reported polysubstance misuse,
16 with alcohol the most frequently endorsed and therefore primary drug of concern.
17 Seventy-five percent of the participants reported that spirituality and religious faith were
18 "useful components of the treatment program" (Mason, Deane, Kelly & Crowe, 2009).

19 A survey was conducted on a sample of 184 older African-American women,
20 aged 55-89, who were involved in three separate programs sponsored by Catholic Social
21 Services. It examined their belief systems regarding alcohol use and treatment of African-
22 American women to determine how religious affiliation and drinking status affect those
23 belief systems. Findings from the study showed that religion had a significant association

1 with the practice of keeping alcohol at home as well as a reason for abstaining from use.
2 Those who were very religious were less likely than the not very religious to report that
3 they followed this practice. This study also observed that religion was significant to belief
4 systems as well as practices regarding alcohol use (Hatchett, 1999).

5 In total, these studies suggest a direct relationship between religiosity and positive
6 outcomes in overcoming substance use disorders; association between religiosity and
7 moderation and control in alcohol and drugs use has now become well established
8 Religiosity may protect against substance abuse by developing a healthy life style. Highly
9 religious people are consistently less likely to abuse drugs or alcohol than less religious
10 people, and there appears to be clear evidence that religiosity/spirituality plays a
11 significant role in overall physical and mental health well-being. Health care
12 professionals therefore should utilize the beneficial and skillful use of religious/spiritual
13 dimensions in the recovery treatment of their clients. Since many patients in the recovery
14 process report that religious/spiritual experiences may play a leading role in their path to
15 recovery, clinicians simply cannot afford, anymore, to underestimate or ignore the
16 importance of religion/spirituality in such personal recovery efforts.

17 **Religiosity and Substance abuse among Women**

18 Most African-American communities consider church and church involvement as
19 center of their lives. There they experience a sense of belonging, being protected and of
20 being at home. It is in church they find hope even they go through hard times (e.g.,
21 slavery). A number of studies have also suggested that church was always something
22 women "clinged on to" when in recovery from addiction. In general, African-Americans

1 are very religious and African-American women even more so; religious community
2 participation is central to their lives.

3 A study of 102 African-American and Anglo women in Coastal Texas to
4 determine the nature and extent of religious organizations' involvement in women's
5 recovery from alcohol and other drug abuse, found that almost all of them reported that
6 religious beliefs or spiritual experiences had played some important part early in their
7 recovery. These participants had been in continuous abstinence from alcohol/drugs from
8 1-5 years and over three-fourths had reported attending church, or religious services,
9 regularly at some point in their life, even though most had stopped by age 21. While most
10 of the respondents reported that religious organizations did NOT play an important role
11 in recovery, this was attributed to the fact that many conservative Texas coastal churches
12 viewed any addiction as a moral weakness and an active choice. Conservative churches'
13 doctrine particularly were found to represent addiction as sin and to judge those who are
14 addicted as sinners. This attitude by the church prevented members from seeking
15 addiction help from, or through, church organizations (Turner, O'Dell & Weaver, 1999,
16 p. 146).

17 A study among 250 adult women from the Atlanta, Georgia metropolitan area,
18 known for having high rates of drug abuse characterized by frequent drug sales and
19 widespread drug abuse, found that women who were more religious tended to use drugs
20 less than their counterparts who were less religious. This study clearly indicated a
21 negative correlation between religiosity and drug use among "at risk" women (Klein,
22 Elifson & Sterk, 2006, p. 49).

1 Research conducted among 30 African American women, between the ages of 18-
2 56 in Rural North Central Florida; found that their ability to stop using cocaine, whether
3 long-term or short-term, was influenced by religious beliefs. All of them had Christian
4 upbringing and thus relied on their belief system to regain and/or maintain sobriety even
5 if only for short periods. Most of them were engaged in some form of religious rituals
6 throughout the process of their personal drug use. They embraced and internalized the
7 traditional Protestant religious values (Brown, 2006, p. 34-35).

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Chapter Three

17

Research Methodology

18

 In contrast to quantitative studies that rely on experimental study and statistics,
19 this research work is based on qualitative data; case study is the methodology I followed.

20

Qualitative Research studies primarily deal with the understanding of people's experience
21 and use a humanistic, interpretive approach. Narrative data are investigated to elucidate

22

phenomena which occur in a naturalistic context; it seeks not quantifiable answers but
23 purports to develop and expand hypothetical constructs or concepts, in order to help

1 understand social phenomena observed in natural settings; it emphasizes the subjective
2 meaning of the experiences and views of the participants (Matveev, 2002). The focus of
3 qualitative study is to understand the experiences of recovered alcoholics and their
4 specific reflections regarding those recovering experiences.

5 The goal of this qualitative study is to understand and to identify the meaning of
6 intervention for study participants. It is to understand the events, situations, and actions
7 involved in their recovery and the influence that this context, especially religiosity had on
8 their recovery, that is, how their actions influence their lives, how the process by which
9 events and actions take place and how their perspectives of the realities of their situations
10 led to recovery.

11 The merits of a qualitative approach are that it lends itself to a more realistic feel
12 of the world that cannot be experienced through just numerical data and statistical
13 analysis, the basis for quantitative study. There is a greater flexibility for data collection,
14 use of a more non-structured methodology way, and data analysis and interpretation of
15 collected information that captures the subjective essence of how individuals recover. It
16 is a more holistic view of the social phenomena under investigation. Finally it allows
17 interaction with the participants of the research study in their own language and on their
18 own terms thereby allowing conclusions from the study based upon descriptive, yet
19 primary and structured subjective data.

20 The limitations of qualitative studies are difficulty in explaining the differences in
21 the quality and quantity of information gathered from such different participants who
22 may arrive at different perspectives and therefore different, highly subjective and/or
23 inconsistent conclusions. The results are less generalizable to a larger general population

1 because of a limited number of participants, a fact which can also limit the type and
2 power (i.e., how robust) the statistical analyses available used would be. A final
3 limitation is that the researcher might allow his, or her, own subjective bias to influence
4 the study findings, or conclusions, again compromising objectivity and generalizability.

5 Case study methods have their origin in social anthropology and draw on the
6 principles of naturalistic inquiry. Case studies are deemed an appropriate research design
7 when examining process and outcomes in dynamic health care organizations, where it is
8 important to gather multiple perspectives. Interviews, observation and documentary data
9 analysis are the three principal methods of data collection in a case study (Payne, Field,
10 Rolls, Hawker & Kerr, 2007). Case studies are used in a number of fields, to include
11 psychology (Flower & Epting, 1976) and mental health (Turner-Shults, 2002). Selection
12 of participants in this particular study was based first on my professional acquaintances
13 with the participants, and secondly on the participants willingness to volunteer to
14 participate in the study. In order to facilitate data gathering in the study, I formulated a
15 set of standardized questions for each interview and I documented participants'
16 demographic factors such as, age, gender, military service, previous occupation(s), and
17 marital status.

18 **Description of the Medical Facility**

19 The Chillicothe VA Medical Center (VAMC) provides a wide range of mental
20 health and nursing homecare services to all veterans residing in southeastern and central
21 Ohio (see Appendix A). The facility has a total of 297 beds which includes 35 medical
22 beds, 25 mental health beds, 25 psychosocial residential rehabilitative program (PRRTP)
23 beds, 50 domiciliary beds and 162 community living center beds. Specialized inpatient

1 mental health programs include a Substance Abuse Treatment Program (SATP) and a
2 Dual Diagnosis program. An active ambulatory care setting includes separate outpatient
3 Mental Health and Post Traumatic Stress Disorder clinics; specialized women veterans'
4 clinics are also available. This VA facility operates five community based outpatient
5 (satellite) clinics (aka CBOCs) in Athens, Cambridge, Lancaster, Marietta and
6 Portsmouth Ohio; these clinics offer outpatient primary care, specialty mental health
7 services and several community programs, such as, community based nursing home,
8 residential, home-based primary and overall community care coordination.

9 I owe deep appreciation and profound gratitude to the veterans who were in
10 uniform and those who are in uniform. These are people whom I serve in my daily
11 ministry as a professional chaplain. As a Chaplain, I am part of the mental health care
12 team who try to provide the best care for the veterans. The team consists of
13 psychologists, medical doctors, social workers, therapists, physician assistants, nurse and
14 nurse practitioners. I give orientation to the participants on chaplain services, make
15 spiritual assessments, complete consult notes, teach classes on spirituality, provide
16 reading materials on religion/spirituality, participate in treatment team meetings, attend
17 morning meetings with the staff & participants, hold religious services, do one-on-one
18 counseling and hold memorial services among many other things.

19 Post traumatic stress disorder (PTSD), traumatic brain injury(TBI), substance
20 abuse, and co-occurring psychiatric disorder are few of the many struggles veterans face
21 on daily basis at Chillicothe Ohio VAMC.

22 PTSD is a type of anxiety that affects people who have had a particularly
23 traumatic experience that created fear, horror, hopelessness or helplessness. About one in

1 five OIF/OEF veterans now seek help for PTSD symptoms. According to American
2 Psychiatric Association (APA), the hallmark of PTSD symptoms include re-experiencing
3 the particular traumatic event, nightmares, flashbacks, physiological responses to fear,
4 extreme measures take to avoid reminders of the event, an overactive startle response,
5 and detachment from people, surroundings and activities. The destructive impact of this
6 syndrome includes reduced marital satisfaction and divorce, relationship or interpersonal
7 difficulties outside the home, abuse within home environments, homelessness,
8 unemployment, poly substances abuse and heightened risk of suicide or homicide. PTSD
9 frequently co-occurs with substance abuse and other mental disorders, especially
10 depression.

11 Traumatic Brain Injury (TBI) is also frequently encountered in our new returnees
12 from combat. It is estimated that half of all physical injuries to veterans are TBI related
13 usually due to explosions and blast injury. Injuries are caused by being hit in the head
14 with an object and or being thrown in the air and landing on their heads in addition to
15 direct and indirect concussive pressure effects upon the brain. Co-occurring psychiatric
16 disorders are common. The overwhelming majority of co-morbid diagnoses are:
17 depressive disorder, sleep disorder, stress disorder, mood disorder, anxiety disorder,
18 personality disorder, neurotic disorder, tobacco use disorder, bipolar disorder, explosive
19 disorder and substance induced mood disorder, some with suicidal ideation.

20 Substance Abuse issues are pervasive in and after military service. The disorder
21 may have occurred before they left home for service, during service/war, or after
22 returning home. "Many in the military personnel see drinking heavily as a rite of passage
23 or as part of their military culture....Many describe smoking cigarettes as a way to pass

1 time. Often, what may start as a social practice or coping strategy can (later) become an
2 addiction" (Eggleston, Straits-Troster, Kudler, 2009). Many of those suffering from
3 alcohol dependence and/or poly substance dependence, such as cocaine dependence,
4 cannabis dependence, heroin dependence, opiate dependence, marijuana dependence and
5 abuse of prescription drugs seek help through the VA.

6 Medical/physical problems are also often present especially as veterans' age. To
7 list but a few, there are Hepatitis B and C, chronic back pain, degeneration of cervical
8 intervertebral disc, chronic obstructive pulmonary disease, chronic pancreatitis, blurred
9 vision, hyperlipidemia, dysphagia, diabetics, bronchitis, sprains and strains, dermatitis,
10 male erectile disorder, gastroesophageal reflux disorder, obesity, hypertension, nausea
11 and vomiting. Gender related problems among female veterans such as sexual abuse;
12 sexual trauma, spousal abuse and domestic violence have been on the rise. Many female
13 veterans who serve in combat areas experience military sexual trauma caused by fellow
14 military personnel.

15 **Challenges for VA Chaplaincy**

16 In my ministry as a chaplain at the VA, I face many daily challenges. First of all,
17 there exists a nationwide policy of separation of state and religion which is closely
18 monitored in any of our government funded facilities. Like the founder of Alcoholics
19 Anonymous, the mental health care professionals at Chillicothe VAMC never advocate,
20 nor discourage, any patient/client from practicing his or her personal religion.

21 Lack of acceptance and appreciation of the role of chaplaincy in mental health
22 treatment programs by mental health professionals and its care participants remains a
23 challenge in my VA ministry. As a professional chaplain I typically know more about the

1 language of mental health care providers vis-à-vis their respective fields than they know
2 my language as a chaplain. Staff tend to minimize and/or underutilize relevant religious
3 resources found readily at the disposal of any VA chaplain, especially those who are
4 involved in the Twelve-Step recovery process. At this VAMC, I am allowed one hour on
5 a weekly basis to teach spirituality classes in SATP. What surprised me is that, on the
6 one hand SATP is based on Twelve-Step Spirituality; while on the other hand, each
7 individual chaplain has such a limited and circumscribed role to play in the care program.

8 Some, if not many, of the participants, although brought up in a Judeo-Christian
9 faith tradition, seem to lack the basic knowledge of how and when to seek professional
10 help from chaplains. To some of them, I am seen as "a man of the collar" who represents
11 only organized religion and all that that represents to them. Often they are unaware that I
12 am not there to preach, but to provide emotional and spiritual help in this most difficult
13 time in their life. Some of the veterans, perhaps as a direct consequence of very complex
14 mental illness, come to me feeling isolated, unworthy and hopeless. They have lost their
15 faith in themselves and find it hard to see it in others, including me.

16 As stated previously, the Twelve-Step Spirituality emphasizes a Higher Power as
17 "God" rather than the traditional Judeo-Christian concept of God. As a chaplain I must
18 limit myself to speak about spirituality and often apart from religion. I am deeply
19 convinced that providing pastoral ministry to these veterans, who are actively fighting
20 their personal addictions, is also a great way of expressing deep appreciation and my
21 gratitude for what they have sacrificed in the military while serving our country. If I can
22 but share their journey of faith/spirituality on their way to a personal recovery, my role as
23 a chaplain is satisfied; if I can bring them back to faith based assistance and support,

1 along their journey, then my role is even more personally fulfilling. Most veterans in the
2 mental health programs do not actively seek out our chaplain service; I reach out to them.

3 The basis of any pastoral care is to build relationships based on mutual respect
4 and trust. It is truly difficult for many of our veterans to trust our doctors and non-
5 medical staff, sometime because of past unhappy experiences with the VA system.
6 Therefore, to place trust in me as a VA chaplain must also be difficult because, for some,
7 I also represent the VA system. Once veterans realize that I am there to empower them in
8 their recovery and spiritual progress, they then express appreciation for my role at the VA
9 and my ministry to them. As a consequence, I constantly make a cautious, but conscious
10 and concrete pastoral approach to establish positive, and mutual, trust and respect.

11 I have become acutely aware that an important contribution to SATP is to simply
12 make it clear how my role as a care professional from the field of faith/spirituality can,
13 and will, help others in personal recovery. My heritage is multicultural. My roots, an
14 Asian and Indian from the historical context of a Christian Catholic community that is
15 two thousand years old and governed by colonial British Empire for over three centuries,
16 led me, early in life, to seek training about English laws and their court system. This
17 background (i.e., I am a member of the Indian bar) later allowed me to more intuitively
18 and intimately understand how majority rule interacted with and toward minority
19 interests, (e.g. Muslims, Hindus and Buddhists and their faith systems during my ministry
20 in India) and, as a result, I can more readily and react helpfully to the very diverse patient
21 population that I serve. It helps that I have always been encouraged and supported by the
22 members of a large and successful Indian, faith-based community in America.

1 Another issue I considered was the fact that I do not have a military background.
2 Could I really come to understand the stresses of military life and the effects of the
3 pressure of combat? I found that what the veterans wanted and needed is non-judgmental
4 empathy and acceptance (Rogers, 1951). I love and have read much history so I know
5 just how important the service of our veterans has been.

6 Finally the issue was raised by American physicians I met from urban
7 backgrounds concerning the challenges presented by practicing in an Appalachian
8 culture. They noted that the people are deeply suspicious of all authority figures to
9 include high school teachers, doctors, administrators, lawyers, law enforcement officers
10 and even work supervisors. In a more positive vein, their religious faith is pervasive and
11 the number of their churches is very large. With relatively small congregations across
12 many churches in rural areas, trust can be gained in time and once accomplished, these
13 people can be intensely loyal and warm.

14 Spiritual assessment is the process by which a chaplain provider evaluates the
15 spiritual outlook, spiritual needs and wishes of a veteran and develops a plan to meet
16 those needs. In the VA medical centers this is done by chaplains, chaplain interns and
17 chaplain residents. Assessment is necessary in order to meet the spiritual needs of each
18 veteran as part of the facility's care of the whole person. It is also necessary to determine
19 how religious and/or ethical concerns of the veteran can impact his or her health care
20 needs. Lastly, VA, VHA and JACHO guidelines require each accredited facility to
21 complete spiritual assessments to meet and fulfill the spiritual care of patients/veterans.

22 Many of our veterans go through a spiritual struggle in their most difficult days.
23 Spiritual struggle comes about when a person has tension and conflict which involves his

1 or her sense of relationship to the Divine, to religious institutions or to their teaching and
2 to personally held beliefs and values. Spiritual struggle is recognizable as loss in
3 meaning and purpose, despair, anger at God, grief or loss/change, hopelessness, feeling
4 punished or abandoned by God/others, guilt or reconciliation and so on. My role as a
5 "spiritual clinician" is to identify where and how veterans experience spiritual struggle
6 and their level of religious/spiritual coping. I then develop a mutual language using my
7 dialects for assessing veterans' spiritual needs/hopes/expectations and offer a framework
8 of pastoral diagnosis, care and positive prognostic change.

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Chapter Four

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Results of the Study

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All the participants in this study have used alcohol and drugs beginning as early as age 14 years old to as late as 45 years old. They used substances from 14-29 years; they have been sober from 7-22 years. All of them sought treatment, and have remained sober; they no longer use substances. Participants' ages vary from 43-60 with a mean of 51 years. Except for one, all participants were males. Participants were veterans and

1 represented all branches of the US military, except US Navy. Active service ranged from
2 2-10 years.

3 **Of primary importance in this study, that is, the dependent variable, or**
4 **criterion measure, was what is the role of religious beliefs and practices in recovery?**

5 This study found that for four of the six participants, religious beliefs and practices did
6 NOT contribute to their recovery. Participant A specifically relied on religious beliefs to
7 recover; for participant B, religious beliefs and practices plus Twelve Step spirituality led
8 to her recovery. But for participants C, D, E and F, religious beliefs and practices did not
9 contribute in a primary way to early recovery. The Twelve Step program, having a
10 sponsor and practicing personal spirituality helped, but specific religious beliefs and
11 practices, per se, were not believed to have been primary in their recovery efforts.

12 **A similar question, "what contributed the most for your recovery?" was**
13 **supported by the above criterion findings.** Participant A considered religious beliefs
14 and practices, attendance of AA and NA (Narcotics Anonymous) meetings with
15 participation in their Fellowships, and involvement in church, AA and NA services to be
16 major contributors to his current sobriety. Likewise, participant B attributed her recovery
17 to a combination of a) Divine intervention, b) Twelve Step program, c) the desire and
18 willingness to remain in recovery, d) social support from family, friends and colleagues
19 and e) religious beliefs. For these two participants, church and God helped them to
20 remain sober, the steps of AA kept them focused, and religious practices continue to keep
21 them balanced and well grounded. For Participants C-E, the Twelve Steps and
22 willingness to work this program contributed most to recovery. Having a sponsor,
23 attending AA meetings or aftercare and doing service work continued mightily to

1 sobriety. Participant F said his personal relationship with God combined with the above
2 AA practices, not traditional religious beliefs, contributed the most to his recovery.

3 In order to investigate whether any of the other survey questions would assist in
4 understanding why only two of six participants felt this way, a close look at the answers
5 given to survey questions was re-examined with the following results.

6 **1. Religious Upbringing and practices:** Most of the study participants
7 experienced a traditional, Christian based upbringing. Three of the participants attended
8 worship services on a regular basis, two attended occasionally and one rarely, if ever such
9 services. As expected, participants A and B regularly while participants C and D attended
10 church only occasionally. Contrary to hypothetical expectations, both participant E and
11 participant F attended church worship on Sundays on a regular basis albeit only until the
12 preteen to teen years.

13 **2. Reasons for substance abuse:** The reasons for substance use varied and did
14 not seem correlated to the absence or presence of religiosity. Peer pressure for two
15 participants, trauma as causal for one female and one male and genetic pre-loading for
16 the remaining two participants was discovered through survey questioning.

17 **3. Substances they used:** Substances used also varied and did not correlate to
18 religiosity. Three participants used beer. Vodka and hard liquor was used by three
19 participants. Five of the six subjects used illicit substances, such as, marijuana, cocaine,
20 heroin, or hashish, in addiction to alcohol.

21 **4. Duration of their use:** Findings revealed that the first participant used
22 substances from age 16 until he was 45 years old. His use was for 29 years and sober for
23 last seven years. The second participant started using at age 18. He used for 12 years and

1 is sober for 12 years. The third participant started at age 17, used for 27 years and has
2 been sober for 9 years. The fourth participant used for 22 years after starting at age 17; he
3 is sober for 21 years. The fifth participant started to use at age 16, used for 17 years and
4 is sober for 22 years. The last participant began use at age 14. He used for 17 years and
5 is sober for 12 years. No predictable relationships were found between this variable and
6 the recovery question.

7 **5. Severity of their use:** Severity of the substance abuse did not vary. All
8 participants were considered "very" severe. Without variation, this factor could not be
9 used to predict recovery methods used.

10 **6. Practices of spirituality when they used substances:** As already noted, four
11 participants had religious beliefs while using substances, but two of them never practiced
12 on any regular basis.

13 **7. Things that prompted them to seek help** varied somewhat although all
14 participants suffered from failed relationships, one of whom experienced a complete
15 "nervous breakdown". Spending time in jail also prompted two of the above participants
16 to alter their lifestyle. Insufficient variation of this factor led to no discernible relationship
17 between perceived reasons for help seeking and religiosity.

18 **8. Treatment Modality they sought:** All of them attended a Twelve Step type of
19 treatment programs with typical recovery meetings; one of them attended this kind of
20 program thrice. Two also participated in active aftercare programs and two never showed
21 relapse. Variation here was less evident as all participated in AA but only two of four, as
22 noted above, believed that religious beliefs are primary factors in their overall recovery.

1 regularly attended worship service. One stopped believing in Christian religion when his
2 mother when he was nine. One participant occasionally attended church service with his
3 mother; his father resented organized religion. Three of six participants regularly attended
4 worship services with both their parents. Except in the case of one participant, fathers did
5 not play a primary role in their religious upbringing and overall adult social and
6 psychological development. Except for the father of one, all were Christians.

7 Five of the participants started to use alcohol and drugs while they were in High
8 School. The novelty of experimentation, peer pressure, fun, seeking relief from emotional
9 pain were all factors leading to drug and alcohol abuse. One considered it the social
10 norm-an acceptable and accepted social outlet. Two used substances to deal with Post
11 Traumatic Stress Disorder, one from Vietnam and the other from domestic violence. All
12 used substances while serving on active duty in the military- principally due to easy
13 availability and low cost. Four of six participants came from alcoholic families; the
14 parents of two participants and the grandparents of two other participants were
15 alcoholics. Two participants, after returning from military, lived with addicted spouses.

16 All of them sought Twelve Step program as their primary treatment modality.
17 Two participants attended a detoxification program prior to attending a Twelve Step
18 program. One sought pastoral counseling before her Twelve Step program; 3 of 6
19 voluntarily sought help. When one participant was given a choice to attend Twelve Step
20 program or go to prison, he chose the latter. Another's treatment for PTSD and depression
21 led him to a Twelve Step Program. One participant attended Twelve Step program three
22 times before achieving sobriety; one participant never relapsed once he completed his
23 first Twelve Steps. None of the participants could hold a steady job due to substance

1 dependency; five of them had failed marriages. Four were homeless for a time while
2 three of them spent time in prison or county jails.

3 Religious beliefs and practices did not play a significant role in the recovery of, at
4 least, four out of six participants. One participant utilized religious beliefs and attended
5 Twelve Step program to recover; for the other, religious beliefs and practices played only
6 a partial role in her total recovery from addiction. She, however, was the only participant
7 who practiced her religious beliefs actively while she was still using a variety of illicit
8 substances. Three of the four searched for answers to define the purpose and meaning of
9 life, but this search occurred outside of the type of organized faith tradition in which they
10 grew up. They turned to Eastern Culture, Hinduism, Buddhism, Hare Krishna Movement,
11 Shamanism and Christian Sufism, instead. One participant had religious beliefs during
12 the time he was using substances, but never actually practiced it; he actively practices
13 now. The Spirituality of Twelve Step programs did help two participants return to their
14 faith tradition; two participants entirely turned away from early religious beliefs and
15 practices.

16 In conclusion, Alcoholics Anonymous' Spirituality did play a significant role in
17 the recovery of all the participants. Currently all the participants have some form of
18 spiritual beliefs and practices in addition to the basic practice of AA spirituality to keep
19 them staying sober. AA spirituality did help them to recover, but it alone did not help all
20 of them to become sober. Is there a correlation between substance dependency and
21 dependency upon some form of belief in a Higher Power, traditional or non-traditional?

22 This study disproved the hypothesis that religious beliefs and practices alone (or
23 primarily) help people recover from addictions. The results of this study do support the

1 hypothesis that religious beliefs and practices along with AA spirituality can help addicts
2 and alcoholics recover and maintain sobriety. But Alcoholics Anonymous spirituality
3 alone, as reported by the participants in this study did not help long term sobriety remain
4 so once the participants initially recovered.

5 All the participants in this study attended the Twelve Step based program. The
6 spirituality of Twelve Steps played a major role in the recovery of all participants from
7 alcohol and drug addiction. Three participants in this study have organized religious
8 beliefs and practices at present. Alcoholics Anonymous remains as the most common
9 substance abuse treatment modality for the participants who underwent this study. The
10 Twelve Step philosophy emphasizes "spiritual transformation" as the fundamental
11 component of recovery from substance abuse and dependency.

12 Of note, in addition to an emphasis on the spiritual realm during AA treatment, other
13 positive cognitive behavioral changes reportedly took place whenever the participants
14 attended AA meetings, worked one-on-one with their sponsors, and reread the Big Book
15 and other relevant reading materials. All of these activities helped the participants to
16 become sober. These steps reflected different components of the recovery process. Their
17 participation in these processes reinforced the idea of "loss of control" over substance
18 abuse and the implicit conceptualization that countering the defense mechanisms
19 underlying such behavioral changes (e.g., sobriety) is fundamental to understanding how
20 to effectively overcome substance dependency.

21 Religious beliefs and practices, along with the Twelve Step program, did not
22 serve as a primary protective factor against substance problems among these participants.
23 For some participants, for whom religion/spirituality is more salient, a

1 religion/spirituality based treatment programs may be the most effective. Once the
2 participants became involved in Twelve Step programs, they began to enjoy
3 religious/spiritual practices like prayer, meditation, scripture reading, and public worship
4 service. They listened to the stories of others who had identical abuse problems, took
5 personal inventory of their lives, corrected their defects, surrendered to a God/Higher
6 Power and made restitutions necessary to precede with full recovery. Thus, although it
7 may not constitute religion per se, a Twelve Step program does promote basic religious
8 beliefs and practices such as rituals, prayers, meditation, scripture reading and works of
9 charity among its participants. Their participation in Twelve Step programs helped them
10 to accommodate such diverse religious/ spiritual belief systems as shamanism and
11 Christian Sufism, which in turn helped them to be more flexible, open minded, supportive
12 in their daily lives.

13 **Implications of the study**

14 This paper supports a positive relationship between religion and spirituality and
15 highlights the importance of religious and spiritual elements present in substance abuse
16 treatment of the participants' recovery and sobriety. Inclusion of religious/spiritual
17 mechanisms within the substance abuse treatment plans, or any other form of
18 inpatient/outpatient therapeutic practice, should not be a new or novel addition to
19 standard mental health care by today's healthcare professionals. Clearly this is the case
20 for this study's participants who are currently involved in working as addiction therapists.

21 These findings suggest the importance of accelerating newer Substance Abuse
22 Treatment Program paradigms toward a greater linkage between religious and spiritual
23 based treatment programs. Traditional approaches to substance abuse treatment programs

1 typically have rejected, prima facie, the therapeutic values of the religious/spiritual
2 experience and therefore conflated hostility to religion with hostility to spirituality. These
3 findings also suggest controlled studies to determine if the unveiling, or simple inclusion,
4 of religious beliefs/practices (the primary inner resource for those participants who had
5 believed in religion while growing up) in substance treatment can produce even more
6 positive outcomes.

7 Blagen and Yang (2008) wrote that while religion may be seen as a social
8 institution with specific and often rigid beliefs, practices, and rituals shared by a group of
9 people, spirituality is typically based on personal and individual experiences without
10 specific (institutional) boundaries. If addiction is considered a spiritual disorder (a theory
11 recognized by treatment programs, but oft neglected by empirical research) and if clients'
12 own unique belief systems are influenced by religion and spirituality, then recent
13 developments in positive psychology and the integration of spirituality and psychology
14 might make "courage and hope", for example, not just psychological constructs but the
15 primary factors in any treatment recovery model (Blagen & Yang, 2009). From this
16 newer perspective, it will be important to understand that many beliefs in the Christian
17 tradition may provide answers to the quest for the "courage and hope" that are needed to
18 attain full recovery. Blagen and Yang (2008) wrote:

19 We live in a troubled world and we often work with individuals who struggle for
20 meaning and spiritual direction. A primary goal of counseling is to creatively
21 facilitate healthy changes that bring about courage and hope. The authors
22 attempted to examine courage and hope not only as universal virtues as indicated
23 in positive psychology but also as cultural values and spiritual gifts. An

1 understanding of the client adherence to courage and hope as defined in his/her
2 cultural and spiritual heritage allow us to better use these constructs to assist the
3 client in times of adversity and difficulties (p. 7).

4 Adopting integration of religious beliefs and practices in Twelve Step treatment
5 programs requires both openness to new available information and considerable courage
6 to confront prevailing norms. It may be a challenge for some mental health practitioners
7 to discuss comfortably with their clients about their religious and spiritual beliefs and
8 practices and integrate them in their practice. The goal of integrated mental health care
9 approach is to weave therapeutic insights into what is essentially a spiritual process. The
10 challenge is to create an effective integration of the participants' belief systems in their
11 health care treatment. Therapeutic interventions based on premises endorsed by parties,
12 the practitioners and the participants, may be more effective. Several studies support a
13 relationship between religion/spirituality and positive outcome in substance abuse
14 disorders. Practice of religion/spirituality may protect against disease indirectly by
15 association with a healthy lifestyle.

16 This paper suggests what the present Twelve Steps treatment program lacks, and
17 what may actually hold the key to real recovery paradigm, is to integrate existing wisdom
18 and resources which come from other sources like religious beliefs and practices of the
19 participants. In the light of practice of religious belief system, alcoholics not only
20 aggressively resist their abuse, but also come to redefine their identity not as victims of
21 substance abuse, but as they have the ability, courage and ultimately the power to
22 overcome substance abuse.

1 To be relevant and effective, mental health professionals may need to reframe
2 both clinical and rehabilitation approaches to accommodate religious beliefs and practices
3 and integrate them in their practice. This means a realistic reframing of the treatment
4 program approach from the providers' perspective to the participants' perspective. This
5 new approach, integrating religious beliefs and practices into Twelve Steps treatment
6 program can open the door to a new and deeper vision of recovery. In other words,
7 professionals may meet their clients' religious and spiritual needs in a sacred spiritual
8 space.

9 This study contributes to the existing body of literature relating to the effect of
10 religious beliefs and practices in the recovery process as well as for maintaining sobriety.
11 The observed results while encouraging, need to be interpreted in the light of limitations
12 such as only six veterans participated in this study.

13 **Limitations of the study**

14 This study contributes to the existing body of literature related to the effect of
15 religious beliefs and practices on the recovery process and the maintenance of sobriety.
16 The observed results, while generally encouraging, need to be interpreted in the light of
17 several aforementioned limitations, such as, a sample size of only six veterans. Besides
18 sample size, substance abuse related problems found in veterans, especially while in the
19 military, may be quite unique from the same problems if found in the general public.
20 Two of this study's subjects actually fought in combat in a foreign land. Thirdly, three of
21 this study's participants are currently Substance Abuse Treatment Counselors, again
22 limiting generalizability of the findings.

1 Despite the overall limitations this study, it does suggest that innovative
2 interventions through religious beliefs and practices are a feasible adjunct to the usual 12-
3 Step treatment program, especially for those who show interest in such beliefs and
4 practices. This study observed an overall association between the role of spirituality and
5 success in maintaining sobriety. Participants in this study viewed religion/spirituality as
6 essential for maintaining their sobriety; some, but not all, made religious/spiritual
7 programs a high priority in their overall recovery and in their lives as a whole.

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Chapter Six

19 Work Yet To Be Done

20 Other areas for future exploration would be to focus on the relationship between
21 substance dependency and the apparent inability to maintain a permanent (marital)
22 relationship. Another area worth studying would be the relationship between substance
23 dependency and the inability to hold steady employment and /or between substance abuse

1 and homelessness. Is there a relationship between substance abuse or dependency and the
2 children who come from substance abusing parents, grandparents and spouses? Why did
3 organized religious beliefs and practices fail to help all of them in their recovery efforts?

4 Presently the majority of mental health professionals consider AA to be an
5 effective group intervention with or without religiosity. As a result, AA has become the
6 focus of much more empirical attention than in the past. The movement from active
7 substance abuse to recovery and sobriety is a major life transition that continues to be
8 difficult, complex and all encompassing for the participants in this study and all of those
9 who are actively now trying to recover. . Participation in AA did help them to cope with
10 this painful transition, facilitate their final riddance of substance dependency use, helped
11 them to build up more healthy relationships, and become productive worker citizens.

12 There continues to be a growing interest in a religious/spiritual based approach to
13 other physical and mental health issues; the implications toward patients' overall health
14 and well-being cannot be understated. Physicians and other mental health care providers
15 should routinely take a history of their patients' religious/spiritual backgrounds in order to
16 determine how their patients can utilize religious/spiritual resources in their overall
17 recovery whether that is to cope with chronic illness, or otherwise. This effort on the
18 medical professionals' part will open the door better and future discussions about
19 religious/spiritual issues and quality of life. As there has been greater emphasis towards
20 integrating religious/spiritual resources into patients' health care field, more direct efforts
21 are being made to train all health care providers to listen more appropriately to patients'
22 religious/spiritual concerns and their requests to better understand their personal religious
23 practices.

1 Religious/spiritual beliefs and practices have always helped participants transcend
2 their own individual perspective and has given a sense of spiritual communion with
3 significant others, the universe, or something that lies outside their individual sense of
4 self. Religious/ spiritual practices like prayer, meditation, works of charity, reading
5 scripture empowered these participants to experience feelings of joy and happiness as a
6 direct result of encountering a transcendent reality. Religious/spiritual beliefs and
7 practices broadened these and other participants' view that they are not alone in their
8 suffering; it also taught them that they were not in control of everything.

9 All participants engaged in some kind of search for meaning; such a quest for
10 meaning was fundamental to the process of their recovery. While this process may, or
11 may have not, involved a radical departure from earlier held religious beliefs, their
12 appraisals of self in relation to others and God (or a Higher Power) were believed to be
13 an important way to ascribe some meaning to their experience of life, for better or worse,
14 in this world.

15 This shift, from a punishing God view (as exemplified in the case of one
16 participant who altered his quest for forgiving God toward a more forgiving view of self)
17 to more positive religious/spiritual mechanisms for growth then become the basis for
18 increased motivation to change, increased readiness for treatment and the eventual
19 elimination of substance abuse/dependency.

20 The participants' search for meaning in the midst of meaninglessness, feelings of
21 lost connection, community versus isolation from community, hope versus hopelessness,
22 was proof enough that all participants struggle with religious/spiritual issues while they
23 are trying to recover from substance misuse. Their quest for some kind of spirituality

1 enabled at least one participant to reconnect with the faith of his father's heritage, the
2 Jewish tradition, and helped two others to find peace through Shamanism and Christian
3 Sufism. This shows that none of the participants gave up their faith completely.

4 While it was true that most of them were not actively practicing and their
5 religious beliefs and practices were in a somewhat dormant state, when they did attend
6 the AA and Twelve Step programs, and they were restored from spiritual blindness into
7 the conventional wisdom of some kind of faith, whether or not it was directly related to
8 the faith of their parents and their own childhood religious upbringing. When they were
9 children they went to church with their parents; now they are adults and they make their
10 decisions on how to restore their faith through religious beliefs and practice.

11 While all of the participants were attending Twelve Step programs, they did
12 realize the values inherent in the integration of religious beliefs and practice and sobriety.
13 AA neither prohibits nor encourages members to have specific religious beliefs and
14 practices. Alcoholics Anonymous does advocate that its members create a personal
15 concept of their understanding of God/Higher Power; this does not have to be dictated by
16 religion or any specific authority. It is these religious beliefs and practices along with the
17 theory and practice of AA spirituality that seemed to help them remain sober.

18 Most typical substance abuse treatment programs make a distinction between
19 religion and spirituality; religion is viewed as organized beliefs and practices, whether
20 formal as in church affiliation and attendance, or informal like prayer, meditation and
21 scripture reading. This is in contrast with "spirituality" which is viewed as involving the
22 participants' relationship with self, others and some Transcendent but non-specific Higher
23 Power.

1 Spirituality is said to represent an integrative force in their lives providing
2 meaning and purpose, core human and moral values and principles for organizing their
3 lives. While this may blur the distinction between religion and spirituality, the concept of
4 specific religious involvement (e.g., attendance) may be useful in highlighting any future
5 relationships found between religious beliefs/ practices and spiritual beliefs/ practices.

6 Spiritual transformation involves transformation at an individual level and is
7 viewed as taking place within the context of Twelve Step process. While Twelve Step
8 programs are not typically tied to a specific religion, per se, they do involve some
9 constellation of beliefs and practices that can serve to engage the participants into the
10 collective process of facilitated changes in values, beliefs, norms, new cognitions and
11 ultimately altered substance abuse behaviors.

12 **Question raised in this study in need of further study:**

- 13 1. Is AA spirituality more effective in achieving sobriety while traditional Christian
14 Spirituality more effective for long term maintenance?
- 15 2. What is the exact relationship between the religious principles of the Oxford
16 Group and the current AA Twelve Step philosophy?
- 17 3. How often is substance abuse fatal for permanent marital relationships?
- 18 4. Are substance abuse and steady work habits inherently incompatible?
- 19 5. Is substance abuse a prerequisite for homelessness?
- 20 6. Do recovered addicts, not exposed to Christian religious practices as children, use
21 other personal or group religious practices to maintain their sobriety?
- 22 7. Why did all the participants flourish academically as adults after they became
23 sober even though they were not outstanding students in High School?

1 8. Why could the High School system not identify their academic potential when
2 they were adolescents?

3 9. Is PTSD prevalent in those addicted to drugs and alcohol prior to entering active
4 duty military service? Is the reverse true? Does PTSD lead to addiction?

5 10. Is the long term risk for substance abuse the same for children who have

6 a. alcoholic mothers

7 b. alcoholic fathers

8 c. alcoholic mother and father

9 d. alcoholic parents only,

10 e. alcoholic parents and grandparents?

11 In conclusion, I started with the conjecture that became my hypothesis, namely,
12 that religion played a primary role in drug addiction therapy, both in the acute recovery
13 and in the chronic management (i.e. maintenance) phases. I did not know what role
14 religiosity played in recovery nor did I know how prominent that role might be when
15 compared to other treatment variables. I did not have in- depth knowledge of the origins
16 and evolution of Alcoholics Anonymous nor did I have any deeply held, or rigid,
17 convictions that the conjecture was, or must be, true. Only after all of the interviews were
18 collated, did it become strikingly apparent that acute recovery predominantly involved
19 Alcoholics Anonymous principles. These principals had originated in Christian Protestant
20 tradition and later became highly secularized almost a century ago in a complicated and
21 contentious process whose echoes still reverberate in academic and therapeutic circles
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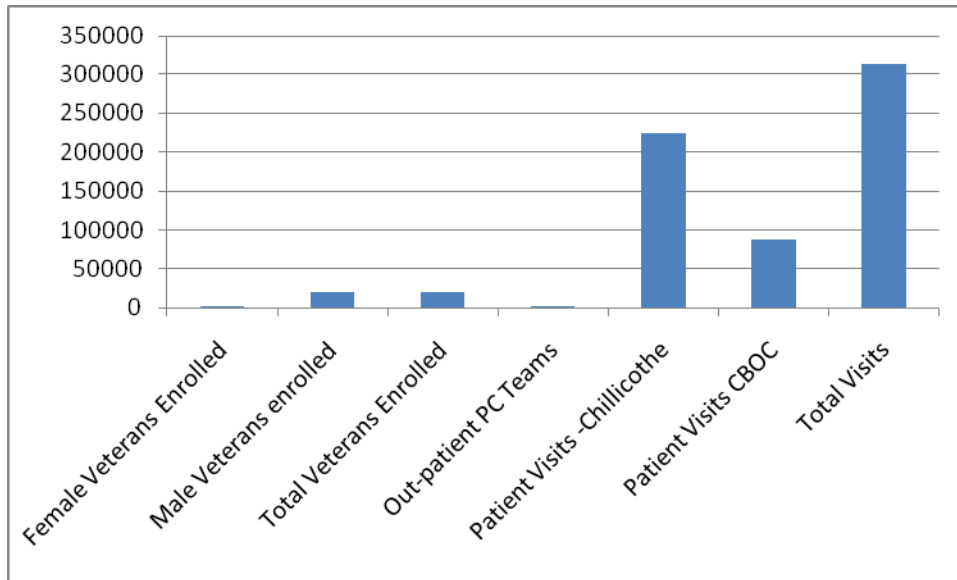
Chapter Eight: Appendices and Glossary of Terms

1 **Appendix A - Description of the Medical Facility**

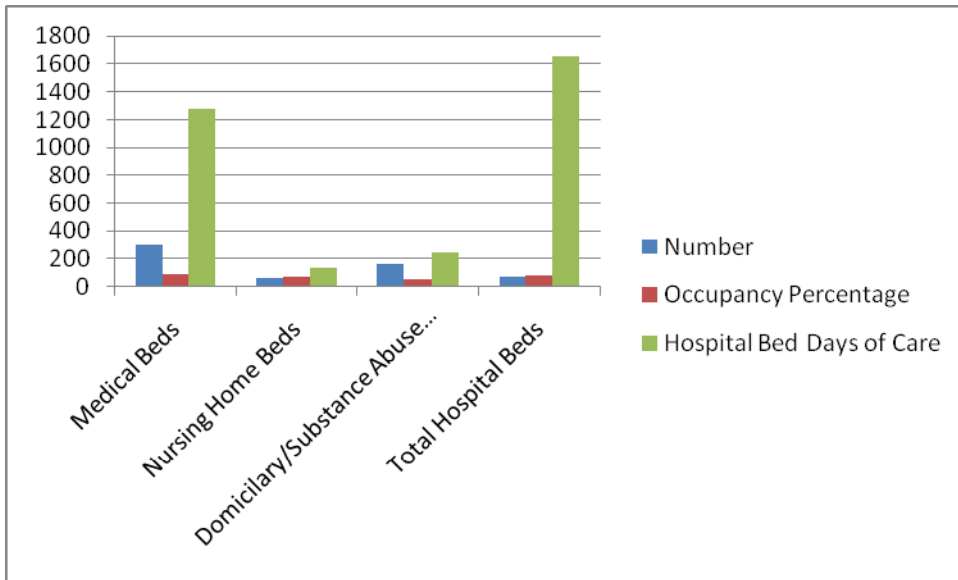
2 Chillicothe Veterans Affairs Medical Center (VAMC) and Community Based
 3 Outpatient Clinics (CBOCs) for fiscal year 2010 which serve the areas of South Central,
 4 Southeastern Ohio, Northern Kentucky and West Virginia. Chart 1 is enrollment data:
 5 Chart 2 is Bed Days by Location.

6

Female Veterans Enrolled	Male Veterans enrolled	Total Veterans Enrolled	Out-patient/Inpatient PC Teams	Patient Visits - Chillicothe	Patient Visits CBOC	Total Visits
794	20048	20848	10	223,808	88,270	312,078



Location	Number	Occupancy Percentage	Hospital Bed Days of Care
Medical Beds	297	87.64	1,281
Nursing Home Beds	60	74.33	132
Domiciliary/Substance Abuse Beds	162	48.65	244
Total Hospital Beds	75	76.99	1657
Total Hospital Bed Days of Care			95,003



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1 **Appendix B - Survey Questions**

- 2 1. What was your religious upbringing?
- 3 2. What are your current personal spiritual/religious practices (i.e., prayer, scripture
- 4 reading)?
- 5 3. What led you to substance abuse (e.g., type of substances used, how long did you
- 6 use and how severe was your use)?
- 7 4. What prompted you to seek help when you were using substances (e.g., were you
- 8 practicing any type of spirituality, what type of treatment modality you sought)?
- 9 5. Have religious beliefs and practices, if any, contributed to your recovery?
- 10 6. What are your organized religious practices (e.g. church attendance: how often,
- 11 how regularly (often, rarely, never); did you attend church)?
- 12 7. What is your "Core belief system"?
- 13 8. What would you say attributed the most towards your recovery?

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1 **Appendix C - Survey Answers**

2 **Participant A** is 52-year-old male who served in the US Air force from 1976-
3 1986 while stationed in countries such as Japan, the Philippines, South Korea, and in the
4 USA. He worked as a truck driver and a mailman prior to his current position as a
5 Chemical Dependency Therapist. He also holds a Master's degree in Social work. He is
6 married and has children and grandchildren.

7 **Religious upbringing:** His mother was a devout Christian. She was a single parent who
8 brought him up in the Southern Baptist faith tradition. His grandmother was the matriarch
9 of the family and played a great role in his religious upbringing. His mother and
10 grandmother took him to church regularly.

11 **Religious practices:** He attended Sunday worship and Wednesday bible classes.
12 Participation in Sunday worship services declined when his grandmother died. Due to
13 physical proximity the family attended the Roman Catholic Church also. He stopped his
14 religious and spiritual practices on regular basis when he joined the US Air Force.

15 **Reasons for substance se:** The novelty and excitement of experimentation and peer
16 pressure led him to alcohol abuse when he was in High School. Use of anything and
17 everything was important for acceptance by his peer group. When he joined the Air
18 Force, the use of alcohol was part of the culture of male bonding and building up
19 comradeship in the military.

20 **Types of substances used:** He used beer, wine and smoked marijuana at High School.

21 **Duration of substance use:** He started to use at age sixteen and continued to use until he
22 was 45 years old. He used substances for twenty-nine years and has been sober for the
23 last seven years.

1 **Severity of substance use:** His substance abuse was so severe that he was discharged
2 from the service. Once he was in civilian life, he was involved in illegal activities, which
3 resulted in felony convictions. He was in a penitentiary for 26 months for arson. Later
4 on he was convicted of drug abuse and was given a chance to choose either prison term
5 or attend the Twelve- Step program of alcoholics anonymous. He chose the latter. Due to
6 the severity of abuse he had three failed marriages and the fourth marriage was failing
7 when he became clean and sober. Use of drugs took priority over his marriages, and he
8 got to a point in his life where he felt there was no hope. He had experienced suicidal
9 ideations. He was homeless, jobless, and had no family relationships to provide
10 emotional support.

11 **Practice of spirituality during using substance abuse:** He continued to have religious
12 beliefs when he was using drugs. He was not practicing religion on a regular basis in the
13 traditional way. He sporadically attended worship services on important days like
14 Christmas and Easter and on certain occasions when he felt like attending. He practiced
15 spirituality while he was using substances.

16 **Things that prompted him to seek help:** Prison terms, failures in marriages and not
17 being a role model for his children prompted him to seek help. He reached a point when
18 he was feeling loss of hope and was feeling very suicidal.

19 **Types of treatment modality received:** He attended a four weeks' program of substance
20 abuse treatment based on the Alcoholics Anonymous model and participated in the
21 aftercare program for one year. These were the interventions that helped him to recover.
22 AA spirituality gave him a spiritual foundation for recovery. An aftercare program helped

1 him to establish healthy relationships and provided employment education. This was the
2 only treatment modality he sought for recovery. Since his recovery, he has not relapsed.

3 **Role of religious beliefs and practices in recovery:** Religious beliefs and the practice of
4 Alcoholics Anonymous spirituality contributed to his recovery. He incorporated his
5 religious beliefs and practices in his recovery. In other words, while practicing Twelve
6 Step spirituality, he relied on religious beliefs to recover. For him both are required for
7 recovery.

8 **Organized religious practices:** His current religious practices: He attends church
9 worship services often, once or twice a month, and bible study class with his 16 year old
10 daughter on a regular weekly basis. He also is involved in church activities.

11 **Personal spiritual practices:** His personal spiritual practices are prayer, meditation and
12 scripture reading and other devotional books. His other personal spiritual practices are
13 reading "Daily Reflections", a book of daily reflections by AA members for AA
14 members. He incorporates honesty, love and charity in his personal life in daily activities.

15 **Current core belief system:** His religious core belief system is based on Christianity
16 and he accepts Jesus Christ as his Lord and Savior. He believes in a God who is a loving
17 and forgiving, always there to welcome him back to His fold.

18 **Things that contributed the most towards recovery and maintenance of sobriety:**

19 Religious beliefs and practices, attendance of AA and NA (Narcotics Anonymous)
20 meetings and participation in their Fellowships, and involvement in church, AA and NA
21 services contribute to current sobriety. His church involvement leads to community
22 service and reintegrates with others outside of recovering fellowship. The church
23 involvement enables him to reengage in normal life, becomes aware of community needs

1 and inspires to reach out to others besides other addicts. The spirituality of the Twelve
2 Step and attendance at the aftercare program contributed the most for his recovery.

3 **Participant B** is a 43-year-old female who served in the US Army from 1989 to
4 1991 while stationed in South Korea for two years. She served in the Reserve until 1996.
5 Currently she is pursuing her studies in Addiction Therapy, Counseling, Physical
6 Dependency and Human Behavior. She worked at Lucent Technology and held many
7 temporary jobs in other fields. She is married and has children and grandchildren.

8 **Religious upbringing:** She was brought up in a family which belonged to different
9 denominations of Christian faith. She studied in a Catholic School as a child and attended
10 Roman Catholic Holy Mass.

11 **Religious Practices:** Once she left the Catholic School, she started to attend Baptist,
12 Episcopalian and other Christian denominations with her family members on a regular
13 basis. Religious beliefs and practices played a great role in her upbringing.

14 **Things that led to substance abuse:** She started to use alcohol and drugs while she was
15 in High School. Separation of her parents caused her emotional pain and led to the use of
16 alcohol and drugs in High School. Sexual trauma, physical abuse by her boyfriend and
17 extreme emotional pain after the removal of her children from her home due to her
18 emotional instability aggravated her dependency on drugs.

19 **Types of substances used:** Beer and cocaine were the preferred substances she used. At
20 the initial stage, she used any substance that would reduce or eliminate her emotional
21 pain.

22 **Duration of Use:** she started to use substances at the age of eighteen. She used
23 substances for fourteen years and has been sober for twelve years.

1 **Severity of the dependency:** The abuse and dependency was so severe that she was
2 homeless for a number of years, could not stick with her jobs, and moved from place to
3 place. Her grandfather was an alcoholic.

4 **Practice of Spirituality while using drugs:** When she was dependent on drugs, she often
5 went to church in an attempt to find the peace she needed to stop abuse. She often prayed
6 for relief from addiction to alcohol and cocaine. She never stopped practicing her
7 religious beliefs and practices while she was using drugs.

8 **Things that prompted to seek help:** she sought help out of sheer desperation. She did
9 not want to live the way she was living any longer and had a psychotic breakdown.

10 **Types of treatment modality she received:** Initially she sought help from her church
11 and received pastoral counseling; later she attended the Twelve Step Program at the VA
12 Medical Center. The combination of both helped her the most.

13 **Role of Religious beliefs and practices contributed to recovery:** Religious beliefs and
14 practices along with the Twelve Step spirituality contributed to her recovery. She
15 strongly believes that recovery is not possible without the combination of both religious
16 beliefs and practices along with Alcoholics Anonymous spirituality.

17 **Organized religious practices:** She regularly attends church worship regardless of
18 where she is at least once a week. She also attends bible study class along with her
19 husband on regular basis.

20 **Her personal spiritual practices:** are prayer, meditation and scripture reading, books
21 from AA and other religiously oriented books, and cultivating an awareness of God's
22 presence in self and in others.

1 **Current core belief system:** It is based on the teachings of the Holy Trinity. The
2 important elements are: to love the Lord Jesus as her God with all the strength of her
3 heart, mind, soul and body. The second is to love her neighbor as herself.

4 **Things that contributed the most for recovery:** She attributes her recovery to the
5 blessings of divine intervention, continued Twelve Step spirituality, the desire and
6 willingness to remain in recovery and social support from her family, peers, friends and
7 colleagues. She believes that a combination of all these elements contributed to her
8 recovery. She acknowledges the importance of attending AA and NA meetings especially
9 for users at the early stage of recovery. She is not attending those meetings now due to
10 the time constraints placed on her by her current academic studies.

11 **Participant C:** is a 53-year-old male who served in the US Marine Corps from
12 1971 to 1975. He served in Vietnam, Laos and Cambodia during the Vietnam War. He
13 has a Bachelor's Degree in Social Work and Psychology, and is a Licensed Addiction
14 Therapist. Currently, he is working as an Licensed Addiction Therapist. He was a
15 firefighter for eight years and suffered a work related injury and left the job. He is
16 divorced and is single.

17 **Religious upbringing:** His mother was Native-American and his father was an African
18 Jew. As a child, he was brought up primarily in his mother's faith tradition. His religious
19 beliefs and practices were taught by his mother. She taught him to respect nature and his
20 elders. She read stories from the bible and from other books. His mother died when he
21 was nine years old and his father was incapable of taking care of him. So he spent his
22 next few years with his sisters, aunts and grandmother.

1 **Religious practices:** His mother raised him in a Christian belief system, but he did not
2 have religious practices till became sober.

3 **Things that led to use alcohol:** At sixteen, he ran away from the family and joined the
4 Service by lying about his age. At the age of 17, he experienced intensely traumatic
5 experiences in the military. He thought he was going to be killed, so he started drinking
6 to give himself courage. This also eased his feelings of guilt and shame he experienced as
7 a survivor after his brother had died in the Vietnam War. He did not meet his family for
8 the next twelve years because of feelings of guilt and shame. He did not get a hero's
9 welcome when he returned from the war. Family and friends looked upon him with
10 suspicion and contempt. This intensified his Post Traumatic Stress Disorder (PTSD). It
11 was PTSD that led him to substance abuse.

12 **Types of alcohol used:** Vodka was his favorite alcohol drink and he drank one and a half
13 quarts daily; it was uncontrollable. He preferred hard liquor compared to beer.

14 **Duration of alcohol use:** He started to use alcohol at the age of seventeen and used it
15 for 28 years from 1972 to 2000. He has been sober for nine years.

16 **Severity of alcohol use:** Due to severity of his alcoholism, he could not hold jobs and
17 was hospitalized on numerous times. He was in and out of jail on a regular basis and
18 moved from state to state, was homeless for a few years and had two failed marriages.
19 The failure of his first marriage was caused by his immaturity and the second was
20 definitely due to his drinking. He started to use alcohol when he was in Vietnam and
21 used it for twenty-eight years and has been sober since the year 2000. He has never
22 relapsed.

1 **Practice of spirituality while using alcohol:** He was not practicing spirituality while
2 drinking. It was impossible for him to practice spiritually and continue to drink. To him
3 that amounted to hypocrisy. However his religious beliefs were always there. At no point
4 in his life did he give up on faith. He held on to his faith though not practicing it in an
5 organized religious manner.

6 **Things that prompted him to seek help:** His treatment for PTSD, depression and
7 failed marriages led him to detox and the Twelve Step program. He received counseling
8 only for PTSD and depression.

9 **Treatment modality:** Spirituality found in AA's Twelve Steps was the only spiritual
10 treatment modality he utilized for recovery. AA spirituality gave him a solid foundation
11 and helped him look at spirituality separate from religion.

12 **Role of religious beliefs and practices in recovery:** Religious beliefs and practices did
13 not contribute to his early recovery. However once he was grounded in AA spirituality he
14 was able to look back to his Jewish faith tradition and embrace it wholeheartedly. When
15 he returned from his military service, he thought that religion would help him put his life
16 back in order and he started to attend church. But he never felt connected and did not fit
17 in. Rather, he experienced isolation and loneliness. He felt that Christianity did not
18 provide him the answers he was looking for. He was always in search of truth.

19 **Organized religious practices:** He did not have any religious beliefs and practices when
20 he was using alcohol. When he was in Vietnam he became interested in Eastern Culture,
21 Hinduism and Buddhism. His organized religious practices are attending synagogue on
22 Sabbath and on Holy Days and observing Jewish religious traditions and rituals to the
23 best of his ability on regular basis.

1 **Personal spiritual practices** are reading the Torah, prayer, meditation and performing
2 good deeds. AA spirituality taught him how to apply spirituality in practical life
3 situations. Standing firm on spiritual grounds he is able to embrace people of different
4 denominations and religions and follows a policy of tolerance towards other religions. He
5 feels comfortable visiting houses of worship of other religious faith. Spirituality gives a
6 very broad outlook towards his life, his relationship with others and finally with God.

7 **Current core belief system** is that through the AA spirituality he reconnected with the
8 God of his understanding, and found Him to be the God of his youth, which in time led
9 him back to his Jewish faith and tradition. Practice of Steps Ten and Eleven in Twelve
10 Steps helped him to rediscover his religion. His religion teaches him to love God, himself
11 and others.

12 **Things that helped him the most to recover:** AA spirituality and religious beliefs
13 helped him to recover physically, mentally, emotionally and spiritually. God helps him to
14 remain sober, the Steps of AA keeps him focused, and religion keeps him balanced and
15 well grounded. Both religious beliefs and practices along with AA spirituality contributed
16 to his recovery and stay in sobriety.

17 **Participant D** is a 60-year-old male and served in US Army from 1969 to 1971.
18 He was in Vietnam for 18 months. He is divorced and single. He is a Licensed
19 Independent Chemical Dependency Therapist. He holds a Bachelor's Degree in Human
20 Development, has completed Master's Studies, and has yet to complete his thesis. His
21 previous occupation was construction work. He has retired recently due to poor health.

22 **Religious upbringing:** He attended church occasionally with his mother as he was
23 growing up. His father was in the US Air Force and the family moved to many places

1 around the world and to many locations in the US. His father was a functional alcoholic
2 as it was acceptable in those days. His father occasionally attended the church. His father
3 resented organized religion.

4 **Religious Practices:** The participant considered that religiosity did not save his father
5 from alcoholism. His father's resentment against organized religion played a great role in
6 his future adult life in his approach towards organized religion. He felt that his family
7 was dysfunctional; it was not healthy family atmosphere to grow up in; it did not provide
8 a safe/loving environment.

9 **Things that led to the use of substance:** He grew up in a family where his father was a
10 functional alcoholic. He started to use alcohol for fun in his last year in High School. He
11 became a weekend drinker with his friends, and enjoyed listening to rock & roll music.
12 Peer group pressure influenced him to drink. At the initial stage he never drank alone.

13 **Types of substance he used:** He used alcohol while he was in High School. When he
14 was serving in Vietnam, lots of drugs were readily available and he started to use
15 marijuana and heroin. He started to drink whisky daily.

16 **Duration of substance abuse:** He used alcohol for 22 yrs; has been sober for 21 years.

17 **Severity of abuse:** His addiction was so severe that he was in the advanced stages,
18 which meant that he no longer enjoyed drinking but had to because of dependency.

19 **Practice of spirituality while using substance:** When he was in Vietnam he did not
20 practice spirituality. He saw the horrors and impact of war in the lives of innocent and
21 helpless people. He questioned the existence of God and how God could allow such
22 havoc in their lives. He could not comprehend how God could allow innocent women
23 and children to be slaughtered without mercy. He considered God as a punishing God.

1 **Things that prompted him to seek help:** Drinking was a major factor in his divorce
2 though his ex- wife was an addict too. He came to a stage where he thought that he was
3 going crazy and could not think straight; there was no way of getting out. Due to this, he
4 could not hold any jobs.

5 **Types of treatment modality:** He spent six days in detox prior to attending the Twelve
6 Step Program for 28 days. He was not practicing spirituality while he used alcohol/drugs.

7 **Role of religious beliefs and practices in recovery:** Religious beliefs and practices did
8 not contribute to his recovery.

9 **Organized religious practices:** Due to his father's resentment towards religion and his
10 own personal experience with churches, he does not participate in organized religion.

11 **His personal spiritual practices:** When he returned from Vietnam, he felt he was an
12 outcast in his community. He did not feel accepted and people looked at him with
13 suspicion. He, as a Vietnam veteran, did not get a hero's welcome as veterans receive
14 today. He tried to reconnect with the church when he returned from service. He was in
15 and out of church participation for about three years. He was always in search of truth,
16 meaning and purpose in life. In his search, he felt that he did not fit in church groups.
17 None of the Christian religious affiliations could fulfill his spiritual quest for truth. He
18 also had difficulty with what they were saying. He felt that people were judgmental and
19 he never felt safe within himself. He did not join in organized religious groups or
20 churches. When he returned home from Vietnam he saw that some of his friends joined in
21 different cults like monism and the Hare Krishna movement.

22 **His current personal spiritual practices** are those of Narcotics Anonymous which
23 taught him to be honest, open-minded and be at service. He prays, meditates, reads

1 Narcotics Anonymous book, "Just for Today", and attends NA meetings. Attendance of
2 NA meetings reminds him what he is supposed to do. He attends meetings two or three
3 times a week. He participates in a number of NA sponsored activities. He believes that
4 attending NA meetings is important in maintaining sobriety.

5 **Current core belief system:** After achieving sobriety, he began to practice Shamanism,
6 which is very close to Native-American Spirituality. The practice of Shamanism gave
7 him a sense of peace, of being one with the spirit and nature, and gave him a concept of
8 God of his understanding. His core belief system is the notion of God as a forgiving God
9 and that God is present in everything. Live a good life you will be taken care of.

10 **Things that contributed the most to his recovery:** Twelve Steps and his willingness to
11 work on it contributed the most to his recovery. The Steps are an ethical platform to
12 interact with people. Working the steps is a lifelong process. He discovered that when he
13 tried to control others he lost everything. The hardest part in working the steps was to
14 look at self and then come to terms with one's self.

15 **Participant E** is a 55-year-old male and served in the US Army from 1974 to
16 1977 and spent time in Korea. He holds a Bachelors' Degree in Social Work and works as
17 a licensed Addiction Therapist.

18 **Religious upbringing:** He was brought up in a family where his mother was a devout
19 Catholic and his father was a Presbyterian. His father did not hold any permanent job
20 due to drinking. His father was a severe alcoholic and did not allow the family to invite
21 other friends and friends to their home. As a result, they suffered from shame and guilt.
22 But he had his own friends and drank with them at home. The family occasionally called

1 their pastor to calm down their father who was yelling and shouting at them. His father
2 did not play a role in his religious beliefs and practices.

3 **Religious Practices:** He, along with his parents, attended church worship on Sundays on
4 a regular basis. He attended religious education and church sponsored youth camps where
5 he could talk to male sponsors.

6 **Things that led him to use alcohol:** Participant grew up in a family where his father
7 was a severe alcoholic. Peer group pressure in high school led him to use alcohol. He
8 served in Korea and was stationed on a mountain for eighteen months with thirteen other
9 servicemen where he suffered from loneliness. Loneliness was a precipitating factor for
10 alcoholism in the army.

11 **Types of substances used:** He consumed beer and liquor. He smoked marijuana a lot,
12 almost daily for eighteen months.

13 **Duration of the use:** He started to drink at the age of sixteen and continued to drink till
14 1988.

15 **Severity of the dependency:** His dependency was so severe that he put his hands on
16 anything he could get. Due to dependency, his first marriage ended in divorce, and he
17 was not allowed to see his children. He quit jobs on numerous occasions and was
18 homeless for a long time. His second wife was an alcoholic and the marriage ended in
19 divorce. He lived with his third wife for ten years until she died. He never lived in streets
20 but always lived with someone and paid rent. The death of his grandmother aggravated
21 his drinking when he returned from service.

22 **Practice of spirituality while using substances:** Religious beliefs and practices did not
23 directly help him in his recovery. When serving in Korea, he learned about his wife's

1 marital infidelity at home. This led to anger, hurt and resentment towards her and against
2 religion. Shortly after his return from Korea, he divorced his wife. He held on to
3 resentment and anger and did not do anything to overcome such feelings. As a result his
4 drinking continued. Alcohol was his Higher Power until he met a friend who discussed
5 spiritual rebirth. This led him to study more about different spiritualities including
6 Native-American Spirituality, Eastern Philosophy and different religions like Hinduism
7 and Buddhism.

8 **What prompted to seek help:** He came to a point when he realized that that he does
9 not have to live the way he lived. He wanted to live a normal life. When he saw other
10 couples live happily he wanted to be like them. Desire to lead a normal life, love of his
11 siblings, and the desire to be part of the family prompted him to seek help.

12 **Type of treatment modality:** He attended the Twelve-Step program thrice and has been
13 sober since 1988. This was the only treatment modality he utilized for recovery. He has
14 relapsed thrice and has remained sober for twenty-two years.

15 **Role of religious beliefs and practices in his recovery:** Religious beliefs and practices
16 did not help him to recovery.

17 **Organized religious practices:** He wanted to continue his faith in the Roman Catholic
18 tradition once he returned from service. He had difficulty in getting his divorce decree
19 from the Catholic Diocese where he lived. That led him to turn away from Roman
20 Catholic Church. He has no organized religious practices now

21 **Personal spiritual practices** are prayer, walking in the woods and meditation. He is
22 involved with rescuing unwanted dogs. He brings them home, provides medical care if
23 needed and places them for adoption. He believes that community service is one way in

1 which to give back to the community. He sees community service as a natural outgrowth
2 of his recovery. He attends AA meetings once a month. He practices the spirituality of
3 Sufism, a form of Christian mysticism, at present. He does not practice it in the
4 traditional sense that he follows rites and rituals.

5 **Current core belief system** is that all are brothers and sisters under God, irrespective of
6 other differences. He treats others as he treats his own self. His belief system is Christ
7 centered and self-realization is the ultimate goal in his spiritual journey.

8 **Things that contributed to recovery:** Attending twenty days of treatment, strong family
9 support and the Practice of Twelve Steps contributed to his recovery. All taught him that
10 he could live an alcohol and drug free life. Spiritual beliefs and practices reinforce his
11 sobriety.

12 **Participant F** is a 43-year-old male and served in US Army from 1985 to 1989
13 and spent two years in Germany. He holds an Associate Degree in Applied Sciences,
14 completed his studies in Chemical Dependency and is working as a Therapy Assistant in
15 the field for the required hours for certification. He worked in the manufacturing
16 industries making coil springs for cars and trains for some time. Later on, he could not
17 hold any permanent job. He is divorced and is single at present.

18 **Religious upbringing:** He was raised in the Methodist faith tradition and attended
19 church with his parents until the age of twelve. The family stopped going to church
20 because his father was employed on weekends. He attended Nazarene church with his
21 neighbors for a short time.

22 **Religious Practices:** Participant stopped practicing religious beliefs at a young age due to
23 the parents' inability to attend worship service on Sundays.

1 **Reasons for substance use:** His grandparents were alcoholics and this had a direct
2 impact on his father's behavior towards his own wife and children. The participant
3 considered substance abuse as a socially acceptable norm and social outlet by his age
4 group. He did not consider it as something wrong or illegal. This led him to substance
5 abuse. He started to drink alcohol when he was fourteen and used drugs at fifteen and
6 experienced blacked out at sixteen.

7 **Types of substances used:** Beer, liquor, marijuana and hashish were the substances he
8 was using. He tried cocaine on five occasions and did not like the taste of it. By the time
9 he joined the army he was already an alcoholic. He spent two years in Germany and
10 alcohol and drugs were readily available there.

11 **Duration of the Use:** He started to drink alcohol at the age of fourteen; he used for
12 seventeen years and is sober for twelve years.

13 **Severity of the use:** Once he returned from service, the use of it was so severe that he
14 spent 23 days in county jail and lost a scholarship for academic studies on four occasions.

15 **Practice of spirituality during substance use:** He was practicing spirituality while he
16 was in substance abuse. He prayed daily. He did not participate in any organized religious
17 practices while he was using substances. His philosophy was to reach out to people who
18 need God rather than people who have God, referring to people who attend church. He
19 ascertains that for most alcoholics, the spiritual experience is a slow and gradual process
20 rather than sudden as experienced by Bill Wilson.

21 **Reasons for seeking help:** One night he drank and ended up hurting his girl friend. As a
22 result, the Sheriff took him to a psychiatric hospital for detox. His attorney and one of his
23 friends helped him to attend the Twelve Step Program.

1 **Treatment modality:** After completion of the program he relapsed after 90 days. He
2 received treatment as an outpatient and attended aftercare program, got a sponsor and
3 started to attend AA meetings 3-5 times a week in the first year. He married and
4 considered his wife as his Higher Power. Later he found that his wife was a drug addict
5 and the marriage ended in divorce. He relapsed again. He attended the program again,
6 sought psychiatric help once a month to control anger, alcoholism, drug addiction and
7 dependency. Psychiatric treatments continued for six months. He has been sober for
8 twelve years.

9 **Role of Religious beliefs and practice in recovery:** Religious beliefs and practices did
10 not contribute to his recovery. Twelve Steps were the cornerstone of his entire recovery.
11 Having a sponsor and the practice of personal spirituality helped him to recover.

12 **Organized religious practices:** He had no organized religious practices because he
13 believed that his lifestyle was in conflict with Christian principles. He thought that his
14 soul was enslaved due to addiction. He had, however, strong religious beliefs based on
15 Christian principles. He plans to join the Episcopalian faith tradition where his girl friend
16 belongs.

17 **His personal spiritual practices** are prayer, meditation and doing volunteer work
18 especially helping other substance abuse veterans to seek professional counseling. He
19 believes and counsels others that the largest percentage of successful recovery he has
20 seen in other people is based on strong religious beliefs. He has a long record of spending
21 hours in voluntary works. He believes that service work is very important for recovering
22 individuals because Twelve Step fellowships encourage community service. Community
23 service is a way of for him to make amends, or give back, to the community. Actually,

1 the spiritual principles of a Twelve Step program lead naturally to community service. He
2 tries to stay active by alleviating the pain of others.

3 **Current core belief system** is that he sees God as a loving, forgiving and guiding force.
4 God will grant to us what we ask for if we will be responsible for our actions. He sees
5 different religions as different paths to God. Love, care and compassion and service are
6 the means to reach that destiny. He tries to create a heart full of gratitude for what he has
7 rather than envious of what he doesn't have in life.

8 **Things that contributed to recovery and sobriety:** In his personal relationship with
9 God, he feels that even though he is single he never feels lonely. Religious beliefs,
10 Twelve Steps, having a sponsor, aftercare program, attending AA meetings and service
11 work contributed to his recovery and sobriety. A combination of all these factors
12 contributed to his recovery. He feels that these different components played a significant
13 role in his recovery and sobriety.

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1 **Appendix D - The Twelve Steps of Alcoholics Anonymous**

2 1. *We admit we are powerless over alcohol—that our lives have become unmanageable.*

3 2. *Come to believe that a Power greater than ourselves could restore us to sanity.*

4 3. *Make a decision to turn our will and our lives over to the care of God as we*
5 *understand Him.*

6 4. *Made a searching and fearless moral inventory of ourselves.*

7 5. *Admit to God, to ourselves, and to another human being the exact nature of our*
8 *wrongs.*

9 6. *Were entirely ready to have God remove all these defects of character.*

10 7. *Humbly asked Him to remove our shortcomings.*

11 8. *Made a list of all persons we had harmed, and became willing to make amends to them*
12 *all.*

13 9. *Made direct amends to such people wherever possible, except when to do so would*
14 *injure them or others.*

15 10. *Continued to take personal inventory and when we were wrong promptly admit it.*

16 11. *Sought through prayer and meditation to improve our conscious contact with God, as*
17 *we understood Him, praying only for knowledge of His will for us and the power to carry*
18 *that out.*

19 12. *Having had a spiritual awakening as the result of these Steps, we tried to carry this*
20 *message to alcoholics, and to practice these principles in all our affairs.*

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1 **Appendix E - A.A.'s 12-Traditions**

- 2 1. Our common welfare should come first; personal recovery depends upon A.A. unity.
- 3 2. For our group purpose there is but one ultimate authority--a loving God as He may
4 express Himself in our group conscience.
- 5 3. Our leaders are but trusted servants; they do not govern.
- 6 4. The only requirement for A.A. membership is a desire to stop drinking.
- 7 5. Each group is autonomous except in matters affecting other groups or AA as whole.
- 8 6. Each group has one primary purpose--carry its message to the alcoholic who still
9 suffers.
- 10 7. An A.A. group ought never endorse, finance, or lend the A.A. name to any related
11 facility or outside enterprise, lest problems of money, property, and prestige divert us
12 from our primary purpose.
- 13 8. Every AA group ought to be fully self-supporting, declining outside contributions.
14 Alcoholics Anonymous should remain forever non-professional, but our service centers
15 may employ special workers.
- 16 9. A.A., as such, ought never to be organized; but we may create service boards or
17 committees directly responsible to those they serve.
- 18 10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought
19 never to be drawn into public controversy.
- 20 11. Our public relationships policy is based on attraction rather than promotion; we need
21 always maintain personal anonymity at the level of press, radio, and films.
- 22 12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place
23 principles before personalities.

1 **Appendix F - Similarities of AA spirituality to Judeo-Christian beliefs and practices**

2	Admission of powerlessness over alcoholism	Admission of powerlessness over sins
3	Belief in a Higher Power	Belief in a Judeo-Christian concept of
4	God	
5	Admission of defects	Admission of sins
6	Confession of shortcomings	Confession of sins
7	Making restitution for harms done	Making restitution for sins committed
8	Engaging in good works	Engaging in good works
9	Prayer and meditation	Prayer and meditation.

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1 **Appendix G - Glossary of Terms**
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3 **Judeo-Christian Spirituality:** Consists of the Old and New Testaments which form the
4 basis for the religions of Judaism and the various forms of Christianity marked the
5 beginning of a mono-deistic form of religion in the world. They worship the same God
6 and have in common the Old Testament as their scripture, with New Testament, which
7 contains the teachings of Christ and the apostles.

8 **Shamanism** is a range of traditional beliefs and practices that involve the ability to
9 diagnose, cure, and sometimes cause human suffering because of a special relationship
10 with control over spirits. It is based on the premise that the visible world is pervaded by
11 invisible forces or spirits over the lives of the living.

12 **Christian Sufism:** While all Muslims believe that they are on the pathway to God and
13 will become close to God in Paradise after death and after the "Final Judgment", Sufis
14 believe that it is possible to become close to God and experience closeness while alive.

15 **Alcoholics Anonymous (AA)** is a voluntary fellowship founded in 1935 and concerned
16 with the recovery and continued sobriety of the alcoholics who turn to the organization
17 for help. The AA program consists basically of the Twelve Steps designed for the
18 personal recovery from alcoholism, and AA is the major proponent of the disease model
19 of alcoholism. It is a fellowship of men and women who share their experience, strength
20 and hope with each other that they may solve their common problem and help others to
21 recovery from alcoholism. Alcoholism is a primary, chronic disease with genetic,
22 psychosocial, and environmental factors influencing its development and manifestations.
23 The disease is often progressive and fatal. It is characterized by continuous or periodic:
24 impaired control over drinking, preoccupation with the drug/alcohol use despite adverse
25 consequences, distortions in thinking, most notably denial.

26 **Anonymous/Anonymity** is the AA concept of anonymity is expressed in this saying,
27 who you see here, what you hear here, when you leave here, let it stay here. It is so
28 important to AA that the word "Anonymous" is part of its name.

29 **Rational Recovery** is a source of counseling, guidance, and direct instruction on self
30 recovery from addiction (alcohol/drugs) through planned, permanent abstinence. It is an
31 alternative to Alcoholics Anonymous founded in 1986 by a licensed Social Worker.

32 **Celebrate Recovery** was founded in 1991 by pastor John Baker of Saddleback Church
33 with the goal of overcoming habits like sex disorders and drug addictions with a twelve-
34 step program based on Christian principles.

35 **Oxford Group** is a spiritual, nondenominational, evangelical movement founded in 1912
36 by Lutheran minister, Dr. Buchman. AA began as an offshoot of this group. Bill Wilson
37 stated that AA got its ideas of self-examination, acknowledgement of character defects,
38 and restitution for harm done, and working with others straight from the Oxford Group.

1 **Big Book** is the nickname given to the book of Alcoholics Anonymous. So named,
2 because of the unusual thickness of the paper it was originally printed on. Although the
3 book is now smaller, the nickname stuck, and is, in fact, registered.

4 **Detox** is the safe withdrawal from alcohol or drugs. It can be done on an outpatient basis
5 with a physician, or on an inpatient basis for more severe or medically complicated
6 situations. It can be a starting point for continued treatment of chemical dependency.

7 **Substance Abuse Treatment:** Screened offenders are assessed for drug and alcohol
8 abuse to determine what service approach is best: long-term or short-term residential
9 treatment, intensive or regular outpatient treatment, chemical detoxification, or some
10 other education modality. The substance abuse treatment is based on the offender's risk
11 of recidivism, the severity of the offender's substance abuse treatment "need," and the
12 offender's responsiveness to different types of treatment.

13 **AA Meeting** is any two or more alcoholics gathered together for the purpose of sobriety,
14 provided, that as a group, they have no other affiliation. At the heart of AA recovery is
15 the meetings. It is here that the members share their experience, strength, and hope with
16 one another and find recovery.

17 **Closed Meeting.** An AA meeting that is 'closed' to nonalcoholic. Only alcoholic and
18 those who think they may have a problem with alcohol/drug are allowed to attend.

19 **Substance Abuse** is a maladaptive pattern of substance use leading to clinically
20 significant impairment or distress as manifested by one (or more) of the following:
21 recurrent use resulting in a failure to fulfill major role obligations, situations in which it is
22 physically hazardous, recurrent substance-related legal problems and continued substance
23 despite having persistent or recurrent social or interpersonal problems caused by or
24 exacerbated by the effects of its use.

25 **Substance Dependency** is a maladaptive pattern of substance use leading to clinically
26 significant impairment or distress.

27 **Tolerance** is normal neurobiological event characterized by the need to increase the dose
28 over time to obtain the original effect. It is a state in which a drug produces a diminishing
29 biological or behavioral response: in other words, higher doses are needed to produce the
30 same effect experienced initially.

31 **Higher Power:** A self-defined power greater than themselves to which we ultimately
32 turn for assistance and guidance in our sober lives. For addicts, substance was their
33 higher power. In sobriety, they choose a different kind of power to fulfill their purposes.

34 **JACHO:** The joint commission, formerly the Joint Commission on accreditation of
35 Healthcare Organization is a private sector United-States based non-profit organization. It
36 operates accreditation programs for a fee to subscribe hospitals and other healthcare

1 organizations. It accredits over 17, 000 healthcare organizations and programs in the
2 United States. A majority of State governments recognize it as a condition of licensure
3 and the receipt of medical reimbursement

4 **PTSD:** Post-Traumatic Disorder is an anxiety disorder that can develop after exposure to
5 a terrifying event or ordeal in which grave physical harm occurred or was threatened.
6 Traumatic events that may trigger PTSD include violent personal assaults, natural or
7 human-caused disasters, or military combat.

8 **Association of American Medical Colleges (AAMC)** is a nonprofit organization based
9 in Washington, D.C and established in 1876. It is involved in M.D granting and
10 medical schools and teaching hospitals in Canada and the United States. It is also the
11 administrator of the medical college admission test.

12 **Quantitative Research** refers to the systematic empirical investigation of quantitative
13 properties and their relationships. The objective of quantitative research is to develop and
14 employ mathematical models, theories and/or hypotheses pertaining to phenomena. The
15 process of measurement is central to quantitative research because it provides the
16 fundamental connection between empirical observation mathematical expressions of
17 quantitative relationships. It is used widely in social sciences such as psychology,
18 sociology, anthropology and political sciences.

19 **Qualitative Research** is a method of inquiry appropriated in many different academic
20 disciplines, traditionally in the social sciences but also in market research and further
21 contexts. Qualitative researchers aim to gather an in-depth understanding of human
22 behavior and the reasons that govern such behavior. The qualitative method investigates
23 the why and how of decision making, not just what, where, when. Hence, smaller but
24 focused samples are more often needed, rather than large samples. Qualitative methods
25 produce information only on the particular cases studied, and any more general
26 conclusions are only hypotheses (informative guesses). It can be used to verify which of
27 such hypotheses are true.

28 **Serenity Prayer:** God, grant me the serenity to accept the things I cannot change;
29 courage to change the things I can; and wisdom to know the difference.

30 **Relapse:** This word signifies a concept in the field of substance abuse treatment:
31 "Relapse is a part of recovery." As with all chronic illnesses or behaviors, change comes
32 slowly. They may fall back into believing that they can manage their addiction on their
33 own, that they no longer need AA or NA, that they can participate in the same activities
34 with the same old friends that they did before they stopped using, that they can "handle"
35 their addiction and have "just one more drink," or that they are justified, based on
36 resentments and rationalizations, in seeking solace from their drug of choice. As with
37 other illnesses, relapse does not mean that one must "start over" from the beginning, but
38 simply pick up where one left off in the recovery process.

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