Published in final edited form as:

Subst Use Misuse. 2010 ; 45(1-2): 134–153. doi:10.3109/10826080903035130.

A focus-group study on spirituality and substance-abuse treatment

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Abstract

Individuals recovering from addictions frequently cite spirituality as a helpful influence. However, little is known about whether or how spirituality could be incorporated into formal treatment in a manner that is sensitive to individual differences. In the present study, focus groups were conducted with 25 methadone-maintained outpatients (primarily high-school educated, African-American males) to examine beliefs about the role of spirituality in recovery and its appropriateness in formal treatment. Groups also discussed the relationship between spirituality and behavior during active addiction. Thematic analyses suggested that spirituality and religious practices suffered in complex ways during active addiction, but went “hand in hand” with recovery. Nearly all participants agreed that integration of a voluntary spiritual discussion group into formal treatment would be preferable to currently available alternatives. One limitation was that all participants identified as strongly spiritual. Studies of more diverse samples will help guide the development and evaluation of spiritually based interventions in formal treatment settings.

Keywords

spirituality; religion; addiction; focus groups; treatment

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Statement from all the authors: When this paper was in manuscript form, some readers apparently wondered whether its motivations included religious advocacy. Therefore, we would like to clarify that we hold a broad range of personal viewpoints on spirituality and religion, including for some of us a strong commitment to secularism. The driving forces behind this paper were our curiosity about participants’ beliefs and our interest in ethnographic research in which participants have a voice.

1. Introduction

One purpose of religion is to facilitate the development of its members' spirituality (Miller, 1998), a more highly individualized concept characterized by a personal relationship with something that is transcendent or beyond the self (Cook, 2004). Although higher levels of religiosity and spirituality have been associated with greater physical and mental health (Ellison and Levin, 1998; George, Larson, Koenig, and McCullough, 2000; Larson, Swyers, and McCullough, 1997; Powell, Shahabi, and Thoresen, 2003), the role of spirituality in facilitating successful addiction treatment outcome has only recently been identified as an area of potential importance to addiction research and clinical practice.

Despite the paucity of research in this area, spirituality has been shown to be a significant and independent predictor of recovery and/or improvement in indices of treatment outcome (Avants, Warburton, and Margolin, 2001; Carter, 1998; Heinz, Epstein, and Preston, in press; Kendler, Gardner, and Prescott, 1997; Piedmont, 2004). Levels of spirituality increase between treatment entry and subsequent recovery (Borman and Dixon, 1998; Mathew, Georgi, Wilson, and Mathew, 1996; Pardini, Plante, Sherman, and Stump, 2000), and levels of spirituality may be greater in individuals whose recovery is successful compared to those who have relapsed (Jarusiewicz, 2000). Length of sobriety has also been positively associated with spirituality (Carter, 1998; Poage, Ketzenberger, and Olson, 2004), while commitment to a higher power may lessen the severity of relapse episodes (Morgenstern, Frey, McCrady, Labouvie, and Neighbors, 1996). In retrospective studies, recovering addicts frequently reported spirituality as an important component of their recovery efforts and to be helpful in maintaining changes made during treatment (Flynn, Joe, Broome, Simpson, and Brown, 2003a, 2003b; Koski-Jannes and Turner, 1999). Additionally, spiritually oriented lay programs such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) are widely popular, especially in the United States, and although it has been notoriously difficult to assess the effectiveness of such programs in their naturalistic incarnations, there is some evidence that they are effective (Fiorentine, 1999; Fiorentine and Hillhouse, 2000; Giffen, 1997; Weiss et al., 1996). Given these encouraging findings, it may be useful to capitalize on spiritually based means of behavioral change to facilitate abstinence and prevent relapse.

Although little is known about the specific aspects or "active ingredients" of religiosity and spirituality that may influence recovery from addiction, several studies suggest that the coping skills derived through religion and spirituality may be an underutilized treatment resource. With respect to prevention of HIV risk behaviors, over 33% of HIV-negative injection drug users credited religious practices such as prayer and "God's help" in their avoidance of behaviors that can lead to infection (Des Jarlais et al., 1997). HIV-positive and HIV-negative injection drug users participating in focus groups reported that spirituality was a source of inner strength and that a spiritual intervention would be helpful for reducing "cravings" and HIV risk behavior, following medical recommendations, and increasing hopefulness (Arnold, Avants, Margolin, and Marcotte, 2002). In another qualitative study, Green, Fullilove, and Fullilove (1998) observed that recovering addicts often undergo intense spiritual awakenings that facilitate abstinence following treatment. Dermatis, Guschwan, Galanter, and Bunt (2004), in a study assessing preference for spirituality-based interventions among substance-abusing residents of a therapeutic community, noted strong support for the incorporation of spirituality or a formal 12-step approach into treatment.

The descriptive studies discussed above all indicate that some substance-using patients report that spirituality is central to their lives as well as to their recovery. Clinicians' perceptions of patients' spiritual needs have sometimes appeared alarmingly inaccurate. For example, in a study of 101 patients and their providers at a dual-diagnosis treatment program, McDowell,

Galanter, Goldfarb, and Lifshutz (1996) found that the nursing staff severely underestimated the patients' level of spirituality and the importance patients placed on spirituality in the recovery process; 97% of the patients reported that they believed in God or a "universal spirit," and 25% reported having attended church during the 7 days prior to admission. Goldfarb, Galanter, McDowell, Lifshutz, and Dermatis (1996) found that medical students responsible for treating substance use were significantly less religious than the patients they treated, tended not to view religion or spirituality as a significant aspect of patient care, and underestimated the degree to which patients would rank spirituality as an important aspect of substance-abuse treatment. Discrepancies between clinicians and patients regarding the perceived importance of spirituality in treatment may hinder incorporation of spirituality into treatment.

It seems unlikely that the spiritual propensities of treatment-seeking drug users arise de novo as their attempts at recovery begin. Some active drug users may be "paradoxical users," whose problems are exacerbated by the moral turmoil and feelings of isolation that occur when they recognize the conflict between their behaviors and the prohibitions of their religious group (Center on Addiction and Substance Abuse, 2001). Other active drug users may reconcile their drug-use behavior with their spiritual beliefs or may simply compartmentalize the two spheres of existence.

To address these questions and concerns, the current study used focus groups to investigate participants' attitudes and beliefs about spirituality, substance use, and recovery. Focus-group methodology provides unique opportunities to gain perspective and insight on issues that can later be studied in quantitative research. Among the questions we hoped to address were how participants had reconciled or compartmentalized any self-perceived incongruities between their beliefs and their behavior while they were still using heroin and cocaine; how participants viewed the relationship between spirituality and recovery; and whether and how spiritual components could be integrated into more standard treatment approaches in a manner that is sensitive to individual differences. (An important issue that we did not attempt to address was that of cultural differences such as those associated with race and ethnicity. We return to this in the Discussion section.) Spirituality and religiosity were also assessed with questionnaires; these data served as a quantifiable backdrop for information collected in the focus groups.

2. Materials and methods

Participants

From March 2005 through April 2006, individuals were recruited from a larger (and still ongoing) 28-week clinical trial at an outpatient treatment program at the National Institute on Drug Abuse (NIDA) Intramural Research Program (IRP) in Baltimore, Maryland. The primary purpose of the trial was to determine whether craving, use, and relapse could be prospectively monitored in heroin- and cocaine-abusing outpatients through ecological momentary assessment using handheld electronic diaries. Participants gave written informed consent prior to participation; the consent form included information about optional participation in the focus groups described here. The larger trial and the focus-group procedure were approved by the NIDA IRP Institutional Review Board. Exclusion criteria for the study were: current psychotic, bipolar or major depressive disorders, current physical dependence on alcohol or sedatives, unstable serious medical illness, and estimated IQ below 80 (Zachary, 1986). HIV serostatus was not an exclusion criterion. Participants who remained in treatment for at least 8 weeks (a total of 79 patients over the period when focus groups were held) were invited by their counselors to attend one focus group. Five focus-group sessions were held, with a total of 25 (4, 5, 7, 3, and 6) participants. One additional participant completed questionnaires but did not take part in a focus group because no one else attended the scheduled session. The 26 study participants ranged in age from 20 to 53; their other demographic characteristics are shown in Table 1.

Instruments

Demographic information and pre-treatment drug-use history were obtained from the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980).

Religious Problem Solving Scale (RPSS)

The RPSS (Pargament, 1988) comprises three subscales that identify how individuals assign responsibility to themselves or God in resolving a problem. These styles are “Self-directing,” which describes a self-reliant style of problem-solving, “Collaborative,” which describes a goal of partnership with God, and “Deferring,” which describes a style of turning the responsibility for problem resolution over to God. Each subscale consists of 6 Likert-scaled items, with a range of possible scores of 6–30. Participants completed each of the 18 items by rating how frequently or infrequently they did each item (1 = never and 5 = always). The RPSS has shown good internal consistency and test-retest reliability (Thurston, 1999).

Religious Background and Behavior Questionnaire (RBBQ)

The RBBQ (Connors, Tonigan, & Miller, 1996) is a brief measure of current and past religious practices and behaviors. The instrument measures two factors, “God consciousness” (reflecting the frequency of internal events such as prayer, thinking about God, and religious self-description) and “Formal practices” (reflecting the frequency of external activities, including meditation, worship-service attendance, reading scriptures, and experiences of God). The first item asks participant to indicate the appropriate descriptor of their beliefs at the present time (atheist = 0, religious = 4). On the next six items, participants indicate (on an 8-point Likert scale) the frequency in which they engaged in various spiritual or religious practices in the past year. The remaining six questions assess lifetime occurrences of the same practices on a three-point ordinal scale (1 = never, 2 = in the past, 3 = yes currently do). The possible ranges of scores for “God consciousness,” “formal practices,” and the total RBBQ are 4–26, 8–44, and 12–70.

God Perception Questionnaire (GPQ)

The GPQ (McGovern, 2003) assesses perception of God as kind or wrathful. Each of ten items is rated on a 4-point scale (1 = strongly agree, 2 = agree, 3 = disagree, 4 = strongly disagree). A principal components analysis yielded two factors labeled “Forgiving God-image” and “Punishing God-image.” The range of possible scores for each factor is 5–20. Reliability is acceptable, with a Cronbach’s alpha of .83 for the “Forgiving” factor and .70 for the “Punishing” factor. Two items are reverse coded because they load more strongly onto the factor to which they were not originally assigned.

Procedure

The RBBQ, RPSS, and GPQ were administered upon arrival to the session. Information regarding issues of confidentiality was verbally reiterated by the moderator before groups convened. Focus groups lasted approximately one hour and were led by a doctoral-level psychologist knowledgeable in the areas of substance-abuse treatment and spirituality research (E.R.D.), following guidelines established by an experienced focus-group moderator (P.C.). The discussion was structured around a set of predetermined questions. Statements made during the discussions that needed further clarification were incorporated into the content of subsequent groups. Sessions were audiotaped, and two members of the investigative team (A.J.H. and L.A.G.) also took notes.

Data Analyses

The data collected from survey questionnaires were summarized descriptively using the SPSS statistical package.

Analysis of the focus-group data was based on the approach laid out in Knodel (1993). By listening to audio recordings of the focus groups and using notes taken during the groups, one of the authors (A.J.H.) developed an initial set of codes with topics and subtopics corresponding to each item in the discussion guidelines. Additional codes were created for topics that arose and were of interest, and codes were consolidated as necessary. An overview grid was constructed, providing a descriptive summary of the content of the discussions. One axis of the grid was the topic headings and the other axis was the focus-group identifiers. The cells contained brief descriptions of the content by group and topic and formed the basis for content analysis.

Reliability of interpretation was optimized by having two other authors (E.R.D. and D.H.E.) independently replicate the interpretation of the audio recordings, starting with A.J.H.'s main thematic codes (but without access to the associated content descriptions). Disagreements were discussed and resolved. At least two of the analysts had been physically present during each focus group.

3. Results

3.1. Quantitative

Mean scores (and SDs) on the RPSS subscales were 22.0 (4.4) for "Collaborative," 19.0 (5.5) for "Deferring," and 14.3 (5.9) for "Self-directed," suggesting that participants most often endorsed a partnership with God in resolving conflict. In this problem-solving style, the individual and God actively work together to reach a solution (Pargament, 1988).

On the RBBQ, the mean total score was 50.0 (9.9). The mean score for "God-consciousness" was 23.7 (2.0) out of 26, while the mean score for "Formal practices" was 26.3 (8.5) out of 44. On the first item (atheist = 0, religious = 4), 13 participants rated themselves 4, and 12 rated themselves 3. One participant rated himself 0, but his stories and comments during the focus-group session vividly indicated a strong belief in God and an active prayer life, so it seems likely that his questionnaire response was an error. (His scores on the questionnaires were otherwise similar to those of the other participants.) The RBBQ scores suggest that all participants had a strong belief in God, and that they were more likely to engage in internal activities such as praying or thinking about God than they were to engage in external activities such as attending religious services or reading religious writings.

Mean score for the GPQ factors "Forgiving God-image" and "Punishing God-image" were 6.8 (2.0) and 17.2 (1.9), respectively: participants strongly disagreed that God was punishing, avenging, and wrathful, and strongly agreed that God was loving, kind, and forgiving.

3.2. Qualitative

The focus-group topic of spirituality and religion was well received; thoughts and opinions were discussed freely, and participants consistently showed respect for each other's views. Questions and discussion points addressed during groups often prompted highly personal and emotional responses, coupled with suggestions for implementation of a spiritually based group. Five themes and several sub-themes emerged from analyses of recordings of the focus-group sessions.

3.2.1. Participants reported substantial religious background—One commonality among participants was exposure to religious and spiritual practices early in life. A majority endorsed a history of regular church attendance in childhood, and several had been educated at religious schools. Familial relations with clergy members and pious individuals were also common [“My mother and father are a deacon and deaconess,” “I had an aunt, I used to regularly go to Sunday school and church, real regular when I was small, like age 8 to 13.”]. Several examples were offered of positive experiences where spiritual support from family members was helpful to participants in their recovery [“My mother and father (were) praying, would not give up on me. They knew I was suffering from an illness,” “My cousin who’s religious let me know she was never going to give up on me...she started saying prayers with me and had me repeat after her”]. Other participants linked their early religious experiences to punitive or coercive parental enforcement: [“When we was comin’ up, you *had* to go (to church) or you was going to get it,” “We couldn’t even eat breakfast without saying grace”]. A small minority implied that their involvement in church was of a superficial or perfunctory nature that otherwise did not influence the course of their addiction [“I always was raised around the church, I just always been a backslider”; “Me and my family, we all use and abuse drugs, and we were all brought up strong Catholics”].

3.2.2. During active addiction, spirituality suffered in complex ways

3.2.2.1. Participants recognized a conflict between abusing drugs and adhering to the organized practices of their religions: Many participants reported that they still prayed and attended church services during periods of active addiction. One participant acknowledged, “I used to go to church high.” For most other participants, the use of heroin on days of church attendance seemed to be a matter of grim necessity [“I shot dope before I went to church....I feel like a heel, doin’ it, but...”; “But if you don’t, you gonna be sick, so...”; “I can honestly say that I have went to church, haven’t used, but come out of church, and *go* use”]. One participant said that he had avoided going to church during periods of active heroin abuse, but had occasionally had little choice [“...if it’s a funeral or something, where I *gotta* go, of course I’m gonna get some before I go, because I’m not gonna go sick”]. The same participant added that he would not necessarily disapprove of churchgoing among other active users [“...I would be down on nobody for (going to a regular church service) after using, because at least you goin’; you tryin’ to better yourself”]—a theme echoed by another participant (see section 3.2.3).

In only one instance did participants allude to having visibly flouted religious strictures; notably, this did not occur in a religious setting [“Sometimes at the subway station, there’d be a guy there preachin’ and everything. And everybody’s still runnin’ sellin’ their drugs, and buyin’ their drugs, and he’s just preachin’ and preachin’”; “Yeah, I bought drugs right in *front* of ’em before” (laughter from group)].

3.2.2.2. For some participants, addiction dampened spirituality—or even fully replaced it: Some participants perceived addiction as a spiritual vacuum and a state of hopelessness and despair [“Addiction makes you numb”; “When you’re using you’re like the walking dead—you’re spiritually dead, your soul is dead, it’s like you’re just a walking corpse”]. For some, this entailed “plac[ing] God on the back-burner” or “on the shelf” [“I still prayed while using, but God was not as important....Oh no, you don’t think about (God). The only thing you think about is how you’re gonna get your next fix”]. Others went further, putting their “faith in drugs instead of God” [“To me I’ve been messing with marijuana and other drugs for so long, they become my spirit, they become the thing I believe in every day and search for and seek out”; “Your addiction has become greater than you, you turn your life over to your addiction, over and over again”].

3.2.2.3. Many other participants described an ongoing, yet bankrupt relationship with God when they were still using: For many participants, religious and spiritual beliefs during periods of active use were diluted by what participants identified as “junkie” rationalizations that fueled poor decision making. Several participants recounted using “foxhole” or “jackpot” prayers in dire situations [“The only time I used to call on God was when I didn’t have no dope and get locked up—I’d be in that bullpen hurting, because I didn’t have no heroin and that would be the only time I would call on God....when I felt like I was at my rock bottom”]; “I had God, but I just had him in different way when I was out there. I’d be like, ‘God, don’t let me get burnt for my last ten dollars’ ... you know, I was just using him in the wrong way”]. These participants summarized their experience of spirituality, while they were in active addiction, as having been largely a bankrupt attempt at manipulation.

3.2.2.4. Participants described a struggle to redefine themselves as having moral values despite guilt and shame evoked by prior behavior: During their time “out there,” many participants took actions they retrospectively judged to have been immoral [“I did a lot of things that I wish I hadn’t done...but you want that next ten dollars to get that next hit”]. In recovery, they found it difficult to define how they could still be a spiritual and ethical people despite this history. Feelings of defensiveness were repeatedly expressed regarding perceptions that others were quick to pass judgment on them because of their history [“Everybody who gets high is not a bad person, they just do bad things”], and some participants admitted that it was hard to return to the religious community for fear of being judged.

Some participants expressed a need for forgiveness, both from others and from themselves [“All the pain I inflicted on my mother, and my wife....If you don’t deal with it, it just festers”]. Some reported feeling that spirituality had helped assuage negative feelings (i.e., pain, guilt, and bitterness) resulting from experiences associated with the lifestyle of an addict.

3.2.2.5. When estrangement from religion occurred among participants’ peers, it seemed to manifest itself as bitterness rather than atheism: Participants never reported any period of complete loss or absence of faith (though we also did not probe for that), and they seemed to have had little contact with anyone who lacked spiritual beliefs [“All the people I know that’s rippin’ and runnin’, they believe in God. Very few of them do not believe—for one thing, I try not to associate with them type of people, but I don’t *know* many of the people that *don’t* believe in God”]. One comment that at first appeared to attribute pushiness to nonreligious individuals [“Them who are lost...I don’t want to be around people like that, because it seems like they try to force their beliefs on me”] turned out to refer to active users who were angry with God [“A lot of them type people, they’re like, what did God do for them? ... We’re the one who make that choice (to be out on the street), not God”].

3.2.3. Participants’ transitions from user to treatment-seeker often accompanied an increase in spirituality—The process of recovery represented a spiritual awakening and a renewed relationship with a higher power. Participants often attributed their recent success to God or a higher power [“He helped me through the way to get clean”; “What I’ve been doing to help me get clean is I’ve been praying and going to my family members that are into church and into the Bible...and that’s been helping me to give me strength to get myself together”]. One participant’s experience seemed to affirm the potential value of maintaining one’s attendance at religious services even while using [“Like I said, I was doin’ dope and goin’ to church. How wrong is that? That’s real wrong. But going to church started me in the right direction—it was still meaning something to me. I was setting the stage, and once the stage was set, then I finally gave up (on using); that’s when I started looking for a place like this (clinic)”].

3.2.3.1. Reflecting on mortality increased participants' awareness of spiritual mission in life: Many participants believed that because they had survived so many life-threatening experiences, the only reason they were still alive was because God had a reason for them to be here ["At the end of my addiction I used to pray, 'God, let this (time I shoot up) be the one that kills me, because I do *not* want to live like this no more.' But I guess He say, 'No, I got plans for you, I ain't gonna let you die yet.' Because I really, really wanted to (die), at the end"; "Back in 2002 I was shot....I died twice on the operating table....I'm wondering, 'Why did God let me live, (when) I done did so much bad stuff in my life?' My mother said, 'He has a plan for you'"; "My body used to hurt so bad that I just wanted to kill myself from the pain, you know, and I knew there had to be some spirituality going on up there, be God or something, because I wouldn't allow myself to do that. Whatever it was gave me strength *not* to hurt myself, and it keeps giving me chance after chance, like it's a *plan*, maybe something out there had a plan for me, because....I could be dead from the things I did out there, lost a limb, or maybe even be in prison for killing somebody that didn't deserve it"].

Many endorsed the belief that God had a predetermined plan for their mission in life and that drugs were "covering up that path for us to follow" and that "to see the path you need to stay in touch with God" ["(Spirituality) gives me a reason to go on with my life...(that reason is) to try and share my knowledge with the next person"; "When I die, I want people to think and remember me, and say, 'What did he do?' I want to make a difference....I don't want, that all in my life I did was getting high....I want to have *meaning*"].

3.2.4. Participants' ongoing effects at recovery were often heavily reliant on spirituality—Most of the focus-group sessions began with the moderator's open-endedly asking what sort of relationship there is, *if any*, between spirituality and recovery; the typical first response was that the two "go hand in hand." Several comments conveyed the belief that efforts put forth towards recovery are futile without the inclusion of spirituality ["If you want to stay clean, eventually you will get a relationship with a higher power. It may not be God, so to speak, but you have to find something greater than yourself"; "You definitely need spirituality in recovery... I don't think I could stay clean without God. I mean I tried it on my own a lot of times and it didn't work ... this time around I have humbled myself to get down on my knees and pray, and it's working"]. Other statements, such as "The addiction thing, it's something you can't do by yourself," implied that addiction felt too powerful and seductive for addicted individuals to overcome alone.

3.2.4.1. Spirituality was described as hope: Spirituality was repeatedly named a primary source of hope and reassurance that life *will* improve, especially at low points ["(Spirituality) is *hope*. If you got *hope* you'll go further, strive further, set goals, it allows you to do more things"; "I know God give me another chance, because He see hope for me, and I see hope for myself because I know that I ain't got to live that way today, and long as I trust in God I'm gonna be better"; "My relationship with God gives me hope. When I wake up in the morning, it gives me reason to go on with my life"]. For most participants it seemed that placing faith in a higher power lessened the perceived overwhelming personal burden of the challenges of recovery.

3.2.4.2. Spirituality was credited with helping improve participants' state of mind by giving strength and peace: For many, spirituality provided strength and solace during trying times on the recovery path; it gave them meaning as well as "something to reach for, to believe in." Participants often recalled utilizing their spirituality to cope with urges and temptations ["It helps give me a straight frame of mind that keeps me from going out to use sometimes. Like when I get the urge to use, I talk to God and it helps me a whole lot"]. The notion that spirituality keeps you "grounded" and provides "a bigger perspective" was widely agreed upon

["I make poor decisions, so I ask God to help me make my decisions"]. Participants suggested that knowing they "weren't in this alone" gave them the mental clarity to make better choices.

Most participants agreed that God is just and merciful, rather than harsh or vindictive ["God does punish and judge but you bring it on yourself. You're given different choices to make, and if you make the wrong ones, you have to pay the consequence. But I don't believe that He's cruel"]. However, some expressed anger and frustration towards God for having been subjected to challenging obstacles in the initial stages of recovery (e.g. having to continue living with other drug users), and alluded to how "He'll show you how fast He can take it all away."

3.2.4.3. Current practices were largely private and internal: While current attendance to church or religious events was reported to be infrequent, many participants endorsed involvement in private, internal activities that served spiritual purposes ["It's personal for me; I believe, but I don't go to church"; "You can stay home and pray; He hears it"; "I talk to God like He's my best friend"; "I read the scriptures—not as much as I used to, but more now, because I try to put myself on a schedule"; "I wake up and thank God for the little things, like yesterday, how pretty it was—if I was using, I never have even noticed that—that the sun was shining, and it was nice and warm"]. One participant who did report very frequent church attendance (three times a week) appeared to view this as just one possible behavioral strategy; speaking of what nonreligious former addicts could do instead, he said, "You could join a gym or something."

3.2.5. Participants generally endorsed the idea of a spirituality group in clinic

3.2.5.1. Participants reported negative experiences with NA as a source of spiritual

support: Participants stated that while the spiritually oriented philosophy of 12-step programs was appealing, their own experiences of 12-step meetings had left them with mostly negative impressions. The primary reasons were perceptions of lack of acceptance and/or hypocrisy, as well as dislike of the format. The 12 steps stipulate total abstinence from all addictive substances (except nicotine and caffeine); for individuals who interpret this doctrine conservatively, methadone maintenance is not congruent with sobriety ["You have people in NA that judge you...they don't accept you, because you not clean, because you using meth (methadone)"]. Methadone Anonymous was founded to address this issue, but participants stated that they found Methadone Anonymous programs rare and difficult to locate. Participants also expressed frustration about the selling, distribution, consumption, and discussion of drugs that they reported having seen at or near 12-step meetings ["People glorify how they used to use, and that gets to me, and I don't want to hear that"; "You got people in there that's still using, still dealing, still manipulating the newcomers, I done seen so much stuff that go on in NA that I don't even deal with it"; "I've seen people coming to meetings when they high as hell, they'll get up there and celebrate anniversaries high"]. Finally, some participants said that the format of 12-step meetings was incompatible with their individual needs and their level of comfort with public speaking ["I've practiced the 12 steps backwards, upwards, sideways, and cross-eyed but it just didn't work for me. I would attend a spirituality group before I would attend a 12-step meeting....I feel more comfortable like this (in a casual group setting)"; "I would like a (small, in-clinic) group because it's a more relaxed setting with less pressure, no set format"].

3.2.5.2. Participants reported isolation from churches, due to self-perceived outsider

status: Several participants reported feeling alienated by religious institutions because of their perceptions that fellow members often passed moral judgment. Many felt that they needed to hide some of their struggles with addiction from other people in church communities ["(parishioners tend to) hold your background and the wreckage of your past against you"; "It

would be good (to have a group in the clinic) because there are things that I can't say to my minister as far as using or sticking a needle in me "; "There is a lot of people there (at church) that isn't like me, I'm the outsider"; "At church, a lot of times, you go and meet over at people's house. They're not gonna want *me* in their house, knowing that I was an addict"]].

Other concerns that dissuaded participants from attending church were fears of not having the proper attire or not knowing the prayers and rituals during services. Some participants were dissuaded from using church-based resources (including support groups for addicts) due to perceived lack of confidentiality.

3.2.5.3. Participants had specific but varied suggestions for implementation of a spirituality group in clinic: Participants generally expressed strong support for implementation of a spiritually oriented group in the clinic. The primary incentive was the fellowship and comfort that would be derived from participating in a group with other recovering addicts who could relate to each other's struggles. Even a participant who had expressed a preference for worshipping privately rather than attending church said approvingly, "I could see that," because "it's just not going to church—it's part of recovery, too." Participants endorsed the idea of welcoming atheists or agnostics to the group ["There could be a patient that don't believe in God but could hear the experiences of others and be like, 'Damn, I could get into that and start going to church, or turn to people in the group for (spiritual) counseling'"]. Several endorsed the belief that "God also works through people"; some participants agreed that reaching out to others would be spiritual and rewarding in itself. Finally, some participants felt that a group would provide them with additional structure and focus that would alleviate boredom and prevent idle time from being the "Devil's time."

Participants had several different opinions regarding who should moderate the group. Some suggested a recovering addict, "a person who has been there, but now they're on a different path," while others endorsed the idea of bringing in a minister or clergyman "as long as they didn't sit there and preach at everybody." It was also repeatedly suggested that the group could largely moderate itself and that a counselor need be present only to ensure the group remain focused on appropriate and relevant issues. The importance of an open discussion format was stressed repeatedly ["I don't want to come to clinic for church"; "If you have those set rules and guidelines, it just turns into the 12 steps"].

Several stipulations were suggested. It was emphasized that participation in such a group had to be voluntary, so that individuals who do not feel comfortable discussing spirituality would be able to waive their right to attend. Participants also expressed reluctance to have specific religious dogma or theology preached in the clinic ["Regardless of what religion anybody is, our problems are still the same...it would be about how our higher power is related to our addiction, it wouldn't be about Jesus or God"; "(If it's too much like church,) 50–60% are not gonna like it; 30–40% will, probably. But I believe everybody will agree on a seminar type of thing"; "You got people in here with different religions, so you gotta accommodate everybody...get some Muslims to come in for the Muslims, some Christians to come in for the Christians"]. Several participants said that the program should be publicized in neutral terms centered around the word *spirituality* ["If you go and say, 'Well, we gonna have *God* for you over here at this program,' they ain't gonna come"]. A few individuals wondered whether spiritual activity should not be a part of treatment, sometimes based on concerns about the political acceptability of integrating the two ["The thing would be the political aspect of it...the people that's backing this (federally funded program), what would *they* say about it? ...It's like, church and state"]. Only one participant explicitly opposed the idea of implementing a spiritual component into treatment ["I don't think having spirituality as part of this program would make my recovery more successful—it's that relationship that you establish where you get honest with yourself, it's all with yourself"].

4. Discussion

We conducted an exploratory study using both quantitative and qualitative tools to examine the role of spirituality in recovery and to determine the appropriateness of providing a spiritual program in an inner-city drug treatment program. Our main finding—that there was considerable support among participants for integrating a voluntary spiritual program into substance-abuse treatment—complements a similar finding in a prior focus-group study (Arnold et al., 2002). In that study, all participants were HIV-positive, and for many of them, the prospect of AIDS had increased their tendency toward spirituality. In our sample, only one participant (of 25 who took part in the focus groups) tested HIV-positive at intake, but, as mentioned in section 3.2.3.1, thoughts of mortality had similarly influenced our participants' perspectives.

Unlike the prior study, ours specifically explored the relationship between drug use and spirituality during periods of active addiction. Before discussing our findings, we should note that drug use and spirituality are not antithetical; under some circumstances, drug use may beentheogenic, inducing or facilitating spiritual experiences (a property not limited to the classes of drugs traditionally used in religious rites, and sometimes seen with stimulants such as amphetamine) (Siegel, 1977). However, we did not expect to find such effects associated with the compulsive use of heroin or cocaine, and no participants reported such effects. For most participants, addiction seemed to hollow their inner experiences of spirituality and to coexist awkwardly, if at all, with their outward observances of religious rituals. (The tension is illustrated in an anecdote shared outside of group by one of our participants: on one occasion, he was listening to gospel music on the radio while driving, but as he approached the neighborhood in which he was about to buy drugs, he turned the radio off.) Our participants did not describe “paradoxical use” (Center on Addiction and Substance Abuse, 2001)—that is, they did not indicate that their moral turmoil exacerbated their addictions—but they did describe some dissonance between their actions during active addiction and their core views of themselves as “not bad.” They also acknowledged that their status as addicts often prevented them from seeking support from clergy or fellow churchgoers.

Perhaps for that reason, participants conveyed the need for a spiritual resource that would serve as an addition or an alternative to traditional church services and 12-step meetings. This resource would incorporate elements from both, while introducing new aspects specifically tailored to individuals faced with the arduous challenges associated with substance abuse recovery. Future research and clinical experimentation will be required in order to determine the format of a group that would be both practical and helpful in a substance-abuse clinic. For example, participants repeatedly stressed that the group should be nonsectarian, but they seemed to envision this largely within a Christian framework (though one participant did mention Islam). One spiritually oriented intervention already in development, Spiritual Self-Schema therapy, avoids such a framework, instead taking a Buddhist-oriented approach (Avants & Margolin, 2004). Among the advantages of such an approach is that it is free of negative associations for most adherents of the major Western monotheistic religions. On the other hand, the use of an unfamiliar form of spirituality could confer some disadvantages; for example, it may not harness the fervor that many individuals bring to their familiar faiths. In addition, the structured, psychoeducational nature of the Spiritual Self-Schema approach does not resemble what was suggested by participants in this project. Nonetheless, a preliminary case report suggests that the approach has potential (Marcotte, Margolin, & Avants, 2003).

Some limitations in the current study should be noted. The most serious limitation is that participants were self-selected; the 26 (out of 79 eligible) clinic patients who agreed to attend a focus group may have been the ones most likely to support incorporating spirituality into drug treatment. On the RBBQ, all participants in the current study (except one who gave

contradictory responses) indicated that they were strongly religious (3 or 4 on a scale of 0–4). Some earlier data from our clinic may put this into perspective. As part of a study that was not focused on spirituality, a non-self-selected group of 169 cocaine- and heroin-abusing outpatients were administered a survey in which they were asked, “How strongly religious (or spiritually oriented) do you consider yourself to be?” Responses were: 14% strong, 41% somewhat strong, 34% not very strong, and 10% not at all (Heinz et al., in press). It seems likely that the 55% of patients who rated their spirituality/religiosity as “strong” or “somewhat strong” represent the population sampled in the present study. In addition, all were Protestant or Catholic. In future studies of this nature, efforts should be made to include individuals from other religious backgrounds and individuals who rate themselves low on spirituality/religiosity.

Other limitations include the fact that some participants knew each other from interactions in the clinic, which may have prompted a bias towards more socially acceptable responses to discussion topics. Several participants reported either past or present involvement in a 12-step program (as one of the focus groups drew to the close, participants decided to recite the Serenity Prayer); it is likely that some of the language used was influenced by the 12-step philosophy.

It should also be noted that the results of studies like this one may be more applicable in the US than in other countries. Survey data have consistently shown that the general population of the US is among the more religious in the world. For example, the statement “I know God exists and I have no doubts about it” was endorsed by 63% of respondents in the US, but only 30% in New Zealand, 27% in West Germany, and 24% in Great Britain (International Social Survey Program, 1991). Even so, spiritually based interventions have been well received in other countries. In Great Britain, at a community treatment center for problem drinkers, the introduction of spirituality discussion group “attracted a small but enthusiastic group of clients” (though no outcome data were reported) (Jackson & Cook, 2005).

As mentioned briefly in the Introduction, we did not attempt to explore cultural differences such as those associated with race and ethnicity. The relevance of race is embodied in Martin Luther King’s famous statement that “the most segregated hour of Christian America is eleven o’clock on Sunday morning” (King, 1958), an assessment still largely borne out by statistics on church membership which document continuing racial segregation (Emerson & Smith, 2001). In a prior study of 169 patients in our clinic, we found that African-American patients rated themselves higher on a spirituality questionnaire than European-American patients, and we found a complex pattern of racial differences in correlations between spirituality and amount of ongoing heroin and cocaine use (Heinz et al., in press). The fact that race was not brought up by any participants in our focus groups may reflect its being less divisive than is sometimes assumed—or conversely may reflect participants’ reluctance to broach the topic in the group format. We cannot draw any conclusions about race from our data, but we would like to suggest a framework for future studies. In considering race in the context of an in-clinic spirituality group, at least two possibilities should be considered:

First, spirituality groups in clinic may have promise. Specifically, they might be a place where spirituality is freed from other elements of 12-step philosophy that are sometimes considered, at least in principle, to be counterproductive for African-Americans and other historically disempowered groups (such elements include professions of powerlessness, and an individual-centered rather than structural or politicized attribution of problems; Saulnier, 1996). Prior qualitative research suggests that African-American attendees may have complex, partly alienated relationships with 12-step programs (Durant, 2005; Saulnier, 1996). We know of no findings to suggest that outcomes of 12-step attendance differ by race. Even so, the perception of 12-step meetings as white, middle-class enclaves remains, and clinic-centered spirituality groups may therefore be attended by members of minority groups who otherwise would not attend self-help meetings.

Second, spirituality groups in clinic may entail risk. One risk could arise as clinicians try to balance a “one size fits all” approach against the need for cultural sensitivity. Some writers have argued that a “one size fits all” approach to recovery is especially inappropriate for minority groups (Saulnier, 1996), and in fact, at least one culturally tailored approach for African-Americans has been piloted (Longshore, Grills, & Annon, 1999). That approach includes serving participants a meal whose overall atmosphere was described as a “pivotal part of the intervention”—and whose menu includes fried chicken, ribs, and greens. While the authors report that the intervention as a whole was well received, it is easy to imagine how such attempts at cultural tailoring could backfire if attempted by clinicians with insufficient understanding of what they are doing. The field may benefit from increased staff training and pre-professional education which addresses the risks and benefits of fostering patients’ spirituality in order to assist individuals in addressing their substance use disorders.

Such concerns notwithstanding, the Joint Commission on Accreditation of Healthcare Organizations has mandated assessment of cultural background and spiritual orientation for outpatients entering substance-abuse treatment (JCAHO, 2006). There appear to be no accompanying recommendations regarding the subsequent use of the information. Such recommendations will have to be based on controlled trials of interventions, but in developing the interventions to be tested, researchers and clinicians might benefit by adopting the stance that patients are the “experts” (Conners & Franklin, 2000), at least in some aspects of recovery. We hope that our findings, combined with those of future qualitative studies with more diverse samples, will build a foundation from which spiritually informed interventions in substance-abuse-treatment settings can be further developed and systematically evaluated.

Acknowledgments

This research was supported by the Intramural Research Program of the NIH, National Institute on Drug Abuse.

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Table 1Demographic characteristics and questionnaire scores⁷

Demographic Characteristics	N	%
Race		
European-American	5	19
African-American	20	77
Hispanic	1	4
Male	16	62
Marital status		
Married	3	12
Divorced/Separated	5	19
Never married	17	65
Widowed	1	4
Employment		
Full-time	11	42
Part-time	7	27
Unemployed/disabled	8	31
Religious Affiliation		
Catholic	4	15
Protestant	18	69
none	4	15
Education		
High-school diploma/GED	17	66
No high-school diploma	5	19
Some college	4	15
Previous Treatment		
Yes	20	77
HIV+ on admission screening	1	4
	Mean	SD
Age (years)	40.9	7.2
Self-reported life years of drug use		
Heroin	11.2	7.5
Cocaine	11.04	8.1

*
N=26