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Religiosity/Spirituality in Individuals with Alcohol Dependence- A Comparative Study

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Abstract
Background*: Alcohol dependence syndrome is a most preventable public health problem. It affects major public health care system which has an impact on all aspects of health care delivery systems. In recent days factors like 'spirituality' and 'religiosity'have been identified as protective for substance intake and preventing factor of relapse.*
Aim: *This study was planned to find out the differentiation of spirituality and religiosity in individuals with alcohol dependence and normal control.*
Method: *In alcohol dependence group according to ICD-10 (DCR) 40 individuals were taken after detoxification and 40 individuals in normal control group were taken after screening with the General Health Questionnaire-12. Age, sex, religion, education and marital status were matched in both groups then Brief Multidimensional Measurement of Religiosity/Spirituality was administered.*
Result and Conclusion: *Study findings indicate thatbothalcohol dependence and normal control group were significantly different on the basis of spirituality and religiosity. Normal control group was more spiritual and religious than alcohol dependence group.*
Key words: *Alcohol dependence, Spirituality, Religiosity*

I. Background:

Alcohol dependence syndrome is a most preventable public health problem. It affects major public health care system which has an impact on all aspects of health care delivery systems. Dependence syndrome is defined as: 'A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco' (ICD-10).

Alcohol as well as other psychoactive substance addiction is not a simple problem to understand as this problem has multifaceted aetiological origins and determinants. Over the years a wide array of factors has been identified to have significant association with the onset of this problem. Those factors were identified both at individual and societal levels. Cumulatively those factors can affect the degree and forms of alcohol consumption in people. Societal and environmental factors like economic development, cultural sanctions, availability of alcohol in the society, presence and enactment of alcohol policies and rules by the authority have been found to have close association with the onset and progression of alcoholism in the society (Babor et al., 2003; Nelson et al., 2013).

Spirituality is understood as a "search for the sacred" with particular emphasis on transcending the boundaries of human material existence (Miller, 1998). Spirituality is a latent construct with multidimensional properties representing aspects of beliefs, motivation (goals and values), mystical or transcendent experiences, and behaviours related to these beliefs, motivations, or experiences. Spirituality steps up and grows through organized religious beliefs, faiths and rituals. In fact most religions are held as organized systems which are designed to support and encourage the attainment of a spiritual life, shared by a community of believers and practitioners. But it is also equally true that despite the close and intensive relation between spirituality and religiosity, spirituality is not synonymous to any particular religious orientation or value system. While the specific beliefs, moral codes, and spiritual practices of religions vary, there are common themes, such as transcending human suffering and the development of greater conscious awareness.

Addictive behaviours, such as alcohol abuse and dependence, is viewed from a spiritual perspective as "misguided attempts to solve the problems of human existence by artificially altering one's state of consciousness with psychoactive substances that temporarily mimic authentic spiritual transformation (by altering senses, thoughts, and behaviour), but which ultimately decrease spiritual capacity, resulting in both physical and mental disorders" (Miller, 1998). From this perspective it can be stated that, authentic spiritual beliefs and practices are natural and healthy ways to prevent and effectively treat, substance use

disorders. Religiosity and spirituality have been shown in the research literature to lead to beneficial health outcomes. Many empirical studies had categorically revealed the fact that spirituality and being regular to religious ritualistic practices could work positively to push aside the substance addiction up to a significant extent. Kaskutas et al., (2003) found that insistence to religiosity could hasten the positive outcome among individuals with the history of alcohol dependence syndrome. They noted that religious and spiritual practices did increase the involvement of these people in Alcohol Anonymous Programme. Author like Carroll (1993) advocated that increased reliance on religious and spiritual practices could fetch positive things for individuals recovering from alcohol dependence syndrome by assisting them to get deeper and positive perspectives of life and become more optimistic about their life. Individuals with high regards to basic moral and human values would become more proactive to keep way alcoholism for longer period. Another important observation was that prolong support from the tertiary social organizations like spiritual and religious organizations could work as 'buffering agent' against any kind of stressors and people with this support would have higher resilience to push aside the temptation of addiction (Corrington, 1989; Nealon-Woods et al., 1995; Warfield & Goldstein, 1996).

Aim of the study:
Aim of this study was to find out the difference of spirituality and religiosity in individuals with alcohol dependence and normal individuals.

II. Methodology:

This study was a hospital-based, cross-sectional study conducted at S.S. Raju Centre for De-Addiction Psychiatry, Central Institute of Psychiatry, Ranchi, India.Purposive sampling method was chosen for dada collections. Total sample size was 80(40 in Alcohol Dependence group and 40 in Normal control group). Inclusion criteria for alcohol dependence group were individuals diagnosed with Alcohol Dependence Syndrome according to ICD -10 (DCR) criteria, SADQ score more than 16, age between 18-50 years and education above 10^{th} standard. For normal control group inclusion criteria were GHQ-12 score <3, no history of substance addiction, age between 18-50 years and education above 10^{th} standard. Exclusion criteria for both groups were any psychiatric or severe physical illness, neurological disorder and mental retardation. Age, education, family income, marital status and religion wise participants of control group were matched with alcohol dependence group. Written informed consent was collected from all the participants and Brief Multidimensional Measurement of Religiousness and Spirituality (BMMRS) scale was applied.

Description of tools-

- ***Socio-Demographic and Clinical Data Sheet*** was used to obtain information about age, education, religion, marital status, family income, duration of alcohol addiction, past history of medical or psychiatric illness and family history of medical or psychiatric illness.
- ***General Health Questionnare-12*** (GHQ-12; Goldberg &Williams, 1988)is a 12 items self-administered screening tool. It is not designed to detect symptoms that occur with specific psychiatric diagnoses such as psychotic disorders, rather, provide a measure of overall psychological health or wellness.The *General Health Questionnaire (GHQ)* is a screening tool which is useful for identifying minor psychiatric disorders in the general population.
- ***Severity of Alcohol Dependence Questionnaire (SADQ)***measures severity of dependence. It covers - physical withdrawal, affective withdrawal, relief drinking, and frequency of alcohol consumption and speed of onset of withdrawal symptoms. Each item is scored on 4-point scale, ranging from "Almost Never" to "Nearly Always", resulting in a corresponding score of 0-3. Thus the total maximum score possible is 60 and the minimum is 0.
- ***Brief Multidimensional Measurement of Religiousness and Spirituality***(BMMRS; Fetzer Institute, 1999)is a brief measure of a broad range of religiousness and spirituality (R/S) dimensions (Harris et al., 2008).This scale measures following 12 aspects of religiousness or spirituality.

Subscale	No. of Item	Item range/directionality
Daily Spiritual Experiences	6	1–6, lower =more frequent experiences
Meaning	2	1–4, lower =greater agreement
Value/Beliefs	2	1-4, lower=strong value/beliefs
Forgiveness	3	1–4, lower =more forgiving
Private Religious Practices	5	1–8, lower =more frequent practices
Positive Religious and Spiritual Coping	3	1–4, lower =greater use
Negative Religious and Spiritual Coping	3	1–4, lower =greater use
Positive Religious Support	2	1–4, lower =greater support
Negative Religious Support	2	1–4, lower =more negative support
Organizational Religiousness	2	1–6, lower =more frequent attendance

Overall Self-Ranking	2	1–4, lower =more religious or spiritual

III. Results:

Socio-Demographic characteristics of samples show that most of the individuals were married (77.5% and 75.0%), Hindu was the major religion (70.0% and 57.5%) in Alcohol dependence group as well as control group. Alcohol dependence group mean age was 33.90 years and 31.55 years was in control group. Education mean was in alcohol dependence group 12.52 years and 13.82 years in control group.

Table-1 Comparison of Spirituality and Religiosity between Alcohol dependence and Control group:

Variables			Alcohol dependence Group n=40 Mean±S.D.	Normal Control Group n=40 Mean±S.D.	t (df=78)	p
Brief Multidimensional Measure of Religiousness/Spirituality	Daily Spiritual Experiences		17.72±5.08	15.27±4.18	2.351	**.021***
	Meaning		4.30±1.43	3.82±1.23	1.585	.117
	Value/Beliefs		4.75±1.33	4.52±1.35	0.747	.457
	Forgiveness		6.85±1.91	5.80±1.91	2.454	**.016***
	Private Religious Practices		19.72±5.60	17.22±3.51	2.389	**.019***
	Religious &Spiritual Coping	Positive	9.07±1.88	8.05±2.40	2.120	**.037***
		Negative	8.50±2.64	9.65±1.88	2.240	**.028***
	Religious Support	Positive	5.57±1.69	4.67±1.70	2.372	**.020***
		negative	5.32±1.63	6.07±1.47	2.152	**.035***
	Organizational Religiousness		9.07±2.49	8.60±2.58	0.837	.405
	Overall Self-Ranking		5.42±1.51	4.75±1.72	1.861	.067

* Indicates 0.05 Level of Significance

Above table shows significant difference between these two groups in various domains of the Brief Multidimensional Measure of Religiousness/Spirituality Scale. Control group had lower score onDaily Spiritual Experiences (15.27±4.18), Forgiveness (5.80±1.91), Private Religious Practices (17.22±3.51), Positive Religious/Spiritual Coping (8.05±2.40) and Positive Religious Support (4.67±1.70), whereas Alcohol dependence group had lower scores on Negative Religious/Spiritual Coping (8.50±2.64), Negative Religious Support (5.32±1.63) which indicate that Control group was more religious in comparison to alcohol dependence group

IV. Discussion:

Study results indicate that Daily spiritual experiences and private religious practices were high in normal control group than alcohol dependent group; this result suggests that they have more faith in God and devote more time in spiritual practices. Religious/spiritual related behaviours, such as prayer, meditation, and reading can be protective factor for substance use. This finding was supported by study done by Koenig et al. (1994), in their study they found that alcohol use disorders were less common among respondents who frequently read the Bible or prayed privately. Spiritual assessments and evaluations at the onset of treatment, as well as incorporating spiritual beliefs and practices into the treatment process, may assist substance abusing clients in identifying strengths, beliefs and practices that are essential for long-term recovery (Carter, 1998).

The forgiveness domain of BMMRS depicts that by forgiving others and own-self a person may feel that he/she is also being forgiven by the God. The ability to forgive own self may reduce the likelihood of alcohol and other drug abuse in individuals who experience higher level of forgiveness, also supports the fact that self-forgiveness is a health protective form of emotion-focused coping strategy that can produce therapeutic benefits in substance abusers (Ianni et al., 2010).

Religious or spiritual coping was significantly lower in the alcohol dependence group, which implies that individuals with alcohol dependence use less religious and spiritual coping. A part of the relation between stressful events and alcohol use is explainable in the ways alcohol is used to reduce or tackle the negative emotions associated with the stress (Cooper et al., 1992). Religious coping use was found to be associated with better adjustment to negative life events and these include benevolent religious reappraisals, religious forgiveness and seeking religious support.

Present study found that individuals with alcohol dependence had lower positive religious support which is consistent with previous study done by Avants et al. (2001). Their study found that perceived religious comfort and support at entry into treatment was an independent predictor of abstinence from substance use by HIV-positive injection drug users. They also found that patients with high ratings of religious support were abstinent from both heroin and cocaine significantly longer than patients with lower ratings.

V. Conclusion:

This study was a hospital based cross sectional comparative study between individuals with alcohol dependence syndrome and normal control group. Sample size and purposive sampling method of this study restricts to generalize the result. Though from this study results and discussion it can be concluded that spirituality and religiosity having a protective role in alcohol intake. It was also found that spirituality and religiosity can be used as therapeutic purpose for management of alcohol addiction and other substance use disorders. Future study should include large sample size and random sampling method for greater generalization.

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