

Spiritual Beliefs and Quality of Life among Persons with Alcohol Dependence Syndrome

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ABSTRACT:

Spirituality as propagated through Alcoholics Anonymous (AA) has resulted in the attainment of sobriety for many persons with Alcohol Dependence Syndrome. The aim of the study was to see the association between Spiritual Beliefs and Quality of Life. We conducted a study using a cross sectional design where two groups (AA and hospital based program) from Bangalore consisting of 60 respondents were recruited for the study and standardized tools were used. The findings suggest that the AA group had a longer duration of abstinence and a positive association was observed between spiritual beliefs and quality of life. Support groups like the AA, are to be integrated as part of the holistic treatment for persons with addiction related disorders.

Keywords: Alcohol Dependence Syndrome (ADS), Alcoholics Anonymous (AA), Abstinence, Spirituality and Quality of Life

INTRODUCTION:

Globally alcohol consumption is considered to be the eighth leading risk factor for mortality and the third leading risk factor of death and disability (Rehm et al., 2009). In India current estimates of alcohol consumption are said to be at 30-35% for adult males and 5% for females (Gururaj, Murthy, Girish, & Benegal, 2011). Consumption of alcohol in the long run leads to dependence causing a major threat to the physical and mental health of the individual (Benegal, 2005). It is known to affect and impair cognitive functions (Chanraud et al., 2007), causes medical co-morbidities (Perälä et al., 2010) and lead to alcohol related deaths (Gururaj et al., 2011; Siddiqi, House, & Holmes, 2006). Since being identified as one of the major causes of the global burden of disease (WHO, 2004b), alcohol dependence is a chronic relapsing disorder (Vaillant, 2003), affecting all spheres such as personal, social, economic, financial (Gururaj, 2006) and family (Chowdhury, Ramakrishna, Chakraborty, & Weiss, 2006).

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Engagement in treatment is often problematic (Passetti, Jones, Chawla, Boland, & Drummond, 2008), and despite conventional treatment patients have poor long term outcomes (Marshall, Edwards, & Taylor, 1994) resulting in multiple episodes of treatment extending over many years. In the last decade addiction related treatment and rehabilitative interventions have sprouted out emphasizing on the need for pharmacological (Johnson, 2008) and psycho social interventions such as brief motivational interventions, group therapy, community reinforcement approach, knowledge and skills training, family therapy, support groups such as self help groups and Alcoholics Anonymous (Jhanjee, 2014). An alternative form of treatment that emerged in the 1930's that stemmed out of the efforts of Bill Wilson and Bob Watson was the Alcoholics Anonymous (AA) in 1935 (AA, 1976). Since its inception it has continued to be one of the most widely used resources for persons with substance use disorders (SUD) (Room & Greenfield, 1993). Though various pharmacological treatments are available, most treatment providers recommend the 12 step meetings of AA to be an effective intervention (Timko, Moos, Finney, & Moos, 1994) and as an adjunct to the clinical treatment (Slaymaker & Sheehan, 2008).

Being religious is known to predict better health related outcomes, report higher levels of life satisfaction, greater happiness and fewer negative consequences (Ellison, 1991; Oleckno & Blacconiere, 1991; Wallace & Forman, 1998). Like this the spiritual beliefs adhered to in the AA fellowship is considered to be an important programme for continued and holistic care where attendance, affiliation and involvement are known to be associated with better substance use disorder outcomes (Gossop et al., 2003; Kelly, Stout, Zywiak, & Schneider, 2006), mediate abstinence and if not reduce the use or abuse of alcohol resulting in a drug-free life (Morjaria & Orford, 2002). Scientific literature not only supports the notion that spirituality and religiousness is associated with decreased risk for substance use (Miller, 1998) but also can enhance health and Quality of Life (Morjaria & Orford, 2002) emerging as a protective factor that could be used by treatment providers.

Laudet and colleagues observed that social support, spirituality, life meaning, religiousness and 12-step affiliation are found to enhance quality of life among recovering persons (these tenets that are imbedded in the AA philosophy) (Laudet, Morgen, & White, 2006), a factor that is considered to be important for mediating abstinence (Rather & Sherman, 1989). A randomized trial comparing spiritually based 12-step facilitation (TSF) with Cognitive Behavioural Therapy and motivational enhancement therapy for alcoholism found that the TSF group was significantly more likely to achieve complete abstinence adding to the large body of evidence that shows an inverse relationship between involvement in religion (e.g., attending services, considering religious beliefs important) and likelihood of substance use across life stages (Project MATCH Group, 1997).

Quality of life of persons with alcohol dependence syndrome takes a toll in the long run and as a result is found to be poor in persons who consume alcohol as compared to those who were abstinent and attending AA meetings (Peltzer & Pengpid, 2012; Savitha, Kumar, Sequira, & Sreemathi, 2011) Several studies in the western context have explored this concept but none in

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the Indian context. With this the researcher conducted a study to explore the relationship between the two groups (AA and clinical group) on spiritual beliefs and quality of life that could shed light on newer treatment approaches.

MATERIALS and METHODS

The aim of the study was to examine if an association exists between Spiritual beliefs and Quality of Life among persons with ADS.

The study utilized a descriptive cross-sectional design using systematic random sampling with patients who sought help for their alcohol related problem from two treatment groups (AA group and Hospital based program). The respondents were abstinent from alcohol for a minimum of 6 months and were following up regularly at both the centres respectively. Thirty respondents were recruited from the out-patient department at the Centre for Addiction Medicine (CAM), National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore who visited the hospital on every two weeks as part of their routine treatment and 30 respondents were recruited from persons who were diagnosed with ADS in the past and were currently attending regular AA meetings at Bangalore.

Inclusion criteria: Patients who belonged to the age group of 20 – 60 years, diagnosed with Alcohol Dependence Syndrome (ADS) according to International Classification of Diseases-10 (ICD-10), (WHO, 1992), abstinent from alcohol use for the last 6 months and were following up regularly at both centres respectively with the absence of co-morbid medical and psychiatric conditions were included based on their willingness to participate in the study. Persons who had co-morbid disorders and were not willing to participate in the study were excluded. The sample that met the inclusion criteria were explained about the study and a written informed consent was obtained. The instruments used for the study were socio-demographic data sheet including clinical variables, Beliefs and Values (King et al., 2006) and Quality of Life (WHOQOL-BREF) scales. The data was analyzed using R software (R Development Core Team, 2008).

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RESULTS:

The mean age of all the respondents was 31.25 years, majority of them were married and belonging to Hinduism.

Table 1: Socio demographic characteristics of respondents from both the groups

Variable	Category	Clinical group		AA group	
		N=30	%	N=30	%
Age (in years)	27 – 35	16	53.3	20	66.7
	36 – 55	14	46.7	10	33.3
Marital status	Unmarried	5	16.7	11	36.7
	Married	25	83.3	19	63.3
Occupational status	Skilled	11	36.7	24	80.0
	Unskilled	10	33.3	0	-
	Professionals	8	26.7	4	13.3
	Business	1	3.3	2	6.6
Educational qualification	Illiterates	8	26.6	0	-
	SSLC	7	23.3	4	13.3
	PUC	5	16.7	3	10.0
	Graduates	10	33.3	23	76.7
Individual income	Below Rs. 2000	7	23.3	0	-
	2001 – 10000	15	50.0	12	40.0
	Above Rs. 10000	8	26.7	18	60.0
Family income	2001 – 10000	25	83.3	16	53.3
	Above Rs.10000	5	16.7	14	46.7
Religion	Hindu	26	86.7	14	46.7
	Christian	4	13.3	16	53.3

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Table 2 – Clinical profile of respondents from both the groups

Variable	Category	Clinical group		AA group	
		N=30	%	N=30	%
Age of initiating alcohol	15yrs - 18yrs	2	6.7	1	3.3
	19yrs - 22yrs	23	76.6	26	86.7
	23yrs - 26yrs	5	16.7	3	10.0
Reason for drinking	Friends	17	56.7	14	46.7
	Curiosity	4	13.3	3	10.0
	Peer-pressure	1	3.3	5	16.7
	Stress	8	26.7	8	26.7
Duration of drinking in years	1yr – 12 yrs	12	40.0	17	56.7
	13yrs – 24yrs	16	53.3	12	40.0
	25yrs – 36yrs	2	6.7	1	3.3
Current abstinence Period (in months)	6m-12m	29	96.7	7	23.3
	13m-19m	1	3.3	0	-
	20m-26m	0	-	23	77.7

The mean age of initiating alcohol use for all the respondents was found to be 21.15 years. Reasons for initiating alcohol use (curiosity, peer pressure and stress) were found to be similar between the groups. The mean duration of drinking alcohol for both groups was 13.5 years (clinical group = 14.7 years, AA group = 12.2 years). The current abstinence period in the clinical group was 9 months and 25 months in the AA group respectively

Table 3: Beliefs and values and Quality of life of persons with ADS

In the AA group, the total spiritual beliefs (M=66.16, S.D.±4.37) and Quality of Life (M=67.3, S.D.±2.89) was found to be better than in the clinical group (M=31.33, S.D.±3.45) and QOL (M=40.9, S.D.±4.28).

Variables	Group	N	Mean±SD
Spiritual Beliefs	Clinical group	30	31.33 ± 3.45
	AA group	30	66.16 ± 4.37
WHOQOL - Physical health	Clinical group	30	10.36 ± 1.18
	AA group	30	17.56 ± .77
WHOQOL – Psychological	Clinical group	30	10.93 ± 1.51
	AA group	30	17.28 ± .69
WHOQOL - Social relationships	Clinical group	30	10.57 ± 1.20
	AA group	30	17.20 ± 1.61
WHOQOL – Environment	Clinical group	30	9.10 ± 1.99
	AA group	30	15.20 ± .99
WHOQOL - Total Quality of Life	Clinical group	30	40.97 ± 4.28
	AA group	30	67.25 ± 2.89

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Table 4: Relationship between Spiritual beliefs and Quality of Life

Variables	Spiritual Beliefs	
	Clinical group	AA group
Physical	0.03	0.35
Psychological	-0.09	0.59**
Social Relationships	-0.08	0.62**
Environment	0.12	0.74**
Total Quality of Life	-0.06	0.68**

** Correlation is significant at the 0.01 level (2-tailed)

There was significant positive correlation observed between total quality of life and beliefs and values in the AA group ($r=0.682^{**}$, $p<0.01$).

DISCUSSION

Socio-demographic and clinical variables: The major group differences observed was that the members from the AA group were well educated, better skilled and were drawing an better income than their counterparts. This could probably be due to the accessibility of the AA meetings around Bangalore thereby allowing for people from upper middle income families to make use of these services. The AA group saw 53.3% who were Christians and there was an almost equal representation of Hindus (46.7%) who were benefited from the meetings. This means that the primary notion that AA is for people from Christian faith is untrue and these findings replicate the results in which non Christian members of AA were found to benefit as it did not emphasize on a religious relationship with a Christian faith (Briggman & McQueen, 1987).

The mean age of initiation of alcohol in both the groups was 21.15 years indicating that these people were exposed to alcohol at a very early age. Reasons for initiating alcohol use (curiosity and peer pressure) were found to be similar in both groups. This finding is evidenced by results where curiosity (Bhullar, Singh, Thind, Aggarwal, & Goyal, 2013) peer pressure (Kuntsche, Knibbe, Gmel, & Engels, 2005) and stress (Laudet, Magura, Vogel, & Knight, 2004) have been found to be significant factors leading to alcohol use. Abstinence rates observed to be longer in the AA group than the hospital based group. This could be due to the fact of the affiliation and attendance in AA which has a positive effect thereby resulting in longer periods of abstinence; these findings have a significant clinical relevance and are consistent with studies (McKellar, Harris, & Moos, 2009; Piderman, Schneekloth, Pankratz, Stevens, & Altchuler, 2008).

Beliefs and values: The AA group was found to show a higher spiritual belief as compared to the clinical group. These findings are consistent with results where persons with addiction related problems are likely to report that spiritually focused interventions and practices (eg, prayer) may facilitate recovery (Gartner, Larson, & Allen, 1991). Increased attendance at AA meetings was

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also associated with better outcomes as higher the attendance meant higher the spiritual affiliation which usually played a positive role in the adjustment and in better health (Blonigen, Timko, Finney, Moos, & Moos, 2011; Hoffmann, Harrison, & Belille, 1983), this was evidenced in the current study.

Quality of life: The members of AA group were found to do better on psychological, social relationships and environment domains (factors are embedded in the AA philosophy) as well as overall quality of life as compared to the clinical group. Similar results was observed which are consistent with the present findings that people attending AA groups were found to not only show increased abstinence rates but as well as experience better quality of life due to the environment that is cultivated by persons attending the support groups meetings creating a need for long lasting social relationships (Gossop et al., 2003; Savitha et al., 2011), the same that which is not present for people attending the hospital based treatment. However QOL being low in the hospital based treatment group does not suggest that the outcome for this group is poor it could be due to the differences in the period of abstinence between the groups. But it also meant that abstinence resulted in better QOL. The results are corroborative with the existing literature which posits that quality of life improves with abstinence, controlled or minimal drinking (Peltzer & Pengpid, 2012; Srivastava & Bhatia, 2013). These results have clinical significance where mental health professionals can improve the linkage of patients to self-help groups so as to improve abstinence rates as well as better Quality of Life.

Association between Quality of Life and Beliefs and values: There was a significant positive correlation observed between Quality of Life and spiritual belief in the AA group. Scientific literature strongly supports the notion that spirituality and religiousness can enhance health and quality of life. Positive relationships were associated with physical and functional status, reduced psychopathology; greater emotional well-being and improved coping (Matthews & Larson, 1995). Koenig and colleagues reported that religious/spiritual beliefs typically have found to play a positive role in adjustment and in better health (Koenig, McCullough, & Larson, 2001). These findings of the present study are consistent with Hall, where a moderately significant relationship was witnessed between spirituality and quality of life (Hall, 1999). Similar results were observed by Savitha and colleagues, where a significant difference in Quality of Life of clients attending AA groups meetings as those who did not (Gossop et al., 2003; Savitha et al., 2011).

Though this study has highlighted few important aspects that have an implication for further investigation, a number of limitations which must be highlighted before one could draw any generalizations. Firstly, the study had a small sample size. Secondly, the interview schedule could have used open ended questions to understand the experiences of the respondents and explore factors that contributed for improvement in quality of life as well as how spirituality has influenced other recovery related changes. Lastly, it is a cross-sectional study and not a prospective one. There could have been a lot of group differences on the clinical profile of the respondents among the two groups. Therefore a more robust study design using matched sample with a large sample size could have been adopted to control for confounding factors.

CONCLUSION

In the wake of addiction related disorders there has been few documented literature relating to the beneficence of AA groups and their active role they play in continuity of care especially in the Indian context. The results lend support to the role of spirituality and influence of support groups in the quest for sobriety leading to better health outcomes which must be a part of the treatment regime. Future studies should look at the processes involved in the facilitation of recovery. The knowledge gained about the positive relationship between spiritual belief and quality of life highlight the importance of religious and spiritual related beliefs which serve as a protective factor. Support groups such as the AA that helps in increasing abstinence rates and promoting better quality of life is to be integrated as an effective add on measures along with hospital based management. This can serve as implications for clinical practice in the holistic treatment for persons the ADS. Future prospective studies can explore this area with large samples and test out the efficacy of AA as an adjunct to routine hospital treatment in the Indian context.

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