

RELAPSE AND SPIRITUALITY: SPIRITUAL WELL-BEING AND QUALITY OF
LIFE AS A CRITICAL FACTOR IN MAINTAINING RECOVERY FROM
ALCOHOL ADDICTION

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ABSTRACT

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<u>Relapse and Spirituality: Spiritual Well-Being and Quality of Life as a Critical Factor in</u> (Title)			
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The purpose of this study was to examine if alcoholics in recovery who demonstrate higher spirituality scores and quality of life, as measured by the Spiritual Well-Being Scale (1982), have less problems associated with alcohol dependency relapse, as indicated on the New Journey Programs Survey (1999). The study sought to determine whether any correlation exists between spiritual well-being/ quality of life of alcoholics in recovery who have maintained sobriety compared with those who have relapsed.

The subjects involved in this study were court-ordered and voluntary individuals who had undergone alcohol outpatient treatment in a counseling clinic in northwestern Wisconsin. The subjects surveyed had received alcohol outpatient treatment at some point during September 1, 1994 to September 1, 1999.

The study was designed to determine the levels of spiritual well-being and quality of life in alcoholics and correlation between those alcoholics who have relapsed and not relapsed.

The results of the study indicated that (1) there were statistically significant differences in the spiritual well-being of alcoholics who have completed treatment when comparing the relapsed and sober groups; (2) consistent with the literature, the findings indicated alcoholics who are in a program of recovery which advocates spiritual and behavioral changes demonstrate improved spiritual well-being and quality of life as well as the skills and ability to prevent relapse; and, (3) there was a correlation between higher spiritual well-being/quality of life scores and the maintenance of relapse-free sobriety.

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CHAPTER ONE

Introduction

A person's identity consists of: Body awareness: how you experience your physical presence; Self-concept: what you think about yourself and your potential; Self-esteem: how you feel about yourself and your ability to grow and change; and Self-determination: your ability to use your volition (will) to actualize your physical, mental, emotional and spiritual potentialities. If people find no room in their lives to reflect deeply on why they have been created, what they must do with their lives, and to listen with all of their being to the guidance of the universe, then they are like birds that have not yet learned to fly. All of the parts are present but something is still missing. To be a whole person is to be alive in a physical, emotional, mental and spiritual way (Bopp, Brown, and Lane, 1984).

Abuse of alcohol damages a person physically, emotionally, mentally, and spiritually. Unfortunately, for the alcoholic, it is the spiritual aspect of well-being that can be overlooked or de-emphasized in treatment programs. The reason appears to be both a lack of understanding by professionals of the role of spirituality in rehabilitation and a reluctance of the alcoholic to become involved in what is presumed to be religion (Booth, 1984a; Kohn, 1984). It is the writer's experience that many professionals understand a need for spiritual well-being, but feel inadequate in understanding the effects of the disease on the alcoholic's spirit. The results appear to be an incomplete and relapse-prone recovery for the alcoholic.

Alcohol dependence is a major medical and psychiatric problem in the United States today (Warfield & Goldstein, 1996). The National Institute of Mental Health

(1987) conducted a study on the lifetime prevalence of specific psychiatric disorders which showed that alcohol abuse or dependence affects 12% to 16% of the population. Only 10% of these alcohol dependent patients saw a mental health specialist (Vaillant, 1988).

Alcoholism, as defined by the National Counsel on Alcoholism and Drug Dependence (1990), is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably, denial (Joint Committee to Study the Criteria for the Diagnosis of Alcoholism, 1990, p.175). While the medical diagnosis of alcoholism (Vaillant, 1983) indicates the specific pathological changes, the prognosis, and the therapeutic implications, it does not consider the symptoms of unknown causes, consisting of different human factors, which show significantly different treatment responses to a variety of therapeutic and holistic methods. The addiction to alcohol and its prevalence (12,000 million known alcoholics) in our culture indicates, on its most basic level, that integrative treatment modalities of alcoholism are vastly essential (Milam & Ketcham, 1988).

Alcoholism can also be defined as spiritual disease and crisis and has been viewed as a threefold disease that affects the afflicted individual's mind, body, and spirit (Nakken, 1988; Underland-Rosow, 1995; Buxton, Smith & Seymour, 1987; Kaam, 1966). It is a direct assault against the Self and a direct attack on the spirit or soul of the person suffering from the addiction.

A person's spirit sustains life; alcohol addiction leads to spiritual death. The longer the addiction goes on, the more spiritually isolated the person becomes (Nakken, 1996). It is the author's opinion that the heavy use of alcohol is often related to, and precipitated by, the individual's need to improve these uncontrollable, intolerable feeling states of loneliness and spiritual isolation. Use of alcohol, for a period of time, can make the individual "feel better" or "feel normal" and can lead to regular use and addiction (Underland-Rosow, 1995).

Alcoholism breaks down the connection to self, to others, to the universe and to a Higher Power. When one is disconnected, one is often dispirited. Spirituality begins with self. By loving ourselves and respecting who we are, we begin to develop a spiritual sense. Alcohol abusers and addicts can use their spiritual quest in recovery to gain control, and thus power, over their lives. People in control are people whose bodies, minds, and spirits are integrated into a strong, healthy whole (Engelmann, 1992). With successful recovery, alcoholics have the opportunity to experience a profound connection to themselves, to others, to nature, to the universe and to a Higher Power (Underland-Rosow, 1995).

Recovery relies upon total abstinence from the addictive substance. Some alcoholics return to drinking (or relapse) because they define abstinence too loosely (Miller, 1996). In order to understand relapse, it is necessary to understand addiction. People often fail to recover because they do not understand their addiction or they fail to do those things that could help them to avoid relapse (Gorski and Miller, 1986).

Recovery from alcohol is the continued acceptance of addiction and the continuous monitoring of the addictive personality in whatever form it may take. Those

in recovery from alcohol addiction must learn to negotiate their way through life's complex maze of disappointments, obstacles, and burdens without the use of alcohol or drugs. They must reestablish relationships and reorder their use of time. They must recognize the rights of others in daily interactions. Their commitment to abstinence, with its complex demand for life change, requires developing new coping skills (Green, Thompson-Fullilove & Fullilove, 1998).

The concept of sobriety (abstinence, plus a program of activity designed to make abstinence comfortable) is essential to the alcoholic and to health-care professionals alike (Milkman & Sederer, 1990). Recovery (or sobriety) is spiritual in that it transforms the individual's view of self, and her/his relation to the world.

More recently, trends have softened the rigid boundaries, which kept spiritual considerations strictly out of ordinary health care. According to Wegscheider-Cruse (1981), "it has been increasingly recognized that humans have a spiritual capacity whether or not it is exercised within religious institutions" (p. 243). The spiritual dimension within the framework of the whole person concept has prompted greater interest in the therapeutic community and greater study of the successful 12-Step model of treatment for alcoholism (Wegscheider-Cruse, 1981).

While many alcoholics choose to understand that they have a physical and spiritual disease many others do not. Some choose not to understand how it occurs, how it affects personality and behavior, why they are depressed when they stop drinking, why drinking alcohol makes them feel better, why they continuously have an urge to drink, why they may never safely drink again, and why they will return to drinking if not protected (Milam, 1988). These issues must be confronted and hopefully answered for

successful recovery. Recovering alcoholics can then use this understanding as part of a spiritual quest to regain control over their lives and avoid relapse.

It is estimated that over 15 million persons now actively participate in 500,000 groups of 12-step programs (Peteet, 1993). As recovering alcoholics and addicts adopt self-help and 12-step principles, they often experience a complete transformation, physically, mentally, and spiritually. Studies by Vaillant (1988) and Vaillant & Milofsky (1982) found that self-help in the form of AA involvement was more useful than clinical treatment in maintaining abstinence. Participants, researchers, professionals and observers recognize studies of the 12-step model's emphasis on spirituality as a key ingredient in the recovery process (Peteet, 1993).

Although limited research has been conducted to describe the ways in which spirituality plays a role in the recovery process this researcher believes understanding the spiritual component of the recovery process as it relates to relapse is essential to alcohol addiction recovery. The need for professionals to address spiritual issues that may be involved in their clients' disorders, or draw upon the clients' spiritual resources as a reservoir of strength, are beginning to be addressed in some mainstream professional circles (Bergin, 1991).

Statement of the Problem and Purpose of the Study

Spirituality is critical in the maintenance of sobriety among recovering alcoholics. However, it is grossly underemphasized in the research literature, in treatment centers, and among professionals treating alcoholics in mental health centers or private practice (Presioso, 1987; Booth, 1985; Royce, 1985). Empirical

research on the concepts of spirituality and “Higher Power” as they relate to recovery from alcoholism is sparse, though much is written at the theoretical level (Green et al., 1998; Kurtz, 1988; Prezioso, 1987; Small, 1982; Warfield & Goldstein, 1996)

Alcoholics constitute a large percentage of caseloads among professional psychologists and psychotherapists, even those who are not directly treating them for alcoholism. Counselors would benefit from recognizing the spiritual needs of alcoholics and would be in a position to better serve clients through direct treatment or appropriate referral. High relapse rates among treated alcoholics is a source of frustration for professionals (Jacobson, 1989). If focusing on the spiritual needs of the alcoholic early in the recovery process increases the likelihood of continued sobriety, then treatment outcome among alcoholics may improve. Emphasis on the spiritual needs of clients could impact alcoholics’ success in maintaining sobriety and decrease the frustration of professionals alike. This focus would allow for more efficient use of treatment dollars as well as the professional services provided.

The purpose of this study is to determine whether alcoholics in recovery who demonstrate higher spirituality scores (SWB) and quality of life scores as assessed by the Existential Well-Being sub-test of Ellison’s (1983) Spiritual Well-Being Scale (see Appendix D), have less problems associated with alcohol dependency relapse as indicated on the New Journey Program Survey (see Appendix C).

Definition of Terms

The following definitions are offered to clarify specific terms and concepts used frequently throughout this study:

1. **Alcoholism:** is a psychological illness that is essentially cognitive, behavioral, and spiritual in nature. It is this researcher's position that any attempt to achieve or influence recovery from alcoholism and wellness must involve all three components.
2. **Spirituality:** is defined as the degree to which one achieves meaning and purpose in life as measured by the scores on the Spiritual Well-Being Scales (SWB) and qualitative responses on the New Journeys Program Survey.
3. **Relapse:** is defined as a process whereby an abstinent alcoholic returns to active drinking. During the relapse process, the alcoholic is dissatisfied with sobriety, continues to feel anxious or depressed, and is unable to attain a sense of meaning and quality of life.
4. **Sobriety/Recovery:** is defined as remaining abstinent from alcohol while making necessary attitudinal, emotional, behavioral, and spiritual changes resulting in greater feelings of meaning and quality of life.

CHAPTER TWO

Review of the Literature

Alcoholism's physical impact on the body is readily apparent and contemporary counselors and therapists are now more likely to view alcoholism as a legitimate disorder with physical and mental symptoms (Chapman, 1996). Traditional therapy has long avoided of the spiritual dimension of humankind and its role in psychological or emotional healing (Green et al, 1998). The consideration of alcohol dependence as a disorder with a spiritual dimension has posed a problem for empirical academics and theorists who believe it resembles a nonscientific, almost mystical perspective (George, 1990; Warfield & Goldstein, 1996).

To date this author has found no systematic research identifying particular mental health and social resources or specific treatment methods that have facilitated spiritual recovery. Many professionals argue that to define alcoholism as including a spiritual component invites nonscientific if not mystical approaches to treatment (Chapman, 1996). Therefore, it has been difficult to legitimize a definition of alcoholism that considers spiritual components in etiology or treatment.

The review of the literature will focus on: (1) Alcoholism; (2) Spirituality; (3) Relapse; and (4) Recovery/Sobriety as aspects of contented, successful recovery.

Alcoholism

It is difficult to achieve any consensus among theorists and practitioners as to the causes of the problem and treatment of alcohol addiction. Unfortunately, the U.S. treatment field continues to disagree regarding the nature and etiology of alcohol problems. Contemporary books and research confidently credit alcoholism to inherent

biochemical abnormalities (Milam & Ketcham, 1981), social learning process (Peele, 1985), family dynamics (Steiner, 1971), sociocultural influences (Cahalan, 1987) and personal choice (Fingarett, 1988). Given the various explanations, it is little wonder that there has been such confusion about how alcohol problems should be treated (Miller & Hester, 1989).

In 1935, along with Alcoholics Anonymous, came the American disease model of alcoholism (Alcoholics Anonymous, 1976). The main assertion of this model is that alcoholism is a unique and progressive condition that is qualitatively (not just quantitatively) different from normality. Alcoholics are regarded as quite different from nonalcoholics, possessing a distinct condition that renders them incapable of drinking in moderation. The disease is seen as arising from a combination of physical, psychological, and spiritual causes (Alcoholics Anonymous, 1976).

The scientific study of alcohol abuse and alcoholism can be traced back to the 1930s and was conceptualized by E. M. Jellinek (1960) as a way to understand alcoholism and has since been applied to the general field of addictions. This view accepts the basic assumptions that alcohol- and drug-dependent individuals have virtually irresistible physical cravings for the substance and they experience loss of control over drinking or other drug use. The disease of alcoholism or drug dependence is seen as progressive and irreversible.

Jellinek (1960) identified variant patterns of consumption and behaviors exhibited by the drinker, and identified five distinct “alcoholisms”: alpha (psychological dependence), beta (physical problems but not psychologically or physically dependent), gamma (tolerance, withdrawal and loss of control), delta (psychological and physical

dependence but no loss of control), and epsilon (periodic or binge drinking) (Jellinek, 1960). Jellinek's work presented one possible explanation for the difficulty that historically existed in diagnosing and treating the disease of alcoholism. Namely, that all alcoholic patients do not manifest the same pattern of symptoms or consumption.

Vaillant brought many in the alcoholism treatment community to the point of accepting alcoholism as a distinct medical condition complete with a recognized organization of symptoms, a documented course of progression, and an accepted method of intervention and treatment with the publication of *The Natural History of Alcoholism* (1983).

During the past 65 years, alcoholism has moved from a little understood and often despised category of human behavior to a recognized and accepted diagnosable disorder. Prior to these considerations, alcoholism and its symptoms were viewed as indicative of either underlying psychopathology (e.g., the psychoanalytic model, that proposes that alcoholism results in part from a failure to accomplish the tasks necessary to successful completion of development; Thombs, 1994), or from a moralistic view characterized by a lack of personal willpower and demonstrated moral degradation (Roger & McMillin, 1989). Contemporary counselors and therapists are more likely to view alcoholism as a legitimate disorder with physical and mental symptoms.

Alcoholism's physical impact on the body is easily apparent. Liver disorders such as cirrhosis, gastrointestinal problems, enzyme imbalances, cardiovascular illnesses and neurological disorders are just some of the few problems associated with alcoholism (7th Report to U.S. Congress, 1990; Rogers & McMillin, 1989).

The mental aspects of alcoholism such as depression, paranoia, mood shifts, personality changes, phobias, compulsions, and hysteria (Kinney & Leaton, 1987) can be easily recognized. Typically, these symptoms were diagnosed as primary presenting problems with the client's alcohol consumption only considered in passing as the patient's attempt to self-medicate (Rogers & McMillin, 1989).

Models other than the American disease model have been presented and each offers an explanation for the onset of alcoholism. Conditioning theory argues that alcoholism is the result of positively or negatively reinforced drinking behaviors (Elkins, 1980). Social learning theory points to one's belief in her or his ability to affect change in drinking behavior as a factor of alcoholism (Marlatt & Gordon, 1985). The family systems model believes that the etiology of alcoholism cannot be explained by looking at the alcoholic alone, but must include the entire family (Tombs, 1994). What all these models have in common is their recognition of physical and mental symptoms of the disorder.

The disease model may be responsible for the increase in diagnosed cases of alcoholism by the medical community and the acceptance of the diagnosis by the individual patient. This model strongly advises abstinence as a prerequisite to recovery and that factor alone is one that has impacted treatment strategies profoundly (Chapman, 1996).

Perhaps the most noted among the proponents of the spiritual disease concept in the treatment of alcoholism, besides the AA community and its founders, was Carl Jung. It was, in fact, Carl Jung who stated that a spiritual experience was needed to help alcoholics in their recovery, because of the medical hopelessness of alcoholism (Kurtz,

1988). AA has from the time of its inception indicated that alcoholics have been spiritually sick and that the AA program with its Twelve Steps is a spiritual program of recovery (AA, 1976). Whitfield (1984a) has concurred that the approach to the successful recovery from alcoholism is that of spirituality. Moreover, the basic premises of AA have been described as being “unambiguously and unapologetically spiritual, transcendental” (Miller, 1989, p.6). Higher spiritual awareness as a component of treatment is needed to provide alcoholics with a meaning to life and successful recovery from alcohol addiction (Benner, 1989).

Spirituality

Spirituality is deemed to be a necessary ingredient for a program of alcoholic recovery by most proponents of AA (Black, 1981; Booth, 1984; Brewster, 1989; Brown, Peterson, & Cunningham, 1988; Peck, 1978; Prezioso, 1987; Wegscheider, 1981; Whitfield, 1985; Woititz, 1983). Royce (1987) has also claimed that position by indicating that alcohol and other drugs have interfered with one’s relationship to a higher power, which has resulted in a spiritual disease.

It is widely maintained that the treatment of chemical dependency is by its very nature a spiritual process (Prezioso, 1987). Alcoholism has been described as a disease that encompasses the whole individual, including the spiritual self (Booth, 1987). Addictions in general have been called a disorder of the mind, body and spirit (Buxton, Smith, & Seymour, 1987) and a counterfeit religion (Kaam, 1966). Alcohol and drug dependence are believed by some to be manifestations of a spiritual malady (Godlaski, 1988) and, by others, to be a form of spiritual bankruptcy (Small, 1982). There appears

to be little doubt in many theorists' minds that "spirituality is a significant factor in the recovery of alcoholism" (Kohn, 1984, p. 250).

Many alcoholics, for many reasons, have become so discouraged with their lives that they have lost their values and meaning. They have lost their spirit for life; they have lost their Self. Many are either agnostic or atheistic. Their higher power seems to have become alcohol, other drugs, and their ego.

Spirituality is a quality that belongs exclusively to the human animal (Royce, 1985). It is the life energy, the restlessness, that call us beyond "self" to concern for, and relationships with, others and to a relationship with the mysterious "other." Spirituality is our ability to stand outside of ourselves and consider the meaning of our actions, the complexity of our motives and the impact we have on the world around us (Prezioso, 1987).

For the purposes of this study the author defines "spirituality" independent of "religion": that is, spirituality can occur in or out of the context of the institution of organized religion, and not all aspects of religion are assumed to be spiritual.

While outside the scope of this paper, there are distinct cultural and gender variables which affect individual's spiritual well-being and can be significant factors impacting the expression of spirituality. The researcher believes spirituality is key to treatment and recovery and must be viewed in the context of the individual's cultural and religious background and programming.

Whitfield (1984) and others (Brown, Peterson, & Cunningham, 1988; Corrington, 1989) define spirituality along three dimensions: one's relationship with self, one's relationship with others, and one's relationship with the universe.

Whitfield (1984) has outlined a developmental sequence of spirituality in recovery from alcoholism corresponding to levels of consciousness. Basically, the sequence is described as: struggle, confusion, surrender, and seeing the light. The first three levels of this model which correlate with survival, passion and mind, constitute the lower realm of consciousness. Survival is the most primitive level and characterizes active, severe addiction. At this level alcoholics drink in a destructive manner because they know no other way to survive. The next level, passion, emerges from the individual's will to feel and his willingness to surrender, although not completely. This level is characterized by self-gratification and develops because alcohol no longer provides relief from existential suffering. Early in recovery most alcoholics block their feelings or use them in a destructive and manipulative fashion. By beginning to feel soberly at this level, the alcoholic may experience life more fully and let go of some of the control maintained during active drinking. The third level of the lower realm of consciousness, the mind level, is characterized by linear, rational thinking. Individuals at this level are full of denial, defensiveness, and are materially oriented. An alcoholic at this level may accept the physiological or medical definitions of the disease of alcoholism, while rejecting the emotional and spiritual damage that has occurred.

Between the lower and higher levels of consciousness lies acceptance which Whitfield (1984) described as the gateway toward the experience of the higher self. Acceptance, or awakening, is driven by the desire for self-creation, and is represented by the capacity of the human heart. Since acceptance lies between the lower and higher levels of consciousness, conflict naturally occurs. Through conflict, confronting

suffering and pain, comes understanding which paves the way toward spirituality, or “seeing the light” (Whitfield, 1984).

Spirituality is concerned with whomever or whatever is most important in a person’s life (George, 1990). Essentially, spirituality involves attitudes that are based on beliefs about our relationships with our self, with other human beings, with our world, with life and ultimately, with God, a Higher Power, or universal consciousness. If those beliefs were formed in circumstances of unconditional love, acceptance, and trust, we would probably exhibit attitudes of unconditional love, acceptance, and trust in all of our relationships. Prezioso (1987) called this positive connectedness with others and with a power greater than self “security in the belief that life has meaning and purpose and that, although imperfect, each of us is acceptable, lovable, and worthwhile” (p. 239).

When individuals experience positive spirituality, they tend to view themselves as lovable, capable, and deserving. They allow others to enter and enrich their lives without feeling a need to manipulate, use, or abuse them. For the most part, the world (job, school, community) can be seen as a safe place wherein individuals are able to develop toward their potential. This can be more difficult for many people in our culture (ethnic & racial minorities, women, homosexuals, etc.) to attain. Yet, many can find a loving God who guides their lives, shares their joys, and sustains them when they are in pain or in need. When positive spirituality dominates humans’ lives, they have no need to alter their moods with addictive substances or behaviors (Warfield & Goldstein, 1996). Such is not the case for active alcoholics and sober nonrecovering alcoholics (i.e., “dry drunks”). Their lives are dominated by a negative spirituality (Prezioso, 1987). They are insecure, defensive, and lacking in self-esteem. They try to fill their unmet relationship needs

using and abusing others whom they fear and distrust. They see the world as unsafe and use that as justification for conning and manipulating their way through it. Life for them has no purpose. A god, if any, for them is either unforgiving or has no part of their life. It seems they constantly strive to realize the joys of a positive spirituality, through a substitute relationship with alcohol (Warfield & Goldstein, 1996).

Spirituality can be a major component of the treatment of alcoholism and can be an important contributor to anyone's mental health according to Benner (1989). Spirituality is needed to provide patients with a meaning to life. It has been recognized as a therapeutic factor in many counseling processes. Kurtz (1988) found that the higher the spiritual awareness of recovering alcoholics, the better their recovery from alcoholism. Therefore, spiritual programs such as AA can be seen to promote successful sobriety in recovering alcoholics through the working of the Twelve Steps which promote spiritual transcendence.

The literature (Kurtz, 1988; Prezioso, 1987; Warfield & Goldstein, 1996; Corrington, 1989; Chapman, 1996) appears to indicate that those alcoholics who achieve this level of spiritual development show the greatest happiness in recovery and seem to have the greatest success maintaining sobriety. They seem to have a special presence about them. The difference between being "abstinent" and experiencing a contented, successful sobriety is believed by this researcher to result from the acceptance or nonacceptance of a spiritual program of recovery.

Relapse

Clinically, a relapse can be defined as any intake of alcohol or substitute drug by a recovering alcoholic. The taking of a substitute drug, although not usually considered a

relapse, seriously interferes with recovery and almost always lead to a return to drinking (Milam & Ketcham, 1981). Relapse, or the uncontrolled return to alcohol or other drug use following competent treatment, is one of the greatest problems substance abusers and their counselors face. In fact, close to 90% of all clients treated for substance abuse relapse within one year after their treatment (Lewis, Dana, & Blevins, 1994). This astounding figure means that a high priority must be placed on relapse prevention.

What is it about alcoholism that makes relapse such an ever-present risk?

Khantzian and Mack referred to alcoholism as “a complex disorder in which problems of self-governance malignantly interact with other vulnerabilities such as disabilities in regulating feelings and self-care to cause biologically susceptible individuals and others to become hopelessly dependent on alcohol” (as cited in Warfield and Goldstein, p. 79-80). This definition recognizes the importance of personality and behavioral characteristics that are subject of change (AA World Services, 1976; Whitfield, 1984c).

Alcoholics suffer from what AA calls “character defects” (AA World Services, 1976, p. 59). These are feelings, beliefs, and behaviors that dispose them to seek a sense of well-being by abusing alcohol. Such “character defects” can be reflective of a pathological narcissism, in which those addicted to alcohol behave as though they were the center of their universe or their own God (Kurtz, 1979). Alcoholics also possess an underlying dependency involving an alienation from their true selves and an inability to establish functional relationships with significant others in their lives (Whitfield, 1989). The combination of these biological and character risk factors makes alcoholism difficult to treat and makes the recovering alcoholic vulnerable to relapse.

Many different theories have been proposed to describe and explain the relapse process, including: conditioning models based on both classical and operant conditioning, social learning models (e.g. Marlatt & Gordon, 1985), and skills deficit models (e.g. O’Leary, O’Leary & Donovan, 1976). However, many of these behavioral views point to the subjective experience of negative emotional states, such as anxiety or depression, as precursors to relapse (Marlatt & Gordon, 1985). Although the inability to develop sober problem-solving skills does lead to frustrations and perhaps depression which precedes relapse, it is more likely that depression and anxiety among relapsed alcoholics results from an inability to develop a sense of wholeness or integration. This includes developing meaning and purpose in the spiritual sense. Thus, problem-solving skills, including implementing the principles and teachings of Alcoholics Anonymous, are the behavioral correlates of developing spirituality in recovery.

Frankl (1955) believed existential problems arise when one feels that life lacks purpose or meaning. Frustration of the spirit results in feeling of depression, isolation, and anxiety from which alcohol serves as a temporary respite. Eventually, for the alcoholic, the existential isolation and despair become overwhelming, leaving them with two choices: continued drinking which results in death or surrender to her/his disease. Many recovering alcoholics have described the experience as the “moment of truth.” For some, this juncture marks the beginning of recovery and the attainment of purpose and meaning in a previously unfulfilled and despairing existence.

For relapsed individuals who are unable to achieve lasting and meaningful sobriety, the existential isolations as described by Frankl (1995), and disintegration as described by Jung (1968) lead to continued frustration and emptiness which can result in

an inability to stay sober. This cycle can prevent the alcoholic from moving forward in recovery as she/he remains trapped in a hopeless world of failure, disillusionment, despair and at continuous risk for relapse.

While several writers (e.g., Jung, 1968; Whitfield, 1984) have described a spiritual conversion along a developmental sequence in recovery from alcoholism, few, if any, empirical studies have addressed spirituality in terms of its effect on both longevity and quality of sobriety. Yet, spiritual development as a forerunner to lasting sobriety is personified in the principles and teachings of the fellowship of Alcoholics Anonymous, with its emphasis on a Higher Power and connected community. Most AA members will support the notion that without a strong sense of spirituality, sobriety is precarious (Small, 1987).

Many abstinent alcoholics continue to be dissatisfied with life and experience emotional and relational unmanageability. Since spiritual needs are usually the last to be fulfilled in recovery, this juncture may trigger a return to drinking. Jacobson (1977) has suggested that immediately including a spiritual component to structured rehabilitation treatment might enhance the recovery process.

The whole issue of alcoholism and the process of recovery includes relapse. The disease is so ingrained in alcoholics that it sometimes takes three or four years for them to even begin to scratch the surface and get to the core where life becomes enjoyable, where recovery becomes a way of life and where they not only believe in it or talk about it but they are able to live it. What each alcoholic needs is love, forgiveness, self-worth and fellowship (Gallant, 1992). Some are not ready to surrender to the disease and subsequently are not able to make any progress. When they are prepared to submit, to

confide and to consult, then sobriety is possible. Only then can they find spirituality and joy in their lives (Gallant, 1992). It is likely that depression and anxiety among relapsed alcoholics results from an inability to develop a sense of wholeness or integration, which includes developing meaning and purpose in the spiritual sense. Thus, including and implementing the principles and teachings of Alcoholics Anonymous are the behavioral correlates of developing spirituality in recovery and relapse prevention.

Recovery & Sobriety

Prezioso (1987) believes spirituality is key to sobriety and recovery because addiction is a spiritual as well as a physical disease. He asserts that recovery is a process that involves building, piece by piece, one day at a time, a healthier and more fulfilling life style. Within this process, spirituality is experienced in the give-and-take of relationships with others, with a higher power and with self. Further, this includes the ability to face and accept one's self, the ability to move toward greater authenticity and compassion in relationship with others, and a deepening relationship to God or a Higher Power.

Early in recovery alcoholics have accepted their disease which is the first spiritual experience. Acceptance also involves forgiveness of self and others. In the process of forgiveness, one must confront self honestly and assume responsibility for one's actions. Steps four and five of the AA program require that alcoholics take "a searching and fearless moral inventory of ourselves, and then admit this to God, ourselves, and another human being" (Alcoholics Anonymous, 1939, p. 105). This process creates intense fear for many alcoholics and is a major stumbling block for spiritual growth. However, if alcoholics are painstakingly honest in endeavoring to take moral inventories they have

demonstrated true acceptance of self, including all of their darkest faults. Steps six through ten involve the process of forgiving self and others and continuing to take a moral inventory in the pursuit of a more spiritual way of life. Thus, the process of recovery, or spiritual transformation, is continually practiced by working the steps of the AA program.

Frankl (1959) emphasized that a major requirement for spiritual growth is responsibility for oneself. Also critical are empathy, altruism, love for one's fellow man, and wisdom characterized compassion. It is the ability to truly feel with another person. The last level of consciousness according to (Whitfield, 1984) is the level of unity consciousness and is characterized by self-mastery. At this level, the person experiences enlightenment and through transformation has joined the unified spirit. Progression through the stages constitutes spiritual wholeness including integration of physical, psychological, and emotional aspects of our being. Spiritual wholeness characterized by enlightenment and unification with humanity may be described as an actualized state of being.

Spiritual actualization is important in the recovery process. It is characterized by increased acceptance of self, others, and nature; increased identification with humanity; improved interpersonal relationships; increased frequency of peak experiences; and changes in the individual's value system (Brown, et al., 1988). Noting the high rates of relapse among treated alcoholics, this author emphasizes the need for alcoholics early in recovery to begin to participate in spiritual behaviors. The author believes that practicing spiritual behaviors on a regular basis will assist the alcoholic in developing a spiritual lifestyle and complete recovery.

Despite the seemingly widespread acceptance of the relationship between spirituality and recovery among alcoholics, there is a hesitancy to view spirituality's influence on onset and recovery from alcoholism (Kohn, 1984). In active alcoholism and throughout early recovery, the spirit is blocked. It seems logical that early in treatment, efforts to nurture the spirit should be made to help improve chances for recovery. Since alcoholism creates physical, psychological, and emotional problems, providers must not neglect these effects of the disease on the person. Complete and successful recovery must proceed to eventual spiritual recovery. In spite of AA's emphasis, alcoholism treatment has ironically neglected the spiritual aspect of the disease which contributes to existential vacuum, including anxiety and depression which have frequently been cited as precursors to relapse (Warfield & Goldstein, 1996).

Interventions aimed at helping alcoholics transcend into the spiritual realm of being must occur in treatment to help fill the existential void and promote sobriety and lasting recovery (Frankl, 1955; Prezioso, 1987; Whitfield, 1984). The emphasis on developing meaning and purpose in life in recovery is necessary because addiction has meaning and purpose to the active alcoholic. Treatment and recovery must offer more fulfilling and sustaining values and meaning to the alcoholic, which includes the spiritual components of life (Ottenberg, 1974).

In conclusion, alcoholics who achieve spiritual development often show greater success in recovery and seem to have less chance of relapse. Alcoholics Anonymous and similar twelve step programs provide a spiritual component essential to recovery. The hope of the author is that more reliable scientific proofs will be accumulated to support the key role of spirituality has in treating alcoholism. Perhaps then, the concept

of spiritual awakening promised by AA and other twelve step programs will be better understood, accepted, and effectively applied by those in recovery and those who counsel alcoholics.

CHAPTER THREE

Methodology

Subjects

The subjects consisted of 210 alcoholics who reside in the northwestern area of Wisconsin. To be included in the study, subjects had a primary diagnosis of alcoholism as identified by the chemical dependency program in which they received alcohol dependency treatment. The subjects cited alcohol as their primary drug of choice. The 30 subjects excluded from the final sample did not complete treatment. The subjects were asked by this researcher to voluntarily participate if they had spent at least five weeks or more in the treatment program. The study focused on patients who had at least six months out of completed alcohol treatment as of September 1999, the time of the study. Subjects of the study were lower to middle class Caucasian men and women. The subjects of the study had all agreed and signed consent forms to be part of any future studies regarding the program upon admission to treatment.

Instrumentation

The variable, spirituality, defined as having achieved a sense of meaning and purpose in life, was measured primarily by scores on the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982). The SWB consists of twenty items evenly divided to comprise two subscales of religious well-being (RWB) and existential well-being (EWB). The SWBS is a Likert-type format, ranging from 1 to 6, with a higher number representing greater well-being. The scale also provides sufficient validity data exist (e.g., positive correlations of SWBS with self-esteem and social skill and

negative correlations with measure of loneliness) to view the SWBS as a quality of life indicator. The Spiritual Well-Being Scale was developed as a general indicator of the subjective state of well-being. It provides an over all measure of the perceived spiritual quality of life, as understood in two senses – a religious sense and an existential sense (Moberg & Bruseck, 1979).

These two meanings of the phrase “spiritual well-being” reflect people’s usage of such language. This is, when people talk about their spirituality they ordinarily mean either (a) their relationship with God or what they understand to be their spiritual being, or (b) their sense of satisfaction with life or purpose in life. This is important because the vast majority of people indicate some kind of belief in a God (Gallup, 1980), and yet there is also a nonreligious meaning to spirituality. Because of this, the SWBS is nonsectarian and composed of the two subscales – Existential and Religious Well-Being. The instruments were confidential (Appendix A). A copy of the actual forms follow (Appendix C & D).

To assess between positive recovery outcome and spiritual well-being, the 20-item Spiritual Well-Being Scale (Paloutzian & Ellison, 1982) was administered in conjunction with the 20-item New Journey Program Survey (1999).

The questionnaires were pen and paper instruments. It took approximately 10-20 minutes to complete, with more time for those responding with comments. The results of the Spiritual Well-Being Scale were then correlated with the data provided on the Program Survey.

Procedure

This study used a self-report format of data collection. Subjects received a survey which they were asked to complete as honestly as possible. The survey included (1) an introductory letter describing the purpose of the study; including an assurance of anonymity of responses and voluntary participation; (Appendix A); (2) The New Journey Program Survey (Appendix C); and (3) the Spiritual Well-Being Scales (Appendix D). Subjects were asked to complete voluntarily the questionnaires within two weeks and return them to the researcher in the envelope provided. Fifty questionnaires were returned within the requested two-week period. A second wave was sent after the two-week period which provided twenty additional responses.

Analysis of the Data

Frequency tables were computed to measure and report spiritual well-being, quality of life, and overall status of alcoholics in recovery. Independent Group T-Test for Equality of Means statistics were used to report each the following components: Spiritual Well-Being, Religious Well-Being, Existential Well-Being, and Quality of Life of the Spiritual Well-Being Scale scores of alcoholics in recovery who have relapsed and those who have not.

Limitations

There are several factors that may have influenced the results of the survey. First, the type of patients surveyed. The majority of patients that went through the treatment programs are employed and have insurance. This type of patient may be more motivated to apply themselves to a recovery program since they generally have more to lose if they don't get sober (i.e., employment).

Second, this particular program (New Journey Program) allows counselors to work closely with patients throughout their first year of recovery. The survey does not accurately reflect the 0-1 year patient population's independent recovery experience.

Third, these cost-effective types of programs do not allow for the patient to go through the Fifth Step of the recovery process of Alcoholics Anonymous ("Admitted to God, to ourselves, and to another human being the exact nature of our wrong"). This Step is proven vital to longtime sobriety and peace of mind (AA, 1976). Much of the power of the Fifth Step lies in the alcoholic's interaction with another person. The results can be immediate. But their connection with a spiritual source is an equally powerful part of the Fifth Step. By telling the truth to a Higher Power, clients open themselves to a deeper communication. This may be the first time they speak directly to their own spiritual source. This may also be the first time they experience the presence of a Higher Power or the possibility of oneness with their spiritual source. This Step removes them from the "ego self" which brings alcoholics to a place where they may move toward a full and meaningful recovery. The absence of the 5th Step is critical to recovery

Fourth, this study did not reflect gender balance. Gender balance variables relating to alcohol treatment studies are receiving increased attention. Most reports indicate gender differences in both interpersonal and environmental experiences. Due to the small number of women in the study and may not be a reliable representation of the general population.

Unknowns

The subjects of the study were of one race may limit the range of spiritual and existential experience of the respondents. While recognizing that ethnicity and culture

can affect a sense of connection and spirituality, the research questions did not reflect alternative methods used to attain quality of life as it relates to spirituality. The Program Survey Questionnaire consists primarily of questions that provided qualitative data regarding recovery and does not include descriptive data of an individual's perception of spirituality and Higher Power before recovery and how these relate to their current recovery and daily life.

CHAPTER FOUR

Results

Introduction

The purpose of this study was to examine whether alcoholics in recovery who demonstrate higher spirituality and quality of life scores as assessed by Paloutzian & Ellison's (1982) Spiritual Well-Being Scale (see Appendix D), have less problems associated with alcohol dependency relapse as indicated on the New Journey Program Survey (see Appendix C). Because the correlation is based on the relationship between spiritual well-being/quality of life and relapse, the Independent Group T-test provided the most reliable measure to determine any significant differences in the spiritual well-being of alcoholics who have relapsed and those who have not.

Findings

Two hundred-ten subjects were initially included in the study. Subjects had a primary diagnosis of alcoholism as identified by the chemical dependency program in which they received alcohol dependency treatment. Thirty subjects were excluded from the final sample because they did not complete treatment. Of the 180 subjects included in the study 70 responded. The rate of return for the study was 39%.

Of the 70 subjects who responded, the average age was 45.39 % (SD = 10.21). The mean months of sobriety of the 29.95 (SD=27.33) with 10% (7) reportedly relapsed. The valid percent of male subjects was 64.3 % and of females was 35.7%.

The following frequency tables report subject demographics recorded on the New Journey Programs Survey pertaining to the hypothesis. The survey items report and support the researcher's hypothesis that alcoholics who report higher spirituality and quality of life on the NJP scales are those who

are chemically free (sober) and have less problems associated with relapse. Tables 1a and 1b demonstrate the rates of relapse as reported on the NJP survey.

Table 1a

Sobriety Status	#	%
Continue to be chemically free	49	73.1
One year of sobriety	10	14.9
Not in recovery	7	12.0

Table 1b

Used Since Treatment (continue to be in recovery)	#	%
Yes	13	18.8
No	56	81.2

Tables 2a and 2b from the NJP survey (treatment history) reports how much exposure subjects had to programs of recovery which advocate cognitive, behavioral, and spiritual changes. These variables influence both relapsed and sober recovering alcoholics.

Table 2a

Treatment History	#	%
Rx before New Journey Programs	24	35.3
Other Rx since New Journey	16	23.5

Table 2b

Completed Aftercare	#	%
Yes	52	75.4
No	15	21.7

Tables 3a and 3b report subjects' satisfaction with the 12-step and spiritual components of treatment on the NJP survey.

Table 3a

Evaluation of AA/NA/Other	#	%
Very Satisfied	29	43.9
Mostly Satisfied	22	33.3
Indifferent	13	19.7
Very Dissatisfied	2	2.9

Table 3b

Spiritual Direction	#	%
Very Satisfied	26	41.9
Mostly Satisfied	25	40.3
Indifferent	11	17.7
Very Dissatisfied	1	1.6

Item 12 of the survey asked the subjects to rate their quality of life since treatment. Table 4a supports the literature when it states alcoholics who are in successful recovery begin to connect with themselves and with others. The frequency Tables 4b and 4c support this researcher's hypothesis and suggests a correlation between spiritual well-being, quality of life and sobriety.

Table 4a

Relationships	#	%
Greatly Improved	39	59.1
Improved Some	20	30.3
Stayed the Same	5	7.6
Gotten Worse	2	3.0

Table 4b

Spiritual Life	#	%
Greatly Improved	43	62.3
Improved Some	20	30.3
Stayed the Same	5	7.6
Gotten Worse	2	3.0

Table 4c

Quality of Life	#	%
Greatly Improved	52	76.5
Improved Some	12	17.6
Stayed the Same	3	4.4
Gotten Worse	1	1.5

Research indicates alcoholics in treatment who participate in 12-step programs such as Alcoholics Anonymous (a spiritual program of recovery), connect with others in recovery, and complete the 4th and 5th step of Alcoholics Anonymous are less likely to relapse. Table 5a, 5b, and 5c from the NJP survey support the findings of this research.

Table 5a

Participate in AA or other	#	%
Yes	78.9	80.9
No	13	19.1

Table 5b

Involved w/others in Recovery	#	%
Yes	47	72.3
No	18	27.7

Table 5c

Completed 4 th & 5 th Step #		%
Yes	58.6	62.1
No	25	37.9

The purpose of this study is to determine whether alcoholics in recovery who demonstrate higher spirituality scores (SWB) and quality of life scores as assessed by the Existential Well-Being sub-test of Ellison's (1983) Spiritual Well-Being Scale (see Appendix D), have less problems associated with alcohol dependency relapse as indicated on the New Journey Program Survey (see Appendix C).

The Spiritual Well-Being Scale is a systematic subjective quality of life measure which includes both religious and existential well-being (quality of life, life purpose). Studies using the scale support conceptualization of the scales as an integrative measure of health and well-being. The following descriptive statistics of the Spiritual Well-Being Scale support the hypothesis of the study that suggests that alcoholics who have higher spiritual well-being scores are those who are chemically free (sober) and those with lower scores are those who are not (relapsed).

Table 6a

Means, Standard Deviations, and t-Tests values and Significant Levels for relapsed and sober groups.

Variable	Spiritual Well-Being				
	M	SD	t	df	Sig. Level
Relapsed	84.50	11.50	-2.380	65	p<.05
Sober	100.41	15.94			

Table 6b
Means, Standard Deviations, *t*-Tests and Significance Levels for relapsed and sober groups .

<u>Religious Well-Being</u>					
<u>Variable</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Relapsed	42.37	13.53	-2.309	66	p<.05
Sober	51.64	15.94			

Table 6c
Means, Standard Deviations, *t*-Tests and Significance Level for relapsed and sober groups.

<u>Existential Well-Being</u>					
<u>Variable</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Relapsed	41.83	9.70	-1.896	66	p<.01
Sober	48.90	8.63			

Table 6d
Means, Standard Deviations, *t*-Tests and Significant Levels for relapsed and sober.

<u>Overall Quality of Life</u>					
<u>Variable</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Relapsed	1.43	.53	-2.843	64	p<.01
Sober	1.30	.64			

Summary

The purpose of this study was to examine empirically the hypothesis that alcoholics in recovery who report greater spiritual and general well-being have less problems associated with relapse. The variable, alcoholics in recovery who have maintained sobriety (sober group), was found to have a significant and positive

relationship with spiritual well-being, religious well being, existential well-being, quality of life and successful recovery. Further explanation for the results of this study will be reviewed in the following chapter.

CHAPTER FIVE

Summary, Conclusion, and Recommendations

Summary

The relationship between spirituality and recovery from alcoholism has been the focus of only limited experimental research in the field of psychology despite widespread belief in AA and among some treating professionals of the relevance of spirituality to ongoing, successful recovery. Whitfield (1984) and Small (1987) have proposed similar models for spiritual development among recovering alcoholics, but adequate experimental research on the subject is sparse. Others (e.g. Brown, et al., 1988; Jacobson, et al., 1977) have also emphasized the relevance of spirituality to alcoholism treatment, and proposed interventions aimed at increasing spirituality among alcoholics early in treatment as relapse prevention measures. The present study sought to determine if there was any correlation between the spiritual well-being scores of recovering alcoholics who have relapsed and those who have not (sober).

Conclusion

The research hypothesis stated that alcoholics in recovery who demonstrate higher spiritual well-being and quality of life scores have fewer problems associated with alcohol dependency relapse. The research supports the literature's assertion that spiritual well-being and quality of life have merit as general indicators of the health, well-being, and sobriety of alcoholics in recovery. It is likely that fundamental experiences as such as good family life, relationships, spiritual life, self-worth and overall quality of life are significantly associated with an alcoholic's risk for relapse. With treatment and a spiritually based recovery programs such as AA, it was hypothesized that the short and

long-term impact of spiritual behaviors and spiritual well-being decreases alcoholics' risk for relapse (Warfield and Goldstein, 1996).

Related to this study's hypothesis, it is interesting to note that there was no correlation between length of sobriety, spiritual well-being/quality of life, and relapse. Perhaps this suggests the longer one is sober, the less motivated she/he is to seek spiritual meaning and quality of life, hence, "the dry drunk" (AA, 1976). Sobriety must be soul fulfilling to provide the alcoholic the means to fill the spiritual/existential void felt during active drinking. Mere abstinence is not sufficient to combat the existential horror of emptiness and meaninglessness temporarily relieved by drinking. Frankl (1955) emphasized that meaning is embedded in relationships and the recovering alcoholic's spiritual actualization is ultimately achieved through the relationships she/he realizes within the fellowship of AA and other spiritual programs of recovery.

The alcoholic's personality can be conceptualized as grounded in a destructive negative spirituality. The AA program and other spiritual-based programs attempt to reverse negative spirituality by helping recovering alcoholics achieve a sense of well-being in their lives. The spiritual components related to successful sobriety examined in the study; i.e., attending AA/NA or other self-help groups, involvement with others in recovery, completion of the 4th and 5th steps and quality of life rating showed a positive relationship between practicing these recovery maintenance objectives and not relapsing.

The results of the study did support the hypothesis that those alcoholics in recovery who achieve spiritual development have less problems associated with alcohol dependency relapse. If positive relationships between SWB and long-term successful

recovery from alcohol addiction continues to be found, the clinical necessity of providing spiritually sensitive interventions that enhance recovery may be established.

Recommendations

The purpose of the study was twofold: to answer specific questions proposed by the investigator, and to raise new questions. This section will discuss new questions generated by the study and the research literature and recommendations for future research.

The generalizability of the study was threatened by using a limited sample of volunteers from a restricted geographic locale. Since this group of recovering alcoholics was from similar backgrounds and was participating in treatment and recovery, they are not representative of the alcoholic population at large. Future research could utilize samples comprised of more subjects from diverse racial/ethnic groups and socioeconomic levels. The results from cross-cultural research could be compared with the current findings to expand our knowledge of the relationship of spirituality/quality of life and relapse from alcoholism among culturally and socioeconomically diverse groups of alcoholics.

A second threat to the validity of the study concerned the use of the New Journey Programs Survey. The survey questionnaire consisted primarily of questions that provided data regarding treatment, and does not include descriptive data of subjects' perception of spirituality and quality of life prior to treatment or descriptive data regarding spiritual well-being as it relates to their current recovery. Also, the survey questionnaire did not provide a statement requesting both sober and relapsed subjects to respond. As a result, a small number of relapsed subjects responded. Although

significant results were found, increasing the relapsed sample size would increase the validity of the findings.

This study did not include sufficient gender variance and did not indicate the possible significant and different interpretations of spirituality by both the men and the women.

Given the limitations encountered in this study, the following specific recommendations for future research are offered:

1. Use of a more culturally and socioeconomically diverse sample would assess the relationship between spirituality and recovery from alcoholism in a broader context. Specifically, the question of whether oppressed alcoholics also experience quality of life could be addressed
2. This study used one exploratory questionnaire to obtain demographic data regarding spirituality, recovery experience, and quality of life. The questionnaire needs to be refined and more objective scoring criteria established so validity and reliability could be demonstrated. Then, the instrument could be used comparatively with other established measures.
3. It would be beneficial to replicate this study using an all-female population, a group known to have an alarming rate of alcoholism and particularly susceptible to existential and spiritual crises. Further, focusing on gender-specific issues could aim at decreasing the existential isolation and increasing spiritual development in treatment programs, thereby potentially decreasing the occurrence of relapse in this group. It would be beneficial to evaluate treatment programs which include teaching spiritual behaviors to clients to

assess the impact of spiritual well-being on recovery from alcoholism more directly.

4. The spiritual component essential to alcoholism rehabilitation continues to be misunderstood and misapplied. This study will have served its purpose if it stimulates further inquiry into the impact of spirituality on recovery from alcoholism and relapse prevention. Nevertheless, there exists a need for specific measures that will accurately demonstrate the therapeutic effectiveness of positive spirituality behaviors in the twelve step rehabilitation programs of recovery such as Alcoholics Anonymous. Such measures should include a questionnaire to determine the positive spiritual behaviors of alcoholics prior to the abuse of alcohol and instruments to assess the development of spiritual well-being during treatment and recovery using it as a deterrent to relapse.
5. This study was conducted in a treatment program (New Journey Programs) which has an unusually long aftercare Program and patient contact (one year). Samples from other types of alcohol dependency treatment programs would expand the applicability of these findings. Furthermore, it is recommended that future studies examine the issue of spiritual well-being, relapse and length of sobriety.

Based on the results of this study, there does appear to be ample support for the positive effect of spirituality on relapse-free recovery from alcoholism. It is hoped that future research will be generated on this critical aspect of alcoholism recovery and relapse so that treatment efforts can more effectively include these factors and improve

success rates that have traditionally been dismally low in recovery from alcohol addiction.

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Dear Patient:

The New Journey Programs at Luther/Midelfort Mayo Health System is conducting a study to continue to build a successful recovery program and understand more fully what methods you have used as a relapse preventative. We sincerely hope you take a few minutes of your time to complete and return the surveys as soon as possible in the envelope provided.

Enclosed are the forms we told you about while you were a patient in our New Journey Program. As you complete the enclosed survey forms, please remember that there are no right or wrong answers. Your honest replies will be the most help to better understand you recovery and improve our programs.

We have a firm policy regarding the privacy of this information and you can be assured that your responses will be kept confidential.

We appreciate your willingness to complete the two enclosed surveys and have returned to us by October 25, 1999. If you have any questions regarding these surveys, please contact Teren Steele at 715-838-5369. Thank you for your prompt assistance in this important study.

Sincerely,

Scott Hansen, AODA Supervisor
New Journey Programs
Behavioral Health Department

SH/rg

Appendix B

NEW JOURNEY PROGRAM RESPONSIBILITIES AND CONTRACT

1. Abstinence from all mood-altering chemicals are required of everyone attending program sessions.
This includes both the client and any concerned persons. This means no usage of alcohol, marijuana, tranquilizers (nerve pills), narcotics, or hallucinogens unless prescribed by a physician. Should any person insist upon using mood-altering chemicals or insist on any type of compulsive-like behavior (i.e. gambling), he/she will not be allowed to participate in the program. This is required in relation to our purpose as a treatment center.
2. Urinalysis testing and/or Breathalyzer testing may be conducted as deemed necessary by staff. Failure to comply with this or any of the other expectations can result in termination from the program. The fee for urinalysis testing will be the client's responsibility.
3. Attendance at all programming is required. Any sickness or emergency absences must be checked with staff members. It is expected that clients will call Luther Hospital/Midelfort Clinic, Adult transitional treatment Program, as soon as possible if they cannot attend that day. Because program continuity is extremely important, any unexcused absence must be made up.
4. Participation in the program is mandatory. Putting forth the effort to change is a requirement to stay in the Transitional Treatment Program. We expect all members to complete all assigned tasks and reading assignments, to obtain a sponsor, and to visit outside 12 Step or other appropriate support group meetings.
5. It is the responsibility of the client to see that family/concerned persons are present for concerned person and/or family sessions.
6. Success in this program is up to you. You are the crucial factor. The staff and program are here to help you; we are committed to you and are accountable to you. You are ultimately responsible for success or failure in this program.
7. I agree to participate actively in the Transitional Treatment Program during the hours at 5:30 p.m. to 3:30 p.m. for 5 consecutive weeks equaling 20 sessions starting _____.
(Date)
8. Also, I agree to participate in the Continued Care Program recommended by my counselor.
9. The Transitional Treatment Program rates are \$47/hour for groups and \$115 for a 45-minute individual counseling session. There will be one individual counseling session per week.
10. It is my responsibility to check my insurance coverage and policy to be sure the costs are covered. If the costs are not covered, it is my responsibility to pay the difference and/or

set up arrangements. Also, keep in mind that mental health charges may come out of the same pool of money.

- 11. I agree to be involved in a follow-up survey. This survey is conducted to determine patient's progress and to possibly make program improvements. I understand the information I give will be kept confidential and my name will never be disclosed.

The Transitional Treatment Program is certified by the State of Wisconsin as Transitional Treatment, not as an outpatient program.

Client Signature
Date

Date

Staff Signature

**LUTHER/MIDELFORT
New Journey Programs Survey**

1. Full Name: _____ D.O.B.

2. Address:

3. Telephone:

-
4. Describe your recovery pattern since leaving New Journey: (Circle one)
- A. Continue to be chemically free.
 - B. Have at least one year continuous sobriety at time of survey.
 - C. Not in recovery.

5. Have you used any of the following since treatment?

1=Yes, did use 2=No, did not use

	<u>Yes</u>	<u>No</u>
a. Alcohol	_____	_____
b. Marijuana/Hashish	_____	_____
c. Cocaine	_____	_____
d. Inhalants	_____	_____

e. Other (explain) _____

6. Are you drinking or using more or less than before entering treatment?

More About the same Less Don't know

7. Had you been in treatment before your New Journey treatment? Yes No

When and where: _____

Completed: _____

What was helpful to you in this program: _____

8. Have you been in any other treatment or counseling since treatment at New Journey and your aftercare? Yes No

If yes: Where and/or with whom: _____

What

type: _____

When: _____

Was it helpful? How?

9. What prompted you to treatment?

<input type="checkbox"/> Self	<input type="checkbox"/> Co-worker
<input type="checkbox"/> Family	<input type="checkbox"/> Counselor
<input type="checkbox"/> Friend	<input type="checkbox"/> Intervention
<input type="checkbox"/> Physician	<input type="checkbox"/> Legal

Employer Other: _____

10. Did you complete your recommended aftercare when you left New Journey?

Yes No

11. Please rate these components of the program on how helpful they were for you:

	Very Satisfied	Mostly Satisfied	Indifferent	Very Dissatisfied	Don't Know
a. Assignments					
b. CD Lectures					
c. Films					
d. Group Therapy					
e. Individual Counseling					
f. A.A., N.A., other					
g. Spiritual Direction					

12. Since leaving New Journey Treatment (please check):

	Greatly Improved	Improved Some	Stayed the same	Gotten Worse	Much Worse
a. My family life has					
b. My work has					
c. Relationship w/spouse, significant other and friends					
d. My spiritual life has					
e. My self-worth has					
f. My overall quality of life					

13. Since treatment, have you participated in A.A. or any other recovery maintenance support groups? Yes No

14. If so, what is the frequency of your A.A. or recovery support attendance?

More than once a week.

Once a week.

Less than once a month.

Do not attend support groups or use any self-support methods.

15. Do you have a sponsor or mentor? Yes No

16. Have you completed a 4th and 5th step? Yes No

17. Are you involved with others in recovery? Yes No
18. How would you rate your quality of life?
- Greatly improved
 - Somewhat improved
 - Remained the same
 - Worse
 - Much Worse
19. What is lacking in your recovery?
20. What, if any, changes would you recommend in the New Journey Program to provide more effective services?

PLEASE CONTINUE ON TO THE NEXT PAGE

u:outpatnt/AODA/AODA Survey(10/99rg)

SWB SCALE

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree
 MA = Moderately Agree
 A = Agree

D = Disagree
 MD = Moderately Disagree
 SD = Strongly Disagree

- | | |
|---|-----------------|
| 1. I don't find much satisfaction in private prayer with God. | SA MA A D MD SD |
| 2. I don't know who I am, where I came from,
or where I am going. | SA MA A D MD SD |
| 3. I believe that God loves me and cares about me. | SA MA A D MD SD |
| 4. I feel that life is a positive experience. | SA MA A D MD SD |
| 5. I believe that God is impersonal and not interested in
my daily situations. | SA MA A D MD SD |
| 6. I feel unsettled about my future. | SA MA A D MD SD |
| 7. I have a personally meaningful relationship with God. | SA MA A D MD SD |
| 8. I feel very fulfilled and satisfied with life. | SA MA A D MD SD |
| 9. I don't get much personal strength and support
from my God. | SA MA A D MD SD |
| 10. I feel a sense of well-being about the direction
my life is headed. | SA MA A D MD SD |
| 11. I believe that God is concerned about my problems. | SA MA A D MD SD |
| 12. I don't enjoy much about life. | SA MA A D MD SD |
| 13. I don't have a personally satisfying relationship with God. | SA MA A D MD SD |
| 14. I feel good about my future. | SA MA A D MD SD |
| 15. My relationship with God helps me not to feel lonely. | SA MA A D MD SD |
| 16. I feel that life is full of conflict and unhappiness. | SA MA A D MD SD |
| 17. I feel most fulfilled when I'm in close communion with God. | SA MA A D MD SD |
| 18. Life doesn't have much meaning. | SA MA A D MD SD |
| 19. My relation with God contributes to my sense of well-being. | SA MA A D MD SD |
| 20. I believe there is some real purpose for my life. | SA MA A D MD SD |

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