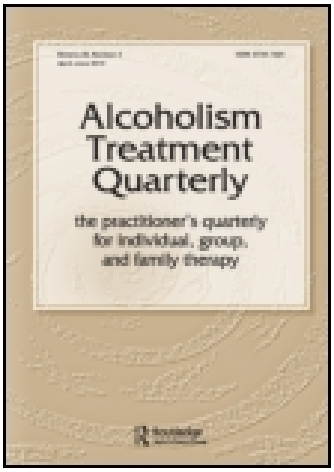

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The Role of Spirituality in Physician Recovery from Alcoholism

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The Role of Spirituality in Physician Recovery from Alcoholism

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Spirituality is a key component of healing. Physicians in the United States have incorporated mind, body, and spiritual connections into their practice, but around the world it has had varying levels of acceptance and utilization by the medical community. When physicians become patients, they also find support and comfort through spirituality, especially those with alcohol use disorders. Physicians who participate in Alcoholics Anonymous (AA) or 12-Step Facilitation (TSF) therapy and experience a spiritual awakening are likely to have a sustained long-term recovery. Those who participate in physician health programs with mandatory AA meeting attendance have high rates of total abstinence.

KEYWORDS Spirituality, Alcoholics Anonymous (AA), Twelve-Step Facilitation (TSF), physician health program (PHP)

"We have good reason to disbelieve those who think spirituality is the way of weakness." (Bill W., cofounder of Alcoholics Anonymous)

BACKGROUND

The concept that spirituality is inextricably linked to healing was expounded by Greek philosophers circa 350 BC. They identified a continuum of mind,

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body, and soul (*nous*), which were required to be in balance for individuals to achieve a state of health. Later in the Middle Ages and before the advent of modern medicine, and still part of preliterate societies, those assigned to perform healing practices (e.g., priests, shaman, or tribal/clan leaders) relied in large part upon spiritual awareness and connectivity with their sick parishioners, clans/tribesmen (Harner, 1990).

Ironically, in the current age of evidence-based medicine, spirituality has emerged as an important adjunctive component to high-tech treatment modalities. *Spirituality* with respect to medical practice is defined as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski, Post, & Sloan, 2009, p. 887). Puchalski, Ferrell, et al. (2009) clarified that spirituality is often expressed as a relationship with God, but it can also incorporate nature art, music, family, or community. Furthermore, a distinction is made between "curing" and "healing." Although the former term involves primarily the scientific model of treatment, the latter brings the patient's wishes, beliefs, and values into the formulation of a treatment plan (Puchalski, Post, & Sloan, 2009).

The Association of American Medical Colleges Medical School Objectives Project (1998) noted that physicians "must seek to understand the meaning of the patients' stories in the contexts of the patients" beliefs, and family and cultural values. They must avoid being judgmental when the patients' beliefs and values conflict with their own" (Anderson, Cohen, Hallock, Kassebaum, Turnbull, & Whitcomb, 1998). Although the majority of medical schools do include the topics of spirituality and health in their curricula (Puchalski, 2006), there is room for further integration throughout medical education. Fazzio, Galanter, Dermatis, and Levounis (2003) found that medical students' attitudes toward the spiritually-oriented approach in addiction treatment became more negative over the course of their psychiatry clerkship. There is some evidence that attitudes toward spirituality change as physicians mature. One study of internal medicine residents showed improved attitudes toward spirituality in addiction treatment after a 45-minute lecture on the topic (Rose, Stein, Arnsten, & Saitz, 2006).

With respect to the attitudes of physicians incorporating spirituality into their practice, there seems to be a general consensus that spirituality is an important component of treatment. In a survey of psychiatrists and nonpsychiatrists, most physicians endorsed the belief that religion and spirituality help patients to cope with illness and suffering while maintaining a positive outlook. About one half of physicians surveyed indicated that religion and spirituality generally provide a "community that offers emotional or practical support." Furthermore, the majority of these physicians did not endorse the concept that religion and spirituality often contribute to a patient's decision to "refuse, delay, or stop medically indicated therapy" or motivate patients

to "avoid taking responsibility for their own health." Barriers to dealing with religion and spirituality in a clinical setting included "insufficient time, insufficient knowledge/training, and concerns about disapproval from colleagues" (Curlin et al., 2007).

Several studies have examined how international physicians view spirituality in the context of treatment and recovery. One study looked at "old age psychiatrists" in the United Kingdom and found that they "recognize that awareness of spiritual dimensions may be important for their patients" (Lawrence et al., 2007). However, despite such awareness, some reports indicate that the 12-Step orientation is generally less prevalent in addiction rehabilitation internationally (Bosch, 2000; Gossop et al., 2001). A European survey of programs in the United Kingdom and Norway found that less than 10% used the 12-Step model (Best et al., 2001; Vederhus, Kristensen, Laudet, & Clausen, 2009). Referral to 12-Step programs among Norwegian addiction professionals was low, as was the level of knowledge about these programs (Vederhus et al., 2009).

Furthermore, patients are requesting that spirituality be integrated into their care. MacLean and colleagues (2003) found that one third of patients surveyed in a primary care setting want their physician to ask about their religious beliefs during routine office visits. Two thirds of patients felt that physicians should be aware of their religious or spiritual beliefs. Patients were more inclined to agree that physicians should incorporate religion or spirituality into care when a patient is hospitalized (29%) or in a near-death scenario (50%) (MacLean et al., 2003). In another survey, Ehman, Ott, Short, Ciampa, and Hansen-Flaschen (1999) looked at patients with and without religious beliefs and found that 94% of patients with religious beliefs and 45% of patients without religious beliefs agreed that physicians should ask about their beliefs if they became gravely ill. Furthermore, 68% of patients were open to being asked about spirituality in their medical history, though only 15% recalled ever being asked about their spiritual or religious beliefs by their physicians (Ehman et al., 1999).

National surveys estimate a prevalence rate of lifetime substance abuse and dependence in the general population of 13% to 18% for abuse and 5% to 13% for dependence (Compton, Thomas, Stinson, & Grant, 2007; Grant et al., 2009; Hasin, Stinson, Ogburn, & Grant, 2007; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Physicians, too, are not immune from substance use disorders (SUDs), but the prevalence rates are not as straightforward, as there are clear gender differences, especially when medical specialties are considered. For surgeons, females (26%) have almost twice the rate of substance abuse or dependence than males (14%) (Oreskovich et al., 2012). In a study of four state physician health programs, female physicians were found to be more impaired than males at time of entry. Female physicians are described as being more vulnerable to the morbidity and consequences of SUDs, as they have a younger age of onset, reported more medical and

psychiatric problems, and were more likely to report past/current suicidal ideation (Wunsch, Knisely, Cropsey, Campbell, & Schnoll, 2007). There is no published data that examines racial or ethnic differences among physicians with SUDs.

Although estimates of alcohol dependence among physicians vary from 8% to 15% (Blondell, 1993; Brewster, 1986; Clare, 1990; McAuliffe et al., 1991; Oreskovich et al., 2012; Skipper, 1997), these values may underestimate the actual rates. Physicians are as likely as professional peers to abuse substances nonmedically (McAuliffe et al., 1991). Alcohol use disorders among physicians have profound implications on patient care. Surgeons reporting a major medical error in the past 3 months were more likely to have alcohol abuse or dependence (Oreskovich et al., 2012).

ROLE OF SPIRITUALITY

There is no single treatment that is effective for all individuals with alcohol use disorders (Nowinski, Baker, & Carroll, 1999). Widely used evidence-based treatments include psychopharmacological approaches, counseling (especially when there are comorbid psychiatric conditions present) (Gallegos et al., 1992), and 12-Step facilitation (TSF) therapy (''Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes,'' Project Match Research Group, 1998).

TSF therapy is based on the model that alcohol dependency has a medical and spiritual component. The spiritual aspect is firmly rooted in the 12 Steps (guiding spiritual principles) of Alcoholics Anonymous (AA), with a primary focus on Steps 1 through 5. The goals of the therapy are twofold: to remain completely abstinent from alcohol consumption and to do so through participation in AA. Participants are actively encouraged to attend AA meetings and keep journals that document participation and the issues encountered. The therapy is time limited to 12 sessions, and each session follows a structured format that includes ''symptoms inquiry, review and reinforcement for AA participation, introduction and explication of the week's theme, and setting goals for AA participation for the next week'' (Reading assignments from AA literature complement each session (Nowinski et al., 1999, p. x). It is important to note that Project Match, a federally funded multisite clinical trial of alcohol treatment funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), found that TSF was more effective in the attainment of complete abstinence than the other modalities studied which included Motivational Enhancement Therapy (MET) and cognitive-behavioral therapy (CBT).

AA is not a specific treatment, but rather ''a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from

alcoholism" (*AA as a Resource for the Health Care Professional*, 1992, p. 2). The only requirement for membership, which is at no financial cost, is a desire to stop drinking. Its primary purpose is for its members to stay sober and for them to assist other alcoholics to achieve sobriety. AA meetings and activities are guided by its 12 Steps and Traditions that are based on spirituality, a belief in a "Higher Power," which is defined by the individual and that represents faith and hope for recovery. AA is also guided by pragmatism, that is, a belief in doing whatever it takes to avoid consuming alcohol (Nowinski et al., 1999).

The spiritual aspect of AA centers on the member's need to experience hope so they can stop drinking. It also includes a belief and trust in a power greater than their own willpower, and a recognition of an individual's character defects, including specific immoral or unethical acts, and harm done to others as a result of their alcoholism (Nowinski et al., 1999).

Physicians who have alcohol problems and who elect to become members of AA may attend meetings that are open to all alcoholics or those specifically for physicians, colloquially referred to as Caduceus Clubs or Meetings (Flowers, 1999). Those participating in AA become oriented to a spiritual role (Grant, Kaplan, Shepard, & Moore, 2003) and subsequently have increases in spiritual practices and then overall spirituality (Kelly, Stout, Magill, Tonigan, & Pagano, 2011). Increased spirituality is associated with increased abstinence (Zemore, 2007) and psychosocial outcomes of treatment (Piedmont, 2004).

To better understand the role of spirituality in AA membership and how AA helps stabilize abstinence, Galanter, Dermatis, Stanievich, and Santucci (2013) studied 144 physicians at a conference of doctors in AA. Most (60%) indicated that they believed in a personal God as opposed to a Higher Power only (22%), or neither God nor a Higher Power (18%). Most (71%) also indicated that they felt God's presence at least most days, an experience often reported by long-term members. Only a minority went to church at least monthly (36%), or designated themselves as religious (37%). Nearly all (97%) designated themselves as spiritual. Most (81%) reported having had a "spiritual awakening" (Galanter et al., 2013), a term used in AA's 12th Step:

> 12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 2001, p. 12).

Those physicians who experienced a spiritual awakening had longer periods of abstinence and were also less likely to report having craving for alcohol (Galanter et al., 2013).

Galanter and colleagues (2013) point out that nowhere else in *Alcoholics Anonymous, 4th Edition* does the term *spiritual awakening* appear. Thus, they suggest that it "may have quite different meanings for different

members, and reflect primarily a self-designation of having experienced the intensity of the group's spiritual orientation" (p. 326). They also acknowledged that past attempts have been made, without success, to draw connections between how spiritual awakening is related to clinical outcomes using questions such as, "Have you ever had a spiritual awakening?" in scales for AA involvement or affiliation (Humphreys, Kaskutas, & Weisner, 1998; Tonigan, Connors, & Miller, 1996).

Galanter and colleages (2013) note that one study that followed AA members over 3 years after entering treatment found that those who had a spiritual awakening during their 3rd year were more than 3 times as likely to be abstinent at the time of that follow-up than those who did not experience a spiritual awakening (Kaskutas, Bond, & Weisner, 2003). Galanter et al. (2013) underscore that "greater antecedent religiosity was not associated with a better outcome, suggesting that this spiritual experience per se, not associated with religion as such, is an important correlate of abstinence" (p. 326).

PHYSICIAN HEALTH PROGRAMS

States have enacted legislation that demonstrates that physician alcohol use disorders are an area of concern for which there are serious legal consequences. Currently 39 states have "sick doctor statutes" that allow for license suspension of physicians who are unable to practice medicine "with reasonable skill and safety" because of their use of alcohol (*Health and Healthcare as Social Problems*, Conrad & Leiter, 2003). All but four states (California, North Dakota, Nebraska, and Wisconsin) have Physician Health Programs (PHP) that are designed to identify, refer to treatment, guide, and monitor the recovery of physicians with alcohol use disorders, other SUDs, as well as behavioral/psychiatric disorders and medical illness (DuPont, McLellan, Carr, Gendel, & Skipper, 2009). Some states (e.g., Massachusetts) have penalties for physicians who fail to report colleagues who are impaired (Berge, Seppala, & Schipper, 2009). At the same time, states such as Minnesota allow physicians who are currently enrolled in a treatment program to continue to practice medicine with medical supervision ("Report of the Ad Hoc Committee on Physician Impairment," Schneidman, et al., 1995; Seppala & Berge, 2010). Reporting requirements related to physicians with SUDs vary from state to state.

It is in this context that PHPs have developed over the past three decades. These programs are also designed to educate the health care community regarding these issues and prevent medical errors and untoward patient care outcomes through early recognition and intervention. Most PHPs are independent agencies, whereas some are subsidiaries of state medical societies, and a small percentage are actually divisions of their respective state medical licensing board. The costs for the services provided to physicians by

PHPs are paid for in a variety of ways depending on the jurisdiction, (e.g., licensing fees, grants from medical professional liability insurers and state medical societies, as well as direct payment by participating physicians). Referrals to PHPs are primarily from practice settings such as hospitals, clinics, and groups where there is greater accountability, supervision, and oversight of practicing physicians. A significant number are referred directly from state licensing boards and face disciplinary action if they refuse, whereas a minority self-refer. Thus, adherence to PHP treatment recommendations and/or the necessity to enter into a PHP monitoring contract can have profound ramifications as to whether a physician can continue to practice medicine (DuPont et al., 2009).

Success, as measured by total abstinence from exogenous psychoactive substances, such as alcohol, among physicians who have monitoring contracts with PHPs range between 75% and 80%, far higher than almost any other form of substance abuse treatment (McLellan, Skipper, Campbell, & DuPont, 2008). One program, over a 10-year period of time, analyzed data from 120 physicians with SUD contracts, 90 (75%) completed successfully, 10 (8%) relapsed, and 20 (17%) did not complete for other reasons. Successful completion of SUD contracts was significantly associated with licensing board involvement (84% vs. 66%, $p = .04$). Time to relapse was significantly shorter for women, suggesting that women may need supplemental services (Knight, Sanchez, Sherritt, Bresnahan, & Fromson, 2007).

There are a number of reasons for the high rates of achieving total abstinence in physicians involved in PHPs. PHP monitoring contracts for alcohol use are between 3 and 5 years and typically include random urine drug screens, monitoring in the workplace, face-to-face interaction with the PHP, involvement with a therapist, and mandatory attendance at AA or Caduceus meetings from once or twice weekly to 90 meetings in 90 days. In addition, noncompliance with monitoring contract requirements or evidence of relapse results in a formal report to the medical licensing board by the PHP. Thus, compliance with PHP monitoring contracts is highly incentivized.

The Galanter and colleagues study (2013) that found that nearly all (97%) of the surveyed physicians in recovery designated themselves as spiritual and most (81%) of the physicians reported having had a "spiritual awakening," a term used in AAs 12th Step. They also point out that "long term AA sobriety was not significantly different for respondents who had been enrolled in State programs from those who had not been on the variables reflecting spiritual experience," different from a denominational religious orientation (Galanter et al., 2013, p. 326). Yet the State program participants had shorter periods of sobriety and were more likely to have attended 90 meetings in 90 days. Galanter et al. conclude "that the spiritual orientation achieved by long-term sober members may be similar even if referred to AA under differing circumstances" (p. 326). Thus, "the acquisition of a spiritual orientation, [is] apparently quite important to long-term Twelve-Step-based recovery.

CONCLUSION

Physicians and patients welcome the inclusion of spirituality into the practice of medicine. Spirituality also plays a crucial role in the recovery process from alcohol use disorders. Physicians with these problems pose a risk to patient safety. Yet, if they experience a spiritual awakening that is part of 12 Steps of AA, they will be more likely to have longer periods of abstinence, less likely to report having craving for alcohol, and have improved psychosocial outcomes of treatment. The spiritual awakening experience is not associated with religion or religious denominational practices, but rather the physician's unique and intense connection with the AA group's spiritual orientation.

Physician health programs play a unique role in identifying, referring to treatment, guiding, and monitoring the recovery of physicians with alcohol use disorders. The high rates of sustained total abstinence for participating physicians are multifactorial and usually include mandatory participation in AA groups and/or Caduceus meetings. It is in this setting that physicians reported having a "spiritual awakening." Whether physicians voluntarily elect or are mandated to participate in physician health programs, it is a spiritual orientation that is a requisite to a sustained 12-Step–based recovery. We agree with Galanter et al. (2013) that additional research is needed to better understand and define *spiritual awakening* so that it can be further integrated into the recovery and improve the outcomes of alcohol dependent individuals.

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