Adolescent Addiction: Is Spirituality a Protective Factor?

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Abstract

Adolescent drug use is a serious problem in the United States. In an effort to protect our youth from this growing epidemic, researchers previously focused on identifying risk factors as a means to developing intervention strategies. But they have not been all that effective. Recent research now suggests there are several protective factors that may minimize an adolescent’s use, with spirituality being identified as an influencing factor. Yet, some studies suggest spirituality may also be a risk factor. This master’s project is a literature review that examines the emerging field of religion and spirituality and explores the relationship between spirituality and its protective influence on adolescents as it relates to substance use.
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“There is a time for everything, and a season for every activity under heaven,” (Ecclesiastes 3:1, The Bible, NIV, 1984).
Dedication

This master’s project is dedicated to the memory of my mother, Dr. Christina Mary Comty; a physician, teacher, and mentor, who tirelessly devoted her life to helping and improving the lives of others despite personal physical, emotional, and financial challenges. Her ceaseless pursuit of knowledge and unfailing passion lives on in me.

Today I pray for wisdom to build a better tomorrow on the mistakes and experiences of yesterday (Al-Anon, 2002).
Definition of Terms

**Addiction** - a chronic, relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences (NIDA, 2007)

**Adolescent** – a young person in the process of developing from a child into an adult (Marshall, 2014); typically in the age range of 10 to 18 years, but up to range of 21 to 25 years (American Psychological Association, 2002)

**Binge Drinking** – 5 or more drinks on a single occasion within a two-hour period (American Psychiatric Association, 2000)

**Drug Prevention** – to delay or inhibit substance abuse (NIDA, 2003)

**Preventive Interventions** – strategies to change balance between risk and protective factors so that protective factors outweigh risk factors (NIDA, 2003)

**Protective Factor** - factors associated with reduced potential for drug abuse (NIDA, 2003)

**Risk Factor** - factors associated with greater potential for drug abuse (NIDA, 2003)

**Spirituality** – the search for ultimate meaning, purpose, and transcendence in life and the experiential relationship of the sacred (GWISH, 2014)

**Substance** – alcohol, nicotine, over-the-counter, illicit, or prescription drugs, and inhalants used with intended purpose of getting “high” (American Psychiatric Association, 2000)

**Substance Abuse** – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use of substances (American Psychiatric Association, 2000)

**Underage** – refers to illicit (i.e., illegal) possession or use of substances, e.g., alcohol under age 21 and nicotine under age 18 (NIDA, 2007)
Adolescent Addiction: Is Spirituality a Protective Factor?

The relationship between spirituality and health has been the focus of considerable interest in recent years. Studies suggest that many Americans believe religion and spirituality play an important role in their lives; that there is a positive correlation between an individual’s spirituality or religious commitment and health outcomes (Hodge, 2011; Koenig, McCullough, & Larson, 2001; Miller, 1998; Pew Research, 2008a). To be sure, religiousness has been shown to exert a protective effect against underage alcohol use (Burris, Sauer, & Carlson, 2011). But just how far that “protective” relationship extends to spirituality, which is related to religiousness, and adolescents’ decisions to resist using alcohol and other illicit substances has generated interesting and confounding discussions in the scientific community.

A new field of research is working to determine if this construct called spirituality protects some adolescents from initiating or continuing use of alcohol and other substances (Burris, et al., 2011; Koenig et al., 2001). If science can prove that spirituality is a protective factor that helps adolescents resist using alcohol and drugs, then the implications are enormous. At issue, however, are some key challenges.

First, how does one define spirituality? Spirituality is not easy to define, though it is generally thought to be individualistic, intrinsic, and subjective; one’s search for the ultimate meaning and purpose in life (Koenig et al., 2001; Miller, 1998; Pew Research, 2008b). This paper will discuss several scientific definitions of spirituality and their limitations. The lack of a single definition from which researchers can operate poses an enormous obstacle (Koenig, et al., 2001; Miller & Thoresen, 2003).

Second, how does one specifically measure spirituality in an individual? Spirituality is not easily measured like blood pressure or weight. In order for spirituality to become an
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Evidence based practice there needs to be an objective yet valid and replicable measurement tool. The sheer number of assessment tools purporting to measure spirituality attests to the lack of agreement in the research field as to what spirituality is and how it is best measured. Moreover, should assessment tools used for adults be similarly employed with adolescents?

This paper looks at these issues through a thoughtful survey of current peer-reviewed research literature. In addition, this paper discusses the following: 1) is spirituality a protective factor to prevent adolescent substance use; 2) to what extent is spirituality a risk factor for substance abuse in adolescents. Additionally, this paper will explore spirituality through the lens of Alfred Adler’s Individual Psychology as it relates to adolescents. Furthermore, this paper will examine how spirituality can be developed in a child; are there practices parents, educators, church, community leaders, and law enforcement should be taking to foster this enigmatic construct? Finally, some conclusions will be drawn and recommendations made for future studies.

The Problem: Adolescents and Substance Use

Adolescent substance use is a major problem in the United States with serious social and economical implications (Marshall, 2014). In the United States, it is illegal to drink alcohol under the age of 21 years and to use tobacco under the age of 18. Twenty-three states plus the District of Columbia permit marijuana use for medical purposes (Governing, n.d.). Furthermore, four states have passed legislation legalizing marijuana for recreational use. Possession and use of all other substances, however, is illegal unless medically prescribed (Governing, n.d.).

Rates of Use: Nationwide

There were over 74 million adolescents in the United States in 2010 (US Census Bureau, 2011). According to SAMSHA (2014b) an estimated 1.3 million American adolescents, ages 12
to 17, had a substance use disorder in 2013 (5.2% of all adolescents). The 2013 national rate of past month illicit drug use was 2.6% among those youth ages 12 to 13, 7.8% among youth ages 14 to 15, and 15.8% among youth ages 16 to 17. The highest rate of current illicit drug use was among youth ages 18 to 20 (22.6%), with the next highest rate occurring among people ages 21 to 25 (20.9%; SAMSHA, 2014b).

According to SAMSHA (2014b), more teens use alcohol than tobacco or other drugs. Consumption of alcohol under the age of 21, also known as underage drinking, is a dangerous and ongoing problem (Marshall, 2014; Miller, Naimi, Brewer, & Jones, 2007; NIDA, 2007). Medical research has found that developing adolescent brains are susceptible to long-term negative consequences of alcohol use (Butler Center for Research, 2010; Marshall, 2014; NIDA, 2007; Winters, 2008). Moreover, adolescents who begin drinking before age 14 are significantly more likely to develop alcohol dependency than individuals who begin drinking after the age of 21 (SAMSHA, 2014b). Additionally, underage drinking contributes to the three leading causes of death (unintentional injury, homicide, and suicide) among persons aged 12 to 20 years (Hingson, Heeren, & Winter, 2006; Miller et al., 2007). In 2012, more than 9 million people between the ages of 12 and 20 reported drinking alcohol in the preceding month. This accounts for almost 25% of people between these ages (SAMSHA, 2014b).

Furthermore, almost 6 million youth between the ages of 12 and 20 defined themselves as binge drinkers with 1.7 million defining themselves as heavy drinkers (SAMSHA, 2014b). Binge drinking is defined as drinking 5 or more drinks on a single occasion (American Psychiatric Association, 2000; Miller et al., 2007; SAMSHA, 2014b). Adolescents who started drinking before age 13 were seven times more likely to binge drink six or more times a month than those who waited until they were 17 years or older to begin drinking (Hingson et al., 2006; SAMSHA,
2014b). Additionally, adolescents who binge drink are more likely to engage in other risky behaviors (Miller et al., 2007; SAMSHA, 2014b; Winters, 2008). Marshall warns of increasing prevalence rates in adolescents and underscores the impact of early adolescent use. “Of the 78.2% of adolescents who consumed alcohol, 15.1% met the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria for lifetime alcohol abuse” (Marshall, 2014, p.160).

According to SAMSHA (2014b), rates of underage alcohol use in the United States were highest in the Northeast (28.3%) and lowest in the South (22.3%). Underage alcohol use rates in the Midwest and West were both around 24.5%. Among ethnic groups, for youth between the ages of 12 and 20, the national rates of alcohol use in 2012 were lowest among Asian Americans (13.7%), followed by African Americans (18%), American Indians/Alaska Natives (22.3%), Hispanics (23.2%), and highest among Whites (27.4%).

In addition to the increasing prevalence rates of alcohol use among adolescents, the rates of use for other substances is concerning. According to the Centers for Disease Control and Prevention (CDC, 2014) in 2013, 10.2% of 9th graders and 21.1% of 11th graders reported past 30 day cigarette smoking. Among ethnic groups, 18.6% of White, 8.2% of Black, and 14% of Hispanic students reported past 30 day cigarette smoking. Additionally, 17.7% of 9th graders reported past 30 day marijuana use and 25.5% of 11th graders reported past 30 day marijuana use. Among ethnic groups, 20.4% White, 28.9% Black, and 27.6% Hispanic students reported past 30 day marijuana use (CDC, 2014).

**Rates of Use: Minnesota**

According to the 2013 Minnesota Student Survey (MSS, 2014), alcohol is the most frequently abused substance by adolescents in the state and the average age at which youth ages
12-17 report they begin to drink is 13 years old. Statewide, 24.1% of 9th graders and 18.1% of 11th graders reported having their first drink of alcohol before age 13. These rates are higher than the national prevalence rates of 22.2% of 9th graders and 17.6% of 11th graders.

The Behavioral Health Barometer (SAMSHA, 2013) which measured substance use among persons aged 12-17 from 2008-2012, showed within the state of Minnesota, the mean age of first use of alcohol is 13.7 years; the mean age of first cigarette use is 12.8 years; the mean age of first marijuana use is 14.1 years; and the mean age of nonmedical use of psychoactive substances is 13.6 years. This same survey reported 67% of 12-17 year olds in Minnesota in 2011-2012 perceived no great risk from (binge) drinking five or more drinks once or twice a week.

Moreover, within the seven-county Minneapolis-St. Paul metropolitan area (Hennepin, Ramsey, Anoka, Dakota, Carver, Scott, and Washington), according to Falkowski (2014b), addiction treatment admissions for alcohol and other substances among adolescents continue to rise. A record-high 14% of admissions to Minnesota addiction treatment centers were for heroin in 2013. Furthermore, heroin related emergency room visits in the metropolitan area more than doubled between 2004-2011 (from 1,940 to 4,836), demonstrating a 149.3 percent increase (Falkowski, 2014b). This alarming statistic led Minnesota to enact a law to make Narcan, a life-saving antidote for heroin overdose, available (Falkowski, 2014a). In addition, marijuana accounted for 15.5% of admissions to Minnesota addiction treatment centers, of which 27.1% were for age 17 or younger (Falkowski, 2014b). Falkowski (2014a) asserts that more youths in the metropolitan area smoke marijuana than cigarettes.
Rates of Use: Crow Wing County – A Rural Population

Adolescent substance use is not strictly an urban problem, however. In 2013 in Crow Wing County (central Minnesota) where this writer and her adolescent high school student reside, cigarette smoking in the past 30 days was 9% for 9th grade males versus a statewide rate of 7.3% for 9th grade males (MSS, 2014). Moreover, in this predominantly rural county, the past 30 day cigarette smoking use rate for 11th graders was 23% for females and 36% for males. This is significantly higher than the statewide cigarette use rate (11.2% female and 13.2% male) and the national rate (18.99% female and 23.4% male) for 11th graders.

Furthermore, within the county, the use of alcohol in the past 30 days among 9th grade males was 19%, which is significantly higher than the statewide rate of 14.7% for 9th grade males. Additionally, among 11th graders in the county, the current alcohol use rate for the past 30 days for female students was 42%. This is significantly higher than both the state-wide rate of 26.9% and the national rate of 37.5% for female 11th graders. Also, the binge drinking rate among Crow Wing County 11th grade males is higher (20%) than the statewide rate (18.1%).

Most surprisingly, were the higher rates of use in this rural county of females than males for both alcohol and tobacco use. According to the MSS (2014), 42% of 11th grade girls in Crow Wing County reported drinking in the last 30 days as compared to 30% reported by 11th grade males. Additionally, among all 8th graders, tobacco use in the past 30 days was significantly higher for females (7%) versus males (2%); alcohol use in the past year was higher for females (13%) versus males (9%); and use of alcohol and marijuana (and no other drugs) was higher for females (5%) versus males (1%). It should be noted, the high rates of substance use in this writer’s county cannot be attributed to race, ethnicity, or culture. In the 2013 survey, students in
5th, 8th, 9th, and 11th grades reported being 88%, 90%, 89%, and 93% White respectively (MSS, 2014).

**Inhalants: A New Problem**

For the first time in 2013, the MSS (2014) began including questions related to the use of inhalants and did so for adolescents as young as fifth grade. The addition was in direct response to the realization that inhalants were an overlooked but increasingly hazardous risk to today’s youth. Inhalants are chemicals found in common household products which are inhaled by adolescents with the purpose of getting “high.” According to the National Institute for Drug Abuse (NIDA) for Teens (n.d), inhaling their fumes, even just once, can be harmful to the brain and body and can lead to death.

**Substance Use and Its Implications**

Adolescents who begin drinking before age 14 are significantly more likely to develop alcohol dependency than individuals who begin drinking after the age of 21 (Hingson et al., 2006). According to Marshall (2014), 15.1% of adolescents met the DSM-IV criteria for past year abuse or dependence on alcohol. An American Medical Association study of 43,093 adults found those individuals who began drinking before age 13 developed alcohol dependence at a younger age (Hingson et al., 2006). Some of these adolescents will not make it to adulthood, but those who do and continue to use will create untold burdens on their families, communities, and society as a whole. Moreover, they will further burden our healthcare, social service, and juvenile justice systems.

Substance use during adolescence can lead to patterns and consequences of behavior that follow them into adulthood (Hodge et al., 2007). Additionally, according to Hodge et al. (2007), addiction in adolescence adds to delinquency and antisocial behavior, often resulting in
encounters with the legal system. Furthermore, adolescents who abuse alcohol and drugs often do poorly academically and drop out of school, which can lead to lower wage earnings as adults (Hodge et al., 2007). Lower productivity and lower wages affect the economy as a whole and have a ripple effect.

In addition to the economic costs, there are intangible personal costs (i.e., quality of life) associated with substance use. These costs include: early onset of diseases, alcohol-related driving injuries, and poor mental health (Hodge et al., 2007; Koenig, et al., 2001). Adolescent substance use presents an enormous toll on the U.S. healthcare system. It is estimated the health care costs related to alcohol and tobacco use in this country exceed $100 billion annually (Hodge et al., 2007). Adolescents engaging in substance use are prone to more risky behaviors than non-using adolescents. For instance, they experience increased risk of infectious diseases such as HIV-AIDS, female users are at increased risk of unplanned pregnancies, and both male and female adolescents become more susceptible to acts of violence (NIDA, 2007).

Moreover, substance abuse is frequently co-morbid with other, psychiatric disorders, such as anxiety and depression (Koenig et al., 2001). More than 80% of adolescents receiving treatment for addiction at the Hazelden Center for Youth have co-occurring disorders (Lee, 2012). It is unclear whether substance use and abuse pre-dates psychiatric disorders in adolescents or if adolescents employ substance use as a coping mechanism for their mental health and the stressors of life (Koenig, et al., 2001). Regardless, “the consequences of alcohol and drug use are vast and varied and affect people of all ages” (NIDA, 2007, p. 2).

**Prevention**

In an effort to curb the adverse consequences of adolescent substance use on society, researchers, educators, community leaders, and law enforcement have sought to prevent or delay
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the onset of use by developing and employing preventative measures (NIDA, 2003).

Interventions for preventing adolescent substance use fall into two distinct approaches:

1) environmental-level interventions which seek to reduce underage consumption, i.e., age 21 for alcohol and age 18 for tobacco, by increasing penalties for violating minimum legal age, and reducing community tolerance for substance use by adolescents; and

2) individual-level interventions which seek to change knowledge, expectancies, attitudes, intentions, motivation, and skills (e.g., school-based prevention programs) so that adolescents are better able to resist the influences and opportunities that surround them (SAMSHA, 2014b). Much of the research and development of prevention programs are focused on identifying risk and protective factors and developing strategies to change the balance so that protective factors outweigh risk factors (NIDA, 2003). By identifying risk factors for substance use, researchers can develop appropriate prevention strategies.

Risk Factors for Substance Use

Over the last two decades, researchers have attempted to determine how substance use begins and progresses in adolescents (Centre for Addiction and Mental Health [CAM], 2009). Understanding the influences on adolescent substance use requires researchers to examine the adolescent and their family, their community, and society as a whole. Numerous studies (Brounstein & Zweig, 1999; Koenig, et al., 2001; Marshall, 2014; Resnick, 2000; Stone, Becker, Huber, & Catlano, 2012) have been conducted to understand these influences and identify the factors that make America’s youth vulnerable to the use of substances. Factors associated with greater potential for drug use are called risk factors and can be used to predict problems in adolescents (NIDA, 2003). Commonly known risk factors include: family dysfunction, ineffective parenting, inappropriate classroom behavior, academic failure, poor social coping
skills, affiliations with deviant peers, perceived external approval of drug use, parental substance use, and mental illness, as well as genetics, race, and ethnic culture (Brounstein & Zweig, 1999; Butler Center for Research, 2010; CAMH, 2009; Koenig et al., 2001; Marshall, 2014; NIDA, 2003).

There are several key risk periods for substance use that occur during major transitions in an adolescent's life (CAMH, 2009). The first transition occurs when the child leaves the security of their family and starts school. Later, when the child leaves elementary school, they experience new academic and social situations, and come into contact with a wider group of peers. It is at this stage children may encounter drugs for the first time. When adolescents enter high school, they face additional academic, social, and emotional challenges. At this stage, they may be exposed to greater availability of illegal substances and alcohol, peers who are substance users, and unmonitored social activities involving substance use. These challenges can increase the risk that the adolescent youth will abuse alcohol, tobacco, and other substances. The final stage occurs when older adolescents leave home for college and are on their own for the first time. It is at this stage the risk for adolescent drug and alcohol use is extremely high (CAMH, 2009; NIDA, 2003).

The idea behind reducing risk factors is to reduce the problems facing adolescents, and thus prevent adolescents from using, or continuing to use, substances. Naturally, federal dollars have followed the research and have been used towards evidenced-based prevention and intervention methods that rely on schools, communities, and law enforcement for dissemination and implementation. But they have not been all that successful (Kumar, O’Malley, Johnston, & Laetz, 2013; McDuffie & Bernt, 1993; Sloboda et al., 2009). A look at research on the well-
known prevention program, DARE, concludes it lacks efficacy in curbing youth substance use (Ennett, Tobler, Ringwalt, & Flewelling, 1994; Lynam et al., 1999).

Risk factors do not necessarily lead to substance use and abuse, but rather they put the adolescent more at risk for developing a substance problem. Conversely, if many protective factors are present, then behaviors like substance use are less likely under these conditions (CAMH, 2009). One of the dangers of focusing exclusively on risk factors in adolescence is that risk factors vary considerably in relation to a youth’s age, psychosocial development, ethnic/cultural identity, and environment (NIDA, 2003).

Additionally, the impact of a specific risk factor on a particular youth may change with age. For example, risk factors within a family have the greatest affect on a younger child, while associating with drug-using peers is more of a risk factor for an older adolescent (NIDA, 2003). Furthermore, a risk factor for one youth may not be a risk factor for another. It should be further noted, exposure to risk factors in a youth’s life does not guarantee that substance use or other problematic behaviors will ensue (CAMH, 2009; NIDA, 2003). In fact, most individuals at risk for drug abuse do not start using drugs or become addicted (NIDA, 2003). Moreover, many individuals growing up in high risk families and environments do so relatively problem-free (Brounstein & Zweig, 1999). An explanation for this may be the presence of protective factors.

**Protective Factors**

As early as 1970s and 1980s, health researchers began looking for a link between risk factors and protective factors as a way of developing effective substance use prevention programs (Hawkins, Catalano, & Miller, 1992; NIDA, 2003; Resnick, 2000). Researchers speculate that if risk factors increase an adolescent’s likelihood of substance use and abuse, then protective factors should reduce the risk. Indeed, protective factors balance and buffer risk
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factors (Brounstein & Zweig, 1999; CAMH, 2009; Hawkins et al., 1992; NIDA, 2003). Protective factors are not always the opposite of a particular risk (Brounstein & Zweig, 1999). But protective factors may lead to positive outcomes by buffering youth from circumstances that put them at risk of engaging in addictive substances by decreasing the likelihood that they will participate in harmful activities (Hodge et al., 2007).

In contrast to a perspective that was focused solely on reducing risk and the negative aspects of an adolescent’s life, protective factor research examines what is positive and healthy in adolescents’ lives. The Centre for Addiction and Health (CAMH, 2009) suggests that protective factors have a layering effect in adolescents. Ideally, there are many protective factors and they exist in multiple and overlapping areas of an adolescent’s life such as: individually, family, and community. Protective factors most often identified include: strong family bonds, parental engagement in a child’s life, clear parental expectations and consequences, academic success, conventional norms about drugs and alcohol, and strong bonds with pro-social institutions such as schools, communities, and churches (Brounstein & Zweig, 1999; Butler Center for Research, 2010; NIDA, 2003).

To be sure, a NIDA-funded study of 1,000 high-risk youths in Rochester, New York, found that an accumulation of protective factors in different areas of an adolescent’s life strongly predicted resistance to drug use (NIDA, 2003). These factors were categorized under four groups: family, educational, peer, and other resources. An adolescent’s involvement in religious activities was included under “other resources.” The longitudinal study, which first measured protective factors while the youths were in 8th and 9th grades, identified family, educational and peer factors as protective factors, and concluded that it is the accumulation of these factors which led to positive resistance three years later. More than 56% of the high-risk youths with six or
more protective factors remained drug free by the time they reached 11th and 12th grades. In contrast, only 20% of youths with three or fewer protective factors remained drug free (NIDA, 2003). Surprisingly, the same study concluded that an adolescent’s involvement in religious activities did not have a deterrent effect on substance use.

It should be noted, however, specific protective factors may change during an adolescent’s development (NIDA, 2003). Thus, the study may have had different results had it been conducted with younger adolescents, beginning in 5th and 6th grades, for example. The NIDA study suggests the effect of some protective factors diminishes as adolescents age and other protective factors replace them as new challenges arise. Although the NIDA study did not find a correlation between religious or spiritual activity and resistance to drug use when the adolescents were between 7th and 11th grades, it is this writer’s opinion religious and spiritual involvement at a younger age could be advantageous and should not be ruled out as a protective factor.

**History of Religion and Spirituality Research**

Francis Galton (1872), a cousin to Charles Darwin, studied the impact of religion on physical health with his retrospective case-control study of intercessory prayer (Koenig, King & Carson, 2012). Peer-reviewed research articles on religion/spirituality and health started to appear in the 1950s. In one of the earliest comprehensive reviews of studies linking religion to health, Jeff Levin and Preston Schiller examined more than 200 studies - most of them focusing on religious affiliation – and concluded that they overwhelming suggest that religious factors are associated with health (in Koenig et al., 2012).

Additionally, in 1980, psychiatrist David B. Larson published his first of nearly 300 articles exploring research on religion and mental health. According to Koenig et al. (2012), it
was Larson who fostered a new generation of researchers to explore the relationship between religion and health at a clinical level and who, in 1991, created the National Institute for Healthcare Research (NIHR) which would become the International Center for the Integration of Health and Spirituality. Momentum continued through the 1990s as research on religion and spirituality appeared in mainstream psychiatric publications. By 1998, the Center for the Study of Religion, Spirituality and Health at Duke University Medical Center, headed by Harold G. Koenig, included mainstream researchers from a cross section of disciplines who conducted research and taught and educated clinicians to integrate spirituality into patient care (Koenig et al., 2012).

In 1995, the John Templeton Foundation began awarding grants to medical schools to initiate courses in religion, spirituality, and medicine. The program was administered by David Larson at NIHR and then by Christina Puchalski at George Washington Institute for Spirituality and Health (GWISH). In 2001, the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) outlined guidelines for spiritual assessment of patients in hospitals and nursing homes. As a result, more health care professionals have included a spiritual history as part of the patient assessment. By 2009, 90% of medical schools offered classes or course content on spirituality and health (Koenig, et al., 2012).

**Spirituality and Religion: Definitions**

One of the newer areas of research in the prevention of substance abuse in adolescents is that of spirituality. Spirituality and religion are often used interchangeably. However, while they have much in common, religion and spirituality are quite different concepts (Hodge, 2011; King, Ramos, & Clardy, 2013; Koenig, et al., 2001; Miller, 1998; Miller & Thoresen, 2003).
Before we can understand how religion and spirituality overlap, it is important to examine religion and spirituality as separate and unique concepts.

**Religion**

The word *religion* comes from the Latin *religare*, meaning "to bind" or "to tie" (Holmquist, 2012; Koenig et al., 2012). Another word with this same root includes *ligature*, meaning suture. According to Holmquist (2012) and Koenig et al. (2012), the original intention of religion is to reconnect the part to the whole. Religion is external and refers to an individual’s identification with a specific faith. It is a set of beliefs and involves ritual observances and a moral code regulating the conduct and behavior of its adherents (American Association of Marriage and Family Therapy [AAMFT], 2014). Religion is defined in Webster’s Dictionary (in Koenig et al., 2001. p.18) as:

(a) Belief in a divine or superhuman power or powers to be obeyed and worshipped as the creator(s) and ruler(s) of the universe, (b) the expression of such a belief in conduct and ritual...[or] (a) any specific system of belief, worship, conduct, etc., often involving a code of ethics and a philosophy (e.g., the Christian *religion*, the Buddhist *religion*); (b) any system of belief, practice, ethical values, etc., resembling suggestive of, or likened to such system.

**Spirituality**

By contrast, spirituality is deeply personal and highly subjective. Spirituality is a person’s existential relationship with God (Hodge, 2011). Spirituality comes from the Latin word *spiritus*, meaning breath (Holmquist, 2012). Thus, breathing, an essential element of human life, implies that spirituality has something to do with the essence of living. Other words with
this common root include inspire, aspire and to conspire which means to breathe together, according to Holmquist (2012).

Spirituality is defined in Koenig et al. (2001, p.18) as:

1. Spiritual character; quality or nature
2. [often plural] the rights, jurisdictions, tithes, etc. belonging to the church or to the ecclesiastic
3. The fact or state of being incorporeal [without material body or substance].

Koenig et al. (2001) cautions, however, that the definitions of religion and spirituality are not particularly useful, noting there is considerable disagreement within the scientific community. He suggests, therefore, that an alternative definition be used, based on distinguishing characteristics:

<table>
<thead>
<tr>
<th>Religious Characteristics</th>
<th>Spiritual Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community focused</td>
<td>Individualistic</td>
</tr>
<tr>
<td>Observable, measurable, objective</td>
<td>Less visible/measurable, more subjective</td>
</tr>
<tr>
<td>Behavior oriented, outward practices</td>
<td>Less formal/orthodox/systematic</td>
</tr>
<tr>
<td>Authoritarian in terms of behaviors</td>
<td>Emotionally oriented, inward directed</td>
</tr>
<tr>
<td>Doctrine separating good from evil</td>
<td>Unifying, not doctrine oriented</td>
</tr>
</tbody>
</table>

(Koenig et al., 2001)

**Differences between Religion and Spirituality**

It is important for researchers and practitioners to understand the difference between religion and spirituality. In the United States, the fabric of society has developed around its white, Anglo-Saxon Protestant founding fathers, and as such the religious perspective has been Western and predominantly Christian (Sue & Sue, 2013).
However, a 2007 survey by the Pew Forum on Religion and Public Life (Pew Research, 2008a) detailed statistics on religion in America and revealed the religious shifts taking place in this country. The survey found religious affiliation is very diverse and extremely fluid. With more non-Christian peoples immigrating to the United States and a burgeoning minority population from diverse ethnic and religious cultures, what was once commonly understood and accepted when discussing religion and culture is changing (Pew Research, 2008a).

Today, there are more than 14 world religions represented in the United States (Pew Research, 2008a). While Christians represent 78% of American adults, Protestants account for only 51% of Americans, with other Christians identifying as Catholic, Mormon, Jehovah’s Witnesses, and Greek or Russian Orthodox. Other religions include: Jewish, Buddhist, Muslim, Hindu, and New Age. According to Pew Research (2008a) another 16% of Americans do not identify with any organized religion.

Scientific Definitions

Koenig et al. (2001) underscores the necessity of having an operational definition of religion in place so that scientific studies can be conducted to measure its impact. Additionally, Koenig outlines 12 components or dimensions (developed by others) that he believes should be included in the definition of religion (Koenig et.al., 2001, pp. 20-23) when examining its effects scientifically:

1. Religious belief: belief in God, or not (atheistic), or do not know (agnostic); measured by how closely beliefs conform to established doctrine of a religious body

2. Religious affiliation or denomination: identification with a particular religious group
3. Organizational religiosity: attendance at religious services and/or religious social activities (Bible study, prayer group), holding church offices, receiving communion or other sacraments or rituals of the church

4. Nonorganizational religiosity: private prayer other than mealtimes (petitionary, intercessory, adoration, confession, contemplative, and meditative types); reading religious scriptures or other inspirational literature, watching religious television

5. Subjective religiosity: how religious does the individual consider oneself (subjective and based on self-report)

6. Religious commitment/motivation: degree of internal or intrinsic religiosity (committed to and motivated by religious beliefs) versus extrinsic religiosity (use religion towards own ends)

7. Religious quest: not aligned with any formal religion; these individuals ask endless “why” questions

8. Religious experience: conversion, born again, i.e., life changing, and mystical experiences; physical or emotional healing; and other experiences with God

9. Religious well-being: the spiritual well-being (SWB) measurement developed by Paloutzian and Ellison (in Koenig et al., 2001) is composed of 10 questions each relating to religious well-being and existential well-being

10. Religious coping: behaviors or thinking that help persons cope with or adapt to difficult life circumstances

11. Religious knowledge: amount of information individual has about the major tenets of their religious faith
12. Religious consequences: practical application of one’s religion in one’s life; e.g., giving money, tithing, volunteering time and talent

In addition to the indigenous Native Americans and the white Europeans who settled here more than 250 years ago, the United States is home to a multi-cultural population of African-Americans, Alaska natives, Asian-Americans/Pacific Islanders, and Latino/Hispanic Americans. Recent immigration and refugees are adding even more ethnic diversity to the American scene (Sue & Sue, 2013). Each of these ethnic/cultural groups bring with them values and perspectives that may differ from the dominant Western perspective of researchers and the dominant Western religions of the adolescents they are investigating. In western cultures, particularly the Anglo-American culture of the United States, value is placed on individual achievement and being oriented toward the future. Life is fast paced, compartmentalized, and organized primarily around family and work, with less importance on spirituality and community (ReadytoTest.com, 2012).

By contrast, in many non-western cultures, spirituality plays an integral part in family life and individual development. In the Native-American and Asian cultures, for example, there is a holistic worldview in which all of nature, the animal world, the spiritual world, and the heavens are intertwined (ReadytoTest.com, 2012). Spiritual beliefs and ceremonies are often central to clients from some cultural groups, including Hispanics/Latinos and Native Americans. Additionally, Muslims, of whom there are an estimated 6 to 10 million now living in the United States, see life as a holistic experience in which the spiritual informs all aspects of their existence (Daneshpour & Dadas, 2014).

While there are many scientific definitions of religion, there are even more definitions of spirituality (Burris et al., 2011). To be sure, in 1999, the Association of American Medical
Colleges Medical School *Objectives Report III* (GWISH, 2014) defined spirituality as an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism and the arts.

Still, another definition of spirituality defines it simply as a set of principles, meanings, beliefs, attributions, creeds, sacred values, and goals (Daneshpour & Dadas, 2014). Spirituality is personal and experiential. Moreover, we cannot know it through our intellect or our reason. Whitfield (1989) refers to spirituality as paradoxically subtle and powerful, like our breath; without it we would die.

In the past, the mental health field distanced itself from spirituality (AAMFT, 2014; Koenig, et al., 2001; Miller & Thoresen, 2003). The foundations of mental health came from atheistic views, such as Freud, who viewed religion and spirituality as delusional (AAMFT, 2014). Now, according to Dr. Dorothy Becvar, “After years of conscious exclusion, spirituality and religion have been recognized as comprising a dimension of people’s lives too important to be ignored….” (AAMFT, 2014, p.19). Moreover, spirituality is now being recognized as a powerful coping mechanism for individuals.

Spirituality as an intervention has long been accepted in the addiction recovery field, particularly in twelve step programs. Millions of individuals are said to be members of a worldwide fellowship called Alcoholics Anonymous (AA). In AA’s, *The Big Book* (2001), Step Twelve states: “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” (p. 60). It is the opinion of Berger (2013), that the Twelve Steps are one of the most innovative psychological interventions of the past century. In Berger’s estimation, *working the steps* leads to a powerful spiritual transformation.
Koenig et al. (2001, p. 19) asserts there are five types of spirituality in the United States that should be considered in scientific research:

1. Humanistic spirituality (about 7% of population): focus is on the human spirit, belief in human self-transcendence on own terms, and no higher power (Camus and Hemingway exemplify)

2. Unmoored spirituality (about 7% of population): mostly upper middle class, cultural elite; includes many educators and mental health professionals; individualistic, not religious or institutional; believe in energy, connection, nature, healing touch, astrology, crystals, and parapsychology

3. Moored spirituality – Eastern type (less than 3% of population): comprises Buddhists, Taoists, Shintoists, and Hindus

4. Moored spirituality – Western type I (about 25% of population): includes evangelical, conservative, Protestants, Catholics, Eastern Orthodox, Jews, Muslims; feel responsible to someone, theocratic; offers prayers that are very specific and directed; focus on a God who intervenes

5. Moored spirituality – Western type II (about 60% of population): includes mainline Protestants, Catholics, Eastern Orthodox, Jews, Muslims; believe all of our lives are under God’s will; much less likely to discern God’s will

According to Koenig et al. (2001), most of the research in the United States has been conducted with subjects who consider themselves type 4- or type 5-moored spirituality, implying they are tethered or anchored to a particular religion or denomination. However, with an increasingly diverse population, it is important that the conclusions reported by empirical studies
pertain to the population studied and extrapolations for all adolescents are made only with caution.

Although, Dr. Chris Habben (AAMFT, 2014) cautions that there is an increasing polarization between the terms religion and spirituality, in the United States and internationally, there is also greater recognition and appreciation of the diversity within spirituality. To be sure, GWISH (2014) for example, crafted an international definition of spirituality:

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.

This international definition of spirituality may lend itself to a better understanding and operational use across diverse ethnic and cultural lines but it has been slow entering the scientific community. Indeed, an informal survey by this writer of The Handbook of Religion and Health (Koenig et al., 2001), from the beginnings through the year 2000, lists few studies assessing the impact of spirituality on substance use in adolescents. By contrast, between two and three dozen studies are referred to in the Koenig et al. book examining various dimensions of religion on drug use/abuse in adolescents. Researchers may desire to assess spirituality instead of religion, but owing to its broadness and personal nature, spirituality is more difficult to measure.

Measuring Spirituality

Part of the problem in assessing spirituality may be due to the inadequacy of measurement instruments. As Koenig et al. (2001, p. 505) point out,

Many measures of spiritually that exist measure simply religiosity. The label “spirituality” has been given these instruments only because the term is less
offensive and more acceptable to academicians than “religiosity.” Spirituality and religion frequently become blurred when one is actually trying to measure one or the other. Some researchers may even question the existence of an independent construct called “spirituality” that is distinct from religiousness and other psychological states (meaning in life, forgiveness, awe, beauty, wonder).

It therefore behooves researchers to develop and identify a set of assessment tools which are: a) sensitive, reliable, and valid; b) analyze religious and spiritual dimensions separately; c) do not also measure mental health outcomes; and, d) measure the intended construct – spirituality or religion (Koenig et al., 2001). Even so, this may not be adequate in the end.

Religiosity has been examined at the Pew Research (2008a) and elsewhere by measuring such things as attendance at religious services or frequency of prayer. That is fairly straightforward. The larger challenger for researchers, however, is in measuring spirituality, which has been previously identified as individualistic, intrinsic, and subjective. According to Alexander Austin, the lead researcher on Spirituality in higher education: A national college students search for meaning and purpose (Pew Research, 2008b), spirituality is related to an individuals’ search for meaning and purpose. Because spirituality is an interior quality, spirituality measures are related to values, attitudes and beliefs. Austin (Pew Research, 2008b) asserts that equanimity, psychological stability and composure, is the prototypic quality of the spiritual person, and is one of the facets of spirituality his study attempted to measure. Other facets Austin and colleagues attempted to measure include the person’s ethic of caring for others and the world, ecumenical worldview (does the person identify with something larger), compassion for others, compassionate self-concept, charitable activity, one’s spiritual self-concept, and one’s spiritual quest for meaning, purpose and value (Pew Research, 2008b).
Spirituality Measurement Scales

Use of a spiritual assessment is a first step in incorporating consideration of an individual’s spirituality into practice. Within the behavioral health care setting there are a number of spiritual assessment tools that have gained widespread acceptance and are described in the Appendix. However, two issues of concern to emerge from this writer’s literature review are the use of religiousness measures to study spirituality and the difficulty in quantifying the results of these spiritual assessments.

Hodge et al. (2007) state most of the early empirical studies on the effect of religion and spirituality on health outcomes used various measures of religion. In their defense, Hodge et al. assert that research focusing specifically on spirituality as a distinct construct from religion was only in its infancy. Rew and Wing (as cited in Burris, Sauer & Carlson, 2011) concur, citing weak measurement tools and poor operational definitions that hampered previous research.

Indeed, the assessments previously identified measure individuals’ subjective interpretation of the questions posed and can lead to informal discussions about the impact of spirituality. Researchers need scientific tools, however, that are reliable and valid, to measure spirituality. One of these tools is the Spiritual Transcendence Scale (STS). The STS is an empirical measure that encompasses an individual’s belief in the unity and purpose of life, a sense of connection to others, and the extent of emotional support one experiences as a result of spiritual practices such as personal prayer and meditation (Burris et al., 2011). In the Burris et al. study, a shortened version of STS was used to measure participants’ spiritual transcendence. Participants in the study responded to items such as, “In the quiet of my prayers and/or meditations, I find a sense of wholeness” and “I feel that on a higher level all of us share a common bond,” using a Likert scale (1 = strongly disagree to 5 = strongly agree). A total score
was calculated by adding all nine items, with higher scores indicating a greater spiritual transcendence (Burris et al., 2011).

Interestingly, from an empirical standpoint, Burris et al. (2011) contest that research needs to involve simultaneous measurements of both religiousness and spirituality. They assert that it is necessary to measure both constructs at the same time in order to identify behavioral correlates of religiousness distinct from spirituality. Otherwise, researchers will mistakenly assume religion and spirituality operate the same way. Of further concern with the current assessment tools is the limited applicability to adolescent populations.

**Limitations in Using Assessment Scales with Adolescents**

According to Cotton, McGrady, and Rosenthal (2010), the religious and spirituality measurement tools being used by researchers may not be relevant for adolescents. Their analysis of scholarly articles reviewed and evaluated trends in measuring religiosity and spirituality in adolescent health outcomes research. Of the 100 articles that met the criteria for their inclusion, Cotton et al. (2010) found that researchers used a wide variety of tools to assess religiosity and spirituality. Moreover, many of the studies used adult-developed measures not developmentally relevant for adolescents; few studies addressed the developmental changes (cognitive, social, and emotional) that adolescents undergo. Furthermore, few studies reported factor analyses aimed at understanding the underlying theoretical constructs of religious and spiritual measurement specifically in adolescents. Additionally, in two-thirds of the studies, Cotton et al. (2010) concluded that researchers often made up their own religious and spiritual measures with little theoretical background or psychometric testing. It was suggested, therefore, that measurement tools be improved to get at the “why” of the relationship which can
then lead to developing more precise interventions and programs that include religiosity and spirituality factors aimed at improving adolescent health outcomes (Cotton et al., 2010).

In a partial response, Miller, Shepperd, and McCullough (2013) developed a new scale, the Religious Commitment Inventory for Adolescents (RCI-A), to assess religious behavior and sentiments in adolescents. The RCI-A was a modification of an existing measurement of religious commitment among adults, the Religious Commitment Inventory (RCI-10), and incorporated 18 of the 105 items on religious coping from the RCOPE scale. Miller et al. (2013) hypothesized higher RCI-A scores would correspond to less risky behaviors, i.e., less alcohol, tobacco, and marijuana use. According to Miller and colleagues (2013), the RCI-A was found to have strong internal consistency, test-retest reliability, and construct validity. Although the RCI-A is appropriate for use with adolescents from a variety of religious faiths, it still does not address spirituality as a separate construct from religiousness.

Is Spirituality A Protective Factor?

In their study, Hodge et al. (2007) used cluster analysis to examine the protective influence of various spiritual-religious lifestyle profiles on smoking and alcohol use. The study measured spirituality using the Index of Core Spiritual Experiences (INSPIRIT) scale developed by Kass, Friedman, Leserman, Zuttermeister, and Benson (in Hodge et al., 2007). Although the study’s sample did not include adolescents, the study is useful for several reasons. First, it is one of the earliest studies to explore the protective influence of lifestyle profiles on self-reported alcohol and tobacco use. Second, the sample was mostly Hispanic (61%), which is both an understudied and growing minority in the United States (Hodge et al., 2007). Third, the results strongly suggest that spirituality and religion are distinct but overlapping constructs.
Cluster analysis is a set of classification procedures that are used to arrange individuals into groups based on their similarities and differences on a set of selected variables. In the Hodge et al. (2007) study, it was religion and spirituality. The Hodge et al. (2007) study controlled for confounding variables, namely income and education, using analysis of covariance, because earlier research suggested their presence clouded the results.

In Cluster 1, respondents were neither spiritual nor religious. In Cluster 2, respondents were spiritual and religious, and in Cluster 3, respondents were spiritual but not religious. Respondents in Cluster 1 scored significantly lower on the spirituality lifestyle profile than respondents in the other two clusters, and scored the lowest absolute religious activity score. Respondents in Clusters 1 and 3 rarely participated in religious activities. Respondents in Cluster 2 fit the lifestyle profile for spiritual and religious; they scored significantly higher spirituality values than respondents in Cluster 1 but not as high as respondents in Cluster 3, although Cluster 2’s spirituality scores were much closer to Cluster 3 than 1. Also, Cluster 2 respondents scored higher religious activity scores than either Cluster 1 or 3. In behavioral terms, Cluster 2 respondents participated in religious activities at least once a week. Cluster 3 respondents fit the spiritual but not the religious lifestyle profile. In behavioral terms, Cluster 3 respondents rarely participated in religious activities (Hodge et al., 2007).

In the Hodge et al. (2007) study, significant differences emerged among clusters for alcohol and tobacco use: Cluster 2 recorded significantly lower levels of tobacco smoking than either Cluster 1 or 3; there were no statistically significant differences between Cluster 1 and 3 for tobacco use; and Cluster 3 recorded significantly higher levels of alcohol use than Cluster 1 or 2.
This last finding is particularly noteworthy because it contradicts generally assumed inferences, namely that spirituality is a protective factor. The authors suggest one reason for this may be that “whereas religion may inhibit substance use by instilling moral values that discourage use, individuals who are spiritual but not religious are not tethered to a particular religion and therefore may not be operating under the same anti-substance norms” (Hodge et al. 2007, p. 217). Additionally, Hodge et al. (2007) reported that other studies have inferred a relationship between spirituality and higher self-esteem in individuals and suggested a potential tendency to minimize the harmful consequences of substance use may actually foster substance use. While this study contraindicates the hypothesis that spirituality is a protective factor, additional studies using cluster analysis with adolescents should be examined.

Burris et al. (2011) also examined spirituality as a protective factor and were able to do so with an adolescent sample. They also found mixed results. Like the Hodge et al. (2007) study, Burris and colleagues clustered participants into three groups; those who identified as religious and spiritual, neither religious nor spiritual, and spiritual but not religious. Interestingly, Burris et al. (2011) purposely measured religion and spirituality simultaneously as separate constructs, stating that this was essential so as to identify the behavioral correlates of spirituality separate from religiousness. To measure only spirituality, Burris and colleagues believed, would mistakenly lead them to assume it operates the same way as religion, i.e. that it would be a protective factor.

The Burris et al. (2011) study used the Religious Involvement Scale (RIS-10) and the Spiritual Transcendence Scale (STS) to measure the two constructs separately and statistically controlled for overlap between them. Results of the analysis showed that both religious commitment and spiritual transcendence contributed significantly to the prediction of underage
alcohol use. Moreover, religious commitment emerged as a protective factor against underage drinking, while spiritual transcendence was a risk factor. By way of explanation, Burris et al. (2011) pointed to the two different ways of searching for the sacred.

Because of its organized, structured, and extrinsic characteristics, religion is a model of social control for religiously-committed adolescents (Burris et al., 2011). It is not surprising to this author that adolescents with high religious commitment and high spiritual transcendence are at less risk of underage drinking; the religious is intertwined with the spiritual, thus making spirituality a protective factor and enhancing its effect. On the other hand, Burris et al. (2011) state that in the absence of any religious commitment an adolescent may embrace alcohol, tobacco, and other substances as a means of finding meaning, purpose, or connectedness to self and others.

A further study (Hodge et al., 2001), explores the relationship between substance use and spirituality and religious participation in a multicultural sample of rural adolescents by using logistic regression to determine the effectiveness of spirituality and religious participation as predictors of never using alcohol, marijuana, and other psychoactive substances. The study found that increased participation in religious activities predicted a greater probability of never using alcohol, but did not predict a greater probability of not using marijuana or other drugs. More importantly, increased spirituality predicted greater probability of never using marijuana and other drugs, but it did not do so for alcohol.

The Hodge et al. (2001) study is noteworthy for several reasons. First, previous research used samples of White or African American youths in urban settings and no prior study explored the relationship between spirituality and substance use in a rural sample of mostly Hispanic (84%) and Native Americans (6%). Moreover, Hodge et al. (2001) assert that Hispanics have a
higher school drop-out rate, which makes their findings important for future prevention efforts for this growing minority.

Second, contrary to the expectations of Hodge et al. (2001), increased religious participation did not predict a greater probability of not using marijuana or other drugs for this sample and increased spirituality did not predict a greater probability of not using alcohol. Third, Hodge et al. (2001) involved local Hispanic adolescents in the development of the assessment tool to ensure it was appropriate to the sample population. On the whole, this seems rational, as the youths would have some investment. However, Koenig et al. (2001) cautions against this practice: “This strategy may unfortunately result in ‘a mixture of apples and oranges,’ as different definitions of spirituality are used and rated by participants” (p.509). Koenig et al. (2001) suggest it is better for researchers to define up front what is meant by spirituality and then ask questions that capture that concept. Although Koenig et al. later concluded that even this approach is problematic as there are so many definitions of spirituality.

Like the study by Hodge, Andereck, and Montoya (2007), the study by Hodge, Cardenas, and Montoya (2001) pointed out that most of the research on substance use among adolescents used measures of religiosity rather than spirituality, which are two distinct, but overlapping constructs that should be examined separately. Moreover, the authors assert that while religiosity and spirituality may individually provide a protective factor to an adolescent, they do so in distinctly different ways. Participation in religious activities may lead to positive peer groups in which shared attitudes, beliefs, and values discourage the use of substances (Kutter & McDermott as cited in Hodge et al., 2001). On the other hand, spirituality, the authors suggest, counteracts derogation, i.e., self-rejection, by fostering a positive self-image and providing personal norms that inhibit the use of substances (Hodge et al., 2001). According to Hodge et al.
(2001), derogation as a framework emphasizes low self-esteem rather than environmental factors as the primary causal factor underlying substance use. These feelings may be particularly relevant to Native Americans and Hispanic adolescents who have been historically oppressed and reduced to minority status (Hodge et al., 2001; Sue & Sue, 2012).

Another interesting finding to emerge from the literature review is that one does not have to be religious in order to be spiritual. This is supported by Francis (1997), who concluded from a study of more than eleven thousand 13-15 year olds that although religiosity is a significant predictor of a negative attitude towards substance use, “it is a personal belief in God rather than public practice which is most important” (p. 101). This was also supported by the results of a longitudinal study conducted by UCLA’s Higher Education Research Institute to assess the spirituality of college students during their undergraduate years (Pew Forum, 2008b). The study found that while attendance at religious services decreases dramatically for most students between their freshman and junior years, the students’ overall level of spirituality increased. The UCLA study hypothesized that spiritual people tend to be religious and vice versa and if one declines, the other will, too, but that did not happen. The study found that although religion and spirituality are related, they are not the same. There are students who are highly spiritual but not necessarily religious (Pew Forum, 2008b).

**Spirituality: A Risk Factor**

Despite the literature suggesting that spirituality may be a protective factor against substance use for adolescents, other studies suggest that it is not. Moreover, some research suggests spirituality has the opposite effect; that it may enhance an adolescent’s desire to use substances. In this regard spirituality can be viewed as a risk factor for adolescents. Hodge et
al. (2007) found that adults who are spiritual but not religious report more alcohol use and
tobacco smoking than adults who are both spiritual and religious.

Meanwhile, Burris et al. (2011) concluded that spiritual transcendence may have a
contradictory relationship to religiousness as it relates to underage alcohol use:

In the absence of a religious commitment, an individual may actually sanctify alcohol
use, tobacco use, hallucinogen use, (etc.) and use these behaviors to discover meaning,
purpose, and connectedness with the self, others, or the transcendent, which is the
essence of spirituality (Burris et al., p. 237).

Although religiousness and spirituality both emphasize the search for the sacred, Burris et
al. (2011) hypothesized that the contradictory relationships to substance use could be explained
by important differences in how, and to what extent, religiousness and spirituality direct that
search. For example, organized religion with its standards and directives operates as a social
control for adolescents with a high level of religious commitment and may act as a restraining
agent on their behavior. On the other hand, spirituality leads to a more subjective evaluation of
values, beliefs, and behavior. Miller (1998) concurs, citing the existence of diverse opinions as
to whether the altered states induced by psychoactive substances invoke, threaten, or are
irrelevant to personal spirituality. The evidence for spirituality as a risk or a protective factor is
unclear. Additional research is needed to examine the relationship between spirituality and
substance use in diverse groups of adolescents.

**Diverse Groups**

The Native American population stands out as one group in which it is unclear if
spirituality is a protective or a risk factor. Native Americans are strongly identified with
spirituality (ReadytoTest.com, 2012; Sue & Sue, 2013). In fact, Limb and Hodge (2011) asserted
that when working with Native Americans in therapeutic settings, to focus solely on biological, physical, or emotional problems while ignoring their spirituality can actually cause them harm.

One of the challenges, however, when looking at spirituality as a risk or a protective factor for this population is that, according to Miller (1998), Native Americans often use hallucinogenic and other psychoactive substances (e.g. peyote, alcohol, tobacco and hashish) as vehicles for spiritual transcendence although spiritual practices are not necessarily linked to addiction. It has been reported that Native Americans begin using substances at higher rates and at a younger age than any other ethnic group (ReadytoTest.com, 2012). In the United States, among all youth ages 12-17, the rate of use is highest among Native Americans.

Additionally, alcoholism, often intergenerational, is a serious problem among Native Americans. More than 75% of Native-American admissions to substance abuse treatment centers are due to alcohol. Furthermore, among the Native-American population, more than 50% have a DSM-TR-IV diagnosable disorder of substance dependence (ReadytoTest.com, 2012).

Another group for whom religion and spirituality may not be a protective factor is lesbian, gay, bisexual, and transgender youths. Rostosky, Danner and Riggle (2007) found few studies examining sexual identity as it relates to religiosity and spirituality in adolescents. Using data from Waves 1 and 3 of the National Longitudinal Study of Adolescent Health, Rostosky et al. (2007) hypothesized that religiosity and spirituality would protect heterosexual adolescents against binge drinking, marijuana use, and cigarette smoking, but not those who identify as sexual minorities. They concluded from their study that religiosity had no significant effect on past-year substance use, measured six years later in sexual minority young adults. By contrast, Rostosky and colleagues found that for heterosexual older adolescents, each unit increase in religiosity reduced the odds of binge drinking by 9%, marijuana use by 20%, and cigarette
smoking by 13%. Rostosky et al. (2007) caution, however, against over-generalizing the findings about the protective effects of religiosity. They claim that future studies on the protective factors of religiosity look at sexual identity and use wider multidimensional measures of both religiosity and spirituality.

Yet another group for whom this writer suggests a closer examination of the effects of spirituality and substance use is Catholic adolescents. In a 2008 review of 115 scientific articles on religion and spirituality as it pertains to adolescent substance use, the study’s authors (Dew et al., 2008) found Catholic church membership was associated with greater alcohol use in adolescents (Amey, Albrecht, & Miller, 1996; Amoateng & Barhr, 1986; Heath, Madden, Grant, McLaughlin, Todorov, & Bucholz, 1999; Perkins, 1987 as cited in Dew et al., 2008).

While it would seem spirituality may be a protective factor for some adolescents, it appears it could be more of a risk factor for other groups of adolescents. The research is unclear. Given that substance use can lead to dependence, it is possible the cultural practices, including spirituality, of some groups is more of a risk factor than a protective factor. Future research studies are needed to assess the impact of spirituality on more cultural, religious and ethnic subgroups of adolescents.

**Spirituality: An Evidence Based Practice**

Among the studies conducted by GWISH (2014), 94% of patients admitted to hospitals believe that spiritual health is as important as physical health and 77% believe physicians should consider their patients’ spiritual needs as part of their medical care. According to GWISH (2014), polls in the U.S. show that 95% of Americans believe in God. And yet, 80% of patients reported that physicians never or rarely discuss spiritual or religious issues with them. Studies show that those who experienced increased spirituality had better medical outcomes and 75% of
studies show a positive association of spirituality and coping with an illness, including prevention of illnesses such as depression, substance abuse, physical illness, and mortality (GWISH, 2014). According to GWISH (2014), spirituality should be considered a patient vital sign.

According to Medved (personal communication, October 27, 2014), more than 75% of U.S. medical schools have incorporated spirituality topics into their curricula, while only three medical schools offered similar courses in 1993. A movement is afoot that focuses on spirituality in health, with the overall objective of integrating spirituality topics into medical schools’ curricula and developing spirituality-based competencies. This movement has led to the coordinated research efforts from the international community of medical, religious, and spiritual leaders.

Spiritual care has long been an accepted practice in palliative care for individuals suffering from life-threatening illnesses and its practitioners have been encouraged to adopt an evidence based orientation (Kalish, 2012). But the acceptance of spirituality as an evidence based practice in other areas of healthcare is still in its infancy. According to Kalish (2012), more research is needed to provide an evidence base to the practice of spirituality, or spiritual care.

The increasing significance of spirituality and religion in the United States has not been lost on the psychological field. According to DeAngelis (2008), American Psychological Association’s Division 36, Psychology of Religion, “brings spirituality into research and practice” (p. 60). The American Psychological Association’s new attitude mirrors the views of American society and confirms that religion and spirituality are integral aspects of Americans’ lives:
Div. 36 promotes research on religion and spirituality; encourages using such research in clinical and other applied settings; and fosters dialogue between research and practice on the one hand and between religious perspectives and institutions on the other. The division is nonsectarian and welcomes the participation of all those who view religion as a key part of human functioning (DeAngelis, 2008, p. 60).

Unquestionably, owing to an increasing number of empirical studies linking religion and spirituality to positive health outcomes, modern medical science and psychology are interested in learning more about the impact of religion and spirituality (McMinn, Hathaway, Woods, & Snow, 2009). Religious and spiritual values are now recognized as “a form of human diversity” (McMinn et al., 2009, p. 3). As evidence of greater interest in religion and spirituality topics in the psychology field, the American Psychological Association began publishing *Psychology of Religion and Spirituality*, the first professional journal devoted exclusively to religious and spiritual issues in psychology (McMinn et al., 2009). The new journal solicits submissions pertaining to:

a) spirituality scale development,  b) developmental processes of spiritual maturation,  c) spiritual and religious coping,  d) spiritual and religious interventions,  e) ethical use of religious constructs in psychotherapy,  
f) development of professional competencies in religious and spiritual issues,  
g) meta-analyses of religious and spiritual constructs,  h) the causal nature of spiritual and religious constructs,  i) neuropsychological bases of spirituality, and  
j) interfaith comparisons of health and social functioning (McMinn et al., 2009, p. 4).
Given the pressure for more research on spirituality and its relationship with mental and physical health, there remains an urgent need for a universally recognized definition of spirituality. That definition is not yet in place. Additionally, while there are many scales or assessment tools in existence, these tools need refining if they are to be used with individuals across a multitude of cultural, economic, ethnic, religious, and social groups that form modern America. Moreover, the tools must be developmentally appropriate for use with adolescents. Many positive strides toward this endeavor have been taken. Collectively, these developments demonstrate that spirituality has a foothold in the medical and psychological fields and is emerging as a credible evidence based practice.

An Adlerian Perspective

In recent years, there has been a greater interest in understanding the interrelatedness of biophysical factors, including spirituality as a protective factor in preventing adolescent substance abuse. Alfred Adler, a medical doctor turned psychotherapist, saw the interconnectedness of the mind, body, and spirit and incorporated it into a psychological theory called Individual Psychology. Individual Psychology is a comprehensive theory in which Adlerians view every person holistically. Individuals are not just the sum of their parts; they are the sum of their feelings, beliefs and behaviors as guided by the individual’s unconscious and subjective truth (Oberst & Stewart, 2003). Adler believed every individual develops core beliefs in childhood which may or may not be accurate, and it is these mistaken beliefs, which trip individuals and cause problems in their life.

Individual Psychology is based on the theory that human behavior is goal oriented and socially embedded. Adler believed we find our place in a world of others and that we must be understood in that same context (Carlson, Watts, & Maniaci, 2006). This feeling of belonging
and contributing to the welfare of others was identified by Adler as *Gemeinschaftsgefühl*, or Social Interest, and is a key component of Adlerian psychology (Ansbacher & Ansbacher, 1956).

Adler viewed *social interest* as the barometer of a child’s normality. As long as the child’s feelings of inferiority are not too great, they will strive to be worthwhile and on the useful side of life, pursuing their interests as well as being interested in others (Ansbacher & Ansbacher, 1956). Adler believed the higher an individual’s social interest, the greater their mental health. According to Adler, “It is almost impossible to exaggerate the value of an increase in social feeling….The feeling of worth and value is heightened, giving courage and an optimistic view” (Ansbacher & Ansbacher, 1956, p. 155).

Adler’s Individual Psychology is a positive and encouraging psychology; one which focuses on an individual’s strengths, assets, and resources, not their limitations. Individuals are not only the product of their circumstances, but are the creators of their circumstances (Oberst & Stewart, 2003). Stressing the importance of encouragement, Adler stated, “Altogether, in every step…we must not deviate from the path of encouragement” (Carlson & Maniacci, 2012, p. 44).

Inferiority feelings arise when a child feels discouraged (Oberst & Stewart, 2003). It was Adler’s opinion; children who are pampered fail to develop courage (Carlson & Maniacci, 2012). This can be seen today in families where helicopter parents are quick to intervene on behalf of their children, robbing the adolescent of an opportunity to solve problems for themselves.

Without these normal developmental milestones, adolescents cannot acquire self-esteem and self-confidence; they begin to feel inadequate (Carlson & Maniacci, 2012). Feelings of inadequacy hold a child back. This safe-guarding mechanism keeps children from trying and prevents them from forward movement. The child does not want to risk failing, so they do not try, or easily give up. The child’s teleology – the fictional goal that organizes their behavior – is
faulty, and needs readjusting. Their private logic, the hidden or unconscious reasons for their feeling, thinking and behaving supports their negative self-perception and perceived inferiority (Mosak & Maniacci, 1999).

Children who are at greatest risk for substance use and other delinquent behaviors are children who lack courage. When children no longer feel secure, reassured, or equal they become discouraged. Furthermore, they see the world around them as hostile and unfair; they lack social interest, and subsequently develop maladaptive methods for coping with difficulties in life (Ansbacher & Ansbacher, 1956). The absence of community feeling leads to neurotic and psychotic illnesses and dooms a child to a life of poor relationships in school, with peers, and at home (Carlson & Maniacci, 2012).

Adolescents who become discouraged in one or more of their life tasks because of dysfunction in their home life, a sense of not belonging to a peer group, or failure in school, for example, come to possess a mistaken style of life and are vulnerable to substance use and other negative behaviors. It was Adler’s view that favorable external circumstances would be enough to protect an adolescent in average circumstances but if a child were severely tested, these same circumstances may not be enough (Ansbacher & Ansbacher, 1956). Adler said the cure of the individual’s maladjustments is “wholly dependent upon increasing the degree of social feeling and cooperation” (Carlson & Maniacci, 2012, p. 17).

Furthermore, Adler insisted that cooperation must be developed and fostered in children. Walton (in Carlson & Maniacci, 2012) concurs, stating that today, there is a tremendous opportunity to teach children as young as preschool to care about their fellow human beings. There is no better opportunity to work at increasing the degree of social feeling and cooperation
and to practice socially interested behavior for which Adler has called (Carlson & Maniacci, 2012).

**Implications**

It is this writer’s opinion; spirituality – a feeling of meaning and purpose - increases social interest and decreases feelings of inferiority and a striving for superiority. Children with positive self-worth will possess more self-confidence and self-control and will act in a more prosocial manner. Studies show that adolescents who identify being religious and/or spiritual are more compassionate, demonstrate caring, and participate in volunteer activities (King, Ramos, & Clardy, 2013).

Families have been shown to be an important influence on adolescent involvement in problem behavior (Dew et al., 2008; Mills & Bogenschneider, 2001). As children age and develop, however, they are increasingly exposed to more settings and influences outside the home: school, peers, community, and youth roles. Greater exposure provides both positive and negative opportunities. Afterall, according to Mills and Bogenschneider (2001), adolescent behavior depends, in part, on individual values and choices.

Families, schools, and communities can take steps to foster spirituality in children. Indeed, a study by Black, Tobler, and Sciacca (1998), demonstrated that interactive prevention programs using peers helping peers are effective at reducing drunkenness, cigarette smoking, and cannabis use. Moreover, these peer-led programs were statistically superior to teacher-led and control groups, as well as to DARE programs.

Additional research conducted by Mills and Bogenschneider (2001) support multidimensional prevention programs that reduce risks associated with known increased adolescent substance use and bolster protective processes that are proven safeguards. Their
findings suggest the more extensive community support for youth, the better (Mills & Bogenschneider, 2001). While the study did not specifically identify spirituality as a risk protective factor, it did so indirectly when identifying churches as a place of opportunity for community service among youth. Engaging youth in service work empowers them and gives them control over their lives, which in turn increases social interest and decreases antisocial behavior. Austin (in Pew Research, 2008b) concurs. Writing on how to encourage spirituality in college students, Austin cites service learning as the most obvious practice that could be expanded and applied to younger adolescents as well.

To be sure, this writer is aware of programs in her county that match older adolescents in middle and high school with those in elementary grades to assist them with reading and math, for example. This type of activity is an inexpensive strategy to bolster adolescent self-esteem and foster social interest, which Adler would say results in less maladaptive behavior, such as the use of substances. Finally, West and Bubenzer (in Carlson & Maniacci, 2012, p. 21-22) write:

Historically, research has been interested in understanding conditions from which problems arise. We may, however, be better served by investing in the study of the spirit of commitment that supports the advancement and well-being of others. For, as human beings, we are not independent of one another, but, rather, we are interdependent creatures who benefit from an ecological perspective indicating that we will only survive and flourish in light of a demonstrated concern for each other. Indeed, meaning and pleasure in life are not derived from inwardly focusing on (oneself)...but in transcending the focus on oneself through concern and commitment to others.
Personal Reflection

At the outset of this literature review, it was the writer’s opinion that spirituality serves in some degree as a protective factor against adolescent substance use. Moreover, this writer believed that spirituality, while not the quintessentially perfect protective factor, would be enhanced by the addition of other protective factors. This writer was surprised, therefore, by those studies which concluded there is little if any correlation between spirituality and resistance to substance use; spirituality is not a protective factor, or at least not protective against certain substances. Moreover, this writer was surprised to find in some studies, spirituality was associated with increased substance use, and may therefore be a risk factor.

Additionally, it is this writer’s belief, spirituality is a construct so personal and sacred it defies exact definition and precise measurement which clouds the studies. Unlike religion, which more easily lends itself to being defined and measured, it may be necessary to agree; spirituality is too complex to define. Spirituality is a personal relationship with a higher power that transcends space, time, and measurement. Therefore, the definition of the spiritual is as unique as every individual. While this writer recognizes the scientific field’s desire for empirical research – that which is measurable, valid and replicable – it is this writer’s opinion there are some aspects of life that cannot be quantified or controlled and all of man’s efforts to do so are futile. In the end, everyone – including scientific researchers – may have to accept, that which is spiritual is immeasurable, and therefore, unexplainable.

Conclusion

Research indicates that adolescents who begin drinking before age 14 are at greater risk of developing life time dependency than youth who delay drinking until 21 years of age. In addition, youth who use alcohol and drugs are more likely to experience negative consequences
in their lives which impact all of society. Therefore, it is crucial that we work to delay the age of first use of alcohol and drugs. Much of the scientific literature looks at adolescent risk factors and risk protective factors in discussing prevention strategies.

While spirituality is not a completely new field of study in psychology, recent focus on spirituality as a protective factor before addiction begins in adolescence has emerged as a significant area of interest to researchers, educators, community leaders, social services, and the juvenile justice system. It has been shown that spirituality may serve as a protective factor for some groups of adolescents. It has also been suggested that spirituality may not be a protective factor, but may be a risk factor for substance abuse. Due to the lack of agreement in defining spirituality and the complexity of measuring it, the exact nature of how it works is unclear. More research is needed in this area.

Furthermore, research with specific adolescent populations is needed so that substance use prevention efforts can be developed and implemented. A limited number of studies have been conducted with Native American, lesbian, gay, bisexual, and transgender youths, and Catholic adolescents, for example, but the effects of spirituality are unclear. What is clear from this writer’s research is that whether spirituality is a risk protective factor for adolescent substance use depends upon a number of factors and is as unique as every individual. Although spirituality has not previously been regarded as part of traditional adolescent preventative health care, the danger of ignoring the potential of this relationship is too high. Moreover, as Cotton, McGrady, and Rosenthal (2010) suggest, it may be time for the psychology field to cooperate with churches and other religious organizations to develop prevention programs to protect adolescents from substance abuse.
It would be naïve to conceive of a singular protective factor as all inclusive or that spirituality is the quintessential protective factor. More likely, protective factors work best when there are multiple factors so that when an adolescent encounters challenges in any one area that individual can fall back on other protective factors to safeguard them from the challenge or risk at hand. A single protective factor may work better or more directly than another protective factor, but it is the multiplicity and interrelatedness of them that protects the individual adolescent. The more layering of risk protective factors, the stronger the adolescent’s motivation to say “no” to alcohol and drugs.

It is hoped the ideas discussed here will continue to generate worthwhile debate and promote additional research on the subject of spirituality as a protective factor in the prevention of adolescent substance use.
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Appendix: Spiritual Assessment Scales

The following describes some well known spiritual assessment scales FICA, HOPE, SPIRIT, FACT, and Spiritual Well-Being, although it should be noted that none of these were designed specifically for use with adolescents. Additional measurements of spirituality may be found in Koenig et al. (2001, p. 503-507). However, once again, none of the scales described in Koenig were designed for use with adolescents. In a partial response, Miller, Shepperd, and McCullough (2013) developed a new scale, the Religious Commitment Inventory for Adolescents (RCI-A) which was discussed in a previous section of this paper.

FICA (Puchalski and Romer, 1996).

The acronym FICA helps practitioners structure questions when taking a spiritual history:

F—Faith and Belief

“Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress? IF the patient responds “No,” the physician might ask, “What gives your life meaning?” Sometimes patients respond with answers such as family, career, or nature.

I—Importance

“What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

C—Community

“Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?”

Communities such as churches, temples, and mosques, or a group of like-minded
friends can serve as strong support systems for some patients.

A—Address in Care

“How would you like me, your healthcare provider, to address these issues in your healthcare?”

HOPE (Anandarajah and Hight, 2001)

The HOPE questions provide another formal tool for a spiritual assessment in a medical interview. The HOPE concepts for discussion are: H—sources of hope, strength, comfort, meaning, peace, love and connection; O—the role of organized religion for the patient; P—personal spirituality and practices; E—effects on medical care and end-of-life decisions.

SPIRIT (Maugens, 1996).

SPIRIT is an interviewing tool that provides a framework for promoting general and specific discussions about spirituality, while remaining respecting the patient’s interest and willingness:

Spiritual belief system: Do you have a formal religious affiliation? Name or describe. Do you have a spiritual life that is important to you? How do you explain the meaning of your life at this time?

Personal spirituality: Describe the beliefs and practices of your religion that you personally accept. Describe those beliefs and practices that you do not accept or follow. In what ways is your spirituality/religion meaningful for you? What is the importance of your spirituality/religion in daily life?

Integration with a spiritual community: Do you belong to any religious or spiritual groups or communities? How do you participate in this group/community? Do you have a role/position? Is this group meaningful and
important to you? How is this group a source of support for you? Does or could this group provide help for you in dealing with health issues?

**Ritualized practices and restrictions:** What specific practices do you carry out as part of your religious and spiritual life (e.g. prayer, meditation, service, etc.)? Are there any lifestyle activities or practices that your religion encourages, discourages, or forbids? What importance do these practices and restrictions have for you? To what extent have you followed these guidelines? Are there any certain elements of medical care that you forbid due to your religious/spiritual beliefs?

**Implications for medical care:** What aspects of your religion/spirituality would you like to keep in mind as I care for you? Is there anything you would like to discuss concerning religious or spiritual implications of health care? What knowledge or understanding would strengthen our relationship as physician and patient? Are there barriers to our relationship based upon religious or spiritual issues?

**Terminal events planning:** As we plan for your medical care near the end of life, in what ways will your faith impact your decisions? Are there particular aspects of medical care that you wish to forgo or have withheld because of your religion/spirituality?

**FACT (LaRocca-Pitts, 2007)**

None of the previously developed spiritual history assessment tools make an objective treatment option that includes referral. Most of the tools developed by physicians (e.g.,
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FICA, SPIRIT, FAITH, HOPE) include follow up only. FACT was developed by LaRocca-Pitts, a chaplain. The acronym stands for:

   F – Faith or Beliefs
   A – Availability, Accessibility, Applicability
   C – Coping or Comfort
   T – Treatment Plan

Specific questions to be asked to help discuss each element of the tool include:

F: What is your faith or belief? Do you consider yourself spiritual or religious?

What things do you believe that give your life meaning and purpose?

A: Is support for your faith available to you? Are you part of a religious or spiritual community? Do you have access to what you need to apply your faith (or your beliefs)? Is there a person or a group whose presence and support you value at a time like this?

C: How are you coping with your medical situation? Is your faith (your beliefs) helping you cope? How is your faith (your beliefs) providing comfort in light of your diagnosis?

T: Treatment Plan

1. Patient is coping well
   a. Support and encourage
   b. Reassess at a later date

2. Patient is coping poorly
   a. Depending on relationship and similarity in faith/beliefs, provide direct intervention: spiritual counseling, prayer, Sacred Scripture, etc.
b. Encourage patient to address these concerns with their own faith leader

c. Make a referral to the hospital chaplain (DO NOT ask if patient wants referral—let the chaplain do own assessment!)

*Spiritual Well-Being Scale: Mental and Physical Health Relationships* (Paloutzian, Bufford, & Wildman, 2012)

The Spiritual Well-Being Scale (SWB) is an outcome indicator of how well a person is doing in the face of whatever the person is confronting. SWB is not synonymous with spirituality, but is closely related to it. Similarly, SWB is not synonymous with mental health or physical health, but is likely to be related to both of them. SWB connotes one’s subjective perception of well-being in both the religious and/or existential dimensions in accordance with whatever is implicitly or explicitly conceived of as a spiritual for the individual. The Spiritual Well-Being Scale (SWBS) was developed in order to be a tool for self-assessment of these aspects of general perceived well-being.