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A Spirituality Discourse in Treating Substance Use Disorders with Marginalised Persons

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Abstract

A spirituality discourse in substance abuse treatment offers useful unconventional constructs in treatment services to ethnic minority groups with substance use disorder (SUDs). It is important to locate spirituality within culture, place, and history in order to understand the spiritual needs of persons from minority groups with SUDs. There are many studies that merit a spiritual approach in treatment for ethnic minority groups with SUDs. However, spirituality is a broad concept that means different things to different people. Therefore, such an unconventional approach should be approached critically and cautiously. This chapter looks at the utilisation of an integrated eclectic approach with a focus on inclusion of spirituality in treatment services from a biopsychosocial-spiritual perspective. Tapping into the spiritual needs and the meaning that people ascribe to spirituality and religion (S&R) in treatment services is often more valued than conventional secular treatment services. Also, the client's spirituality is generally overlooked by professionals offering such services simply because it is so controversial. This chapter proposes an integrated eclectic methodology calling for a biopsychosocial-spiritual perspective to address the needs and well-being of ethnic minority groups with SUDs as a comprehensive person-centred and holistic approach, utilising mindfulness techniques.

Keywords: biopsychosocial-spiritual perspective, integrated electric methodology, mindfulness, person-centred, spirituality discourse, spirituality and religion, substance use disorder

1. Introduction

Similar to international trends, substance abuse is a huge concern and growing phenomenon in South Africa. Similarly more and more persons seeking treatment for substance use disorders (SUDs) present with dual diagnoses of which mental health problems are significantly high [1]. Treatment for SUDs thus has become more complex in that diagnoses and expectations of clients are multifaceted [1, 2]. Equally complex is treating clients with SUDs while paying due diligence to their ethnic, cultural and religious orientation. This chapter presents examples from a research study conducted in South Africa that supports the urgency for an integrated approach that incorporates spirituality in treating coloured persons with SUDs. It needs to point out that coloured people are not part of a minority group as described in conventional terms. However, they are marginalised and at a disadvantage in terms of their low socioeconomic status largely due to the remnants of

apartheid,[1] laws in which the wealth and resources of the country were qualitatively and quantitatively unequally distributed to benefit a minority group in the country at the time [5]. The narratives that will be shared in this chapter are that of persons whose families were forcefully removed from urbanised towns to the outskirts of these towns to areas known as townships in terms of the then South African Group Areas Act of 1950 [3, 4]. While these township communities were characterised by social cohesion and a spirit of Ubuntu[2] [6], often still prevalent today, there were high crime rates and excessive use of alcohol and other drugs (AOD).

Today, 25 years after apartheid has been abolished in South Africa, townships continue to be plagued by poverty, unemployment and a high prevalence of SUDs [4, 7, 8]. As such treatment services offered by community-based non-profit organisations (NPOs) to coloured persons with SUDs are complex firstly, because people have deep psychosocial problems (such as previous disadvantage and high prevalence of poverty), and secondly, these township communities lack resources, such as clinics and hospitals that are overcrowded). Adding to these challenges is the fact that social workers rarely delve into the spiritual and religious (S&R) needs and well-being of clients leaving a gap in addressing the holistic needs of clients [8]. However, there is a growing body of literature that supports working with clients' spirituality, as an effective strategy in treating SUDs [8–13]. The literature also indicates an acknowledgement to facilitate ethnic minority groups' need for inclusion of their spirituality in treating SUDs [8, 14–16]. Such an approach calls for a broader perspective that pays equal attention to the biological, psychological, social and spiritual needs of people with SUDs. Furthermore one cannot look at such an integrated approach without considering mindfulness techniques which is an integral part of such spiritual conventions. It is against this backdrop that this chapter is presented.

2. An integrated eclectic approach for treating SUDs

There is no singular practice model in social work and/or SUD treatment that can be applied in all contexts. As such the intervention model that counsellors, such as social workers, select is unique to the setting and client often culminating in an eclectic approach [17]. Eclecticism is commonly used in social work and SUD treatment. It is the use of a wide range of theories and techniques regardless of its theoretical origins and orientation as long as the client, a group or a community's needs are met [18, 19]. In other words a social worker drawing on eclectic knowledge therefore uses a wide range of theories and techniques that are appropriate for a particular case. Similarly, an integrated approach is also the use of a combination of theories and techniques to address complex needs of individuals, groups and communities. The difference is that eclecticism does not necessarily result in the emergence of a new theory or model, while this is certainly the case with an integrated approach [18, 20].

There are approximately 400 new approaches that have evolved as a result of the integrationist movement, referred to as 'an ubiquitous process of conjunction that comes from relationship and conflict' [20]. Two perspectives that are important to understanding an integrated approach are chaos and complexity science and contiguous integration. Chaos and complexity science is driven by relational

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[1] Apartheid was institutionalised laws and policies by the National Party in South Africa in 1945 which instituted policy and legislation that separated people on the basis of skin colour during 1945–1994 [3, 4].
[2] Ubuntu is a Zulu word that refers to humanity of an individual and/or society and principles of respect for the worth, dignity and humanity of self and others [6].

dynamics and systems theory, while contiguous integration holds that a person is understood in relation to larger groups, organisations or society, a perspective based on a metasystem view of the integration phenomenon [20]. This phenomenon is similar to the concept of Ubuntu in South Africa that holds that a person's worth and dignity is engrained and embedded in relation to others; therefore the saying in Ubuntu: 'I am because you are' [6].

The term integrated approach seems to have replaced the term eclectic approach [18, 19]. However, the two should not be confused and used interchangeably because it means different things. While an eclectic approach is more focused on the techniques used, an integrated approach focused on the theories and techniques and the emergence of a new theory [18]. There is, however, 'no technical eclectic that can totally disregard theory and no theoretical integrationist can totally ignore technique' [18, 20]. For example, social workers often use a biopsychosocial approach to treating SUDs. When social workers are confronted by clients to integrate clients' S&R, social workers are required to explore clients' S&R. Hence a fourth dimension, namely, spirituality, is necessary in an existing model or approach such as in a biopsychosocial model. This would involve not only knowledge of diverse S&R but also interrogating one's own S&R as a therapist.

It is appropriate to link what has been said thus far to the integrated relational model which places emphasis on the relationship of the client/patient and counsellor/doctor. Clients' response to treatment is the best indicator of treatment outcomes. An empathic counsellor/doctor improves and enhances treatment outcomes [21] especially when a strengths-based and problem-solving approach is adopted [22]. The integrated relational approach combines and has several principles in common with patient-centred, person-centred and problem-solving approaches.

A patient-centred approach is a commonly used approach in health settings and takes into consideration the patient's choices and decisions for accepting or declining medical care or procedures [23, 24]. Often a patient's S&R determines and affects his/her choices and decisions for medical intervention. Patient-centredness is often used interchangeably with person-centredness; however, the two are different [24, 25]. Similar to the patient-centred approach, this approach places the focus of intervention on developing relationships and care plans based on the client's preference [24, 26, 27]. However, a person-centred approach goes further and takes into consideration the ethical and legal rights of clients as important factors when providing holistic service [27]. A person-centred approach is therefore more holistic than a patient-centred approach [28]. Adding to the two aforementioned approaches is the problem-solving approach which is a generalist approach in social work that consists of distinct steps for effective problem-solving ([27, 28] Mc **and** Mc 2015). In short, the steps that a social worker will follow are: (1) Determining the exact nature of the problem—If the problem seems too complex, break it up into smaller manageable parts that can be managed one at a time. (2) Finding as many solutions to the problem as possible—Ask for input from clients and colleagues. (3) Narrowing down solutions—Anticipate possible outcomes of each choice, both negative and positive, and list anticipated consequences. (4) Making decision—Mutually decide with the client on what do. (5) Implementing the plan—Be cognizant of the outcome and use the success and challenges to improve and reassess the intervention goals [17]. The three approaches share similar principles worth exploring when working with persons having SUDs.

The common principles in the three approaches are summed up in **Table 1** as follows:

Table 1 presents the principles embedded in patient-centred [24, 25], person-centred [27, 28] and problem-solving [17] approaches. For the purpose of this chapter and since references to persons with SUDs do not only refer to such persons in

Client	The 'expert' in his/her own life		Has the freedom to make his/her own choices	
Counsellor	• Respects the client's worldview • Regards clients as the 'expert' in their own lives	• Emphasises clients' strengths • Views client as capable and motivated to move to wellness	• Responsible to meet clients where they are at • Fosters a therapeutic relationship that would facilitate opportunity for clients to take the responsibility for change	• Gives clients the freedom to make their own choices • Works within clients' frame of reference
Professional relationship	Fundamental to the therapeutic progress	Cooperation rather than confrontation	Goals and expectations for treatment are clearly articulated	

Table 1.
Principles of patient-centred, person-centred and problem-solving approaches.

medical or health settings but also in community-based settings, I will use the terms client (as in service user) and worker (as in service provider) whether in health or community-based setting. The client-worker relationship forms the foundation of the treatment process [17, 24, 27, 28]. The responsibilities and commitment of the worker is the second layer in the treatment process because an emphatic worker encourages clients' motivation for change. The last layer is the clients' role and responsibility as the 'expert' in his/her own life. The principles are not static but interlinked and fluid. The similarities of the principles in these approaches compliment an integrated eclectic model. While the principles may not specifically address spirituality per say, the inference to respect for the client's worldview, beginning where the client is at, honing in on the client's strengths and working in the client's frame of reference could be linked to clients' S&R.

2.1 Biopsychosocial model for treating SUDs

Originally developed for the medical sciences, George Engel (1933–1999) first introduced the biopsychosocial model in the health sciences. Engel [23] laid the foundation for a biopsychosocial model in healthcare. He argued that there is a distinctive interaction between the biological, psychological and social needs of patients that determine the cause, effects and outcomes of disease and well-being [23].

The concept of biopsychosocial model is eloquently described by Borrell-Carrió et al. [29] who propose that the model is a philosophy of clinical care and a practical guide for health practitioners. These authors argue that the model is philosophical on the one hand because it is a means of understanding how multiple levels of organisation, from the societal to the molecular, affect disease, illness and suffering. They further contend that the biopsychosocial model is practical in that it is a way of understanding the pratient's subjective experience as an essential contributing factor to accurate diagnosis, health and humane care [29]. White, Williams and Greenberg [30] took this approach even further by introducing an ecological model of care that added the person in his/her environment context. White et al.'s model thus proposes that the biological, psychological and interpersonal relationships that surround a person require equal attention to achieve a state of health and well-being [30]. The two models, however, did not address the person's spirituality.

The addition of a spiritual dimension to define health was tabled at the 52nd Assembly of the World Health Organization (WHO). The 1948 WHO definition is 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. Thus the proposed definition would be: 'Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity'. Despite the latter being approved at the 1999, the 52nd WHO Assembly, it was not implemented [30]. Katerndahl [12] and Sulmasy, [31] while in favour of the spiritual dimension to the biopsychosocial model, however, warn that spirituality is a complex phenomenon and therefore should be approached critically when practitioners adopt a biopsychosocial-spiritual model in any context.

2.1.1 Biopsychosocial-spiritual model for treating SUDs

In the current milieu of treating ethnic minorities with SUDs, the reductionist scientific model is inadequate to meet the holistic needs of clients [32]. Therefore, a biopsychosocial-spiritual model for treating ethnic minorities with SUDs which utilises mindfulness techniques is proposed. Mindfulness approaches in treating persons with mental health and related conditions are rooted in Buddhist Vipassana meditation, which was introduced by Kabat-Zinn in 1979 [33]. Mindfulness approaches involves 'paying attention in a particular way; on purpose in the present moment' in a non-judgemental way [34, 35]. It involves being aware of and accepting of thoughts and acknowledging and accepting livid experiences, thoughts and feelings instead of modifying and/or suppressing such experiences, thoughts and feelings [35]. In other words clients are encouraged to practise 'reperceiving' (think of SUD, e.g. differently, as an issue externalised rather than internalised) and 'attentional control' (how to externalised SUD) which could facilitate a more mindful response to SUD [33]. So, mindfulness is the practice and process of beginning where the client is at, being cognizant of the 'here and now' and 'being in the present moment' [33–36]. Furthermore, focusing on the here and now could help the client to enhance and improve focus, have a greater awareness and gain perspective regarding the SUD and the adverse consequences associated with it. Using mindfulness techniques could assist the client in recognising risks associated with relapse and could thus assist in avoiding relapse [36]. Skills to facilitate mindfulness techniques can be taught to diverse people regardless of cultural S&R backgrounds and can be used in a variety of intervention approaches such as biopsychosocial-spiritual models [34, 35, 37].

While the need for a biopsychosocial-spiritual model utilising mindfulness techniques in SUDs has been well established [34–37], it is not clear how this new model can be integrated within the reductionist scientific conception of the client. Several empirical studies and systematic literature reviews [9, 20, 29, 31] are drawn on explaining how a biopsychosocial-spiritual model for treatment in SUDs is worth perusing as a feasible approach for working with ethnic minorities. But first it is imperative to explain the distinction between spirituality and religion.

2.1.1.1 Spirituality and religion

Spirituality and religion (S&R) is often used interchangeably as if it means the same thing. What is more, there is not a universal definition for either mainly because the two respective constructs are so diverse [8, 38–40]. S&R has to do with one's beliefs, emotional state of mind experiences and conduct associated with the search for the sacred [10, 39]. At the same time, it can be described as a worldview that places emphasis on the divine, a higher power or being whose followers promote

Spirituality	Religion
• A holistic approach	• An organised set of beliefs
• Captures diverse cultures and beliefs	• A system of beliefs and practices that is shared by a community of people
• Ascribe meaning, purpose and morality	
• Creates awareness of social obligations and relations with self, others, the universe and reality	• Comprises rules and rituals to be observed
	• Rituals offered and communicated to the divine, sacred, God
• Facilitates engagement with other dimensions of the universe such as divinity, with God and/or other beings	• Rules and rituals are institutionalised

Table 2.
Spirituality vs. religion.

spiritual and human well-being in which care and compassion for others take a centre stage as apposed to self-centred materialistic gains [13, 39, 41]. In this chapter, however, briefly, I differentiate between spirituality and religion (see **Table 2**).

In reference to **Table 2**, religion for most part is about a set of beliefs about the moral code governing human conduct, while spirituality is not constrained by theological barriers and/or any particular ideology [38]. Rather it is characterised as the quest to understand and find answers to definitive questions about life, about meaning and about relationship to the divine, sacred or God and may (or may not) emanate from or lead to the development of religious rituals and rules [39]. Spirituality is thus a more holistic and inclusive approach as apposed to religion. Spirituality is rooted in multiculturalism and is therefore diverse in terms of cultures and beliefs [38]. The search for meaning, purpose and morality and fulfilling relations with self, others, the universe and ultimately with reality are central to spirituality [40, 41]. Ubuntu shares similar principles. Spirituality (however a person understands it) has always been part of indigenous and culturally sensitive substance abuse counselling [29]; consider, for example, Alcoholics Anonymous (AA) programmes. I propose that the spiritual dimension (which includes religiosity) should be recognised and incorporated in treatment models regardless of the field of practice.

2.1.1.2 Understanding the spiritual needs of people with SUDs

> *"What treatment, by whom, is more effective for this individual with that specific problem and under which set of circumstances?"* [42]

Social workers treating ethnic minorities with SUDs are confronted with complex challenges experienced by clients. Never has Paul's [42] provocative question been more valid than in the current milieu of SUDs. Understanding the spiritual needs of persons with SUD is important if we are truly holistic in our approach to service delivery and should thus not be perceived as separate from attending to biopsychosocial needs. To holistically assess people with complex challenges associated with SUDs, knowledge about their spirituality is important [43–45] and can thus not be avoided, especially when client themselves raise the need to delve into their S&R.

Several qualitative studies [14, 38, 40, 43, 44, 46] that investigated religious coping and spirituality in relation to SUDs indicate that positive religious coping and dimensions of spirituality protect against SUDs. In a qualitative study [47] that focused on barriers and facilitators to successful transition from long-term residential substance abuse treatment, the researchers found that clients having faith in the

Divine as a facilitator for transitioning from in-patient treatment to reintegration back into the family and community played a pivotal role during the reintegration process. Various studies [8, 45–48] indicate the value of addressing S&R as a factor that enhances and aids treatment for SUDs. However, several studies with ethnic minorities [8, 46, 48, 49] have found that the S&R needs of clients are not generally addressed by counsellors (such as social workers), and instead this role is more likely to be facilitated by clergy and/or recovering addicts. This raises the question though: who should be facilitating this role if clients make explicit their need for S&R well-being? If such high value is placed on the S&R of clients, a counsellor will require some understanding of S&R albeit at a theoretical level in order to effectively provide treatment services. It stands to reason therefore that a biopsychosocial-spiritual approach requires the counsellor to reflect and interrogate his/her own S&R as well as his/her own ambivalence for not wanting to venture into clients' S&R.

3. A spiritual dimension in treating SUDs

Employing a spiritual dimension in treating SUDs is not a new phenomenon. The complexity of dual diagnoses and the multifaceted challenges associated with SUDs necessitated a need to intervene beyond the biological, psychological and social needs of clients with SUDs [1, 2, 8, 10, 15].

3.1 Spirituality and religious coping

South Africans are not averse to managing complex life challenges through prayer, meditation and rituals as coping measures. Such practices are often embedded in people's spirituality which is commonly rooted in their religion and/or culture [6, 9, 16]. The reflections shared next is that of participants in a recent qualitative research study conducted in the Western Cape of South Africa on the experiences of coloured adults seeking substance abuse services at non-profit organisations (NPOs) [8].

John[*3], 32, has been in and out of rehab since he was 14 years old. Most of the rehabs he has been to in the past were what he refers to as *secular* rehabs, meaning that it did not have a spiritual component in its treatment model. According to the facility manager, this is the longest that John has been sober and attributes this to the fact that John is in a faith-based rehab that employs a biopsychosocial-spiritual model. This is John's narrative of his experience of S&R coping:

> *I started using when I was very young, I must have been like fourteen years old. I went to an organisation that was an out-patient programme where they basically counseled me on a weekly basis. This time is different because there is a strong focus on the spiritual side of the addict. Because of my religious background I am more at home at this rehab and I know if I keep to the programme I will stay sober.*

John's situation is indeed complex as SUD cases generally are. Apart from the SUD, he experienced marital problems and homelessness, and his estranged wife refused to grant him visitations with their children. The complexity of SUDs often leaves people discouraged, and many, such as in the case of John, acknowledged drawing strength from God, a higher power, and being part of a religious group that meets on a weekly basis [49]. Like many people with SUDs, John felt that delving into S&R of clients provides a more holistic treatment approach than secular approaches that avoid S&R completely [49–52].

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[3] *Not the service users' real names

3.2 Spiritual mindfulness

While mindfulness theories originate from Buddhism, people of different religious affiliations have become more open to use these techniques because of its usefulness especially in treating SUDs. The use of meditation is a common practice in mindfulness techniques [34, 35, 37, 48]. A case example of a client with dual diagnoses explains the use of prayer as a form of mindfulness technique.

James*, 26, admits being addicted to drugs and sex. He says the sex craving started when he was rehabilitated and during his first treatment programme completion. He believed that when he gave up methamphetamine, the craving for smoking cigarettes started. While in the programme which was an in-patient treatment programme for adults with SUDs, James gave up cigarettes and methamphetamine. However, when he reintegrated back into his community, his cravings for sex started, something according to him that was never an issue in his life before being treated for SUDs. He related that he started smoking after having sex and then later reverted back to using methamphetamine to the point where he felt that he could not cope without using methamphetamine on a daily basis. He explained that he felt that his cravings for methamphetamine were worse than before because he failed God in falling back into drugs. He explains: 'The righteous will fall seven times...' which is a Bible first quoted from Proverbs 24:16–18. Making reference to the quoted scripture, he explained his relapse as follows:

> *...I didn't believe at first but I have experienced it firsthand. I was worse off in a space of a few months after beating my addiction to meth. ... I first started stealing. I sold my personal belongings. In a space of a few months I lost so much weight. I knew where it was going to end, because my mind was constantly on how to get my next fix. My family did not confront me, but they could clearly see that I was back on drugs again. I told my sister that the addiction was out of my control and that I wanted to go back to the rehab.*

James was reflecting and had a greater sense of spiritual mindfulness regarding the SUD and relapse because he described himself as follows:

> *I am a child of God, but I didn't work on all aspects of my life. I had to work on it [referring to his spiritual life]. So I did not equip myself adequately with the word [referring to the Bible] of God. So I am back [at the rehab] to work on a view aspects that I neglected before. So I can give people advice and can share the word of God to the people in my community. I can also refer them to a place for rehabilitation if they want help. But the best thing is to proclaim the Word of the Lord. You do not need a [rehabilitation] program. You can change your life just by adhering to the Word of God. It is easier said than done, but it can be done.*

James attributes his recovery to his spiritual awakening more than the intervention by social workers.

It is not uncommon that the need for close relationships with others and/or an encounter with a divine being or higher power is a motivating factor for maintained sobriety in people with SUDs [53]. Whatever the client's reason for wanting to maintain sobriety, the social worker should tap into the motivating factors and amplify it as strengths [54, 55]. Motivation is a state of readiness to change in which a predictable course is followed. This is where client-centred approaches such as motivational interviewing (MI) and motivational enhancement therapy (MET) are appropriate models because it is aimed at bringing about and enhancing change in the problem situation. These methods emphasise resolving clients' ambivalence [54, 55]. Honing

in on client's motivating factors such as restoring relationships with significant others is important in enhancing motivation and resolving ambivalence. When clients are treated as partners, they are more likely to respond to the counsellor.

MI and MET do not represent any particular theoretical perspective and are thus useful to contextualise in terms of an integrated eclectic approach. Furthermore MI and MET are brief treatment strategies that can be as short as four sessions but can be prolonged depending on the client's level of motivation [53–55]. Thus intervention is time limited and goal directed, when the client reaches a level of high motivation where he/she is able to take responsibility for his/her own recovery.

3.3 Spirituality as a component in treatment programmes

Many community-based organisations in South Africa offer a dual focus, meaning the treatment service includes both a secular social work intervention approach and a spiritual approach. However, the spiritual component is mostly offered by volunteers who are religious leaders in the communities where the organisations are situated. During the course of the day, most of the programmes make provision for meditation and prayer. So clients gather in groups in separate venues or those who preferred to meditate on their own would find a private space in the organisation to engage in prayer and meditation [8].

Strategies employed in self-help groups [56, 57] that focus on the cognitive, spiritual and behaviour changes of the persons with SUDs are more accessible because they are found across communities and are free of charge [52]. However, organisations should caution against whom and what such rituals entail so as not to exploit and/or impose religion or spirituality on clients. Therefore general training should be available for all people involved in substance abuse services including volunteers. It is imperative for such persons to have basic standards and knowledge for practice to avoid possible harm to clients. With the review and implementation of the current White Paper on Health (NHI) [58] and the norms and standards for social welfare services in South Africa, this type and methods of interventions are worth pursuing as services become more expensive and therefore inaccessible to the clients who come from disadvantaged communities, are unemployed and have low incomes.

3.4 Spirituality of the counsellor

Social worker rarely set out to gage clients about their spirituality. However, this topic more often than not emerges during interviews and thus requires social workers to be knowledgeable not necessarily on every spiritual and/or religious practice out there, but at least being able to engage client's expression of his/her S&R needs [59, 60]. This unconventional way of looking at treating SUDs is particularly important in the South African context, where spirituality is ingrained in the culture and value systems of many South Africans and more so in the light of current policy and legislation in South Africa calling for evidence-based, culturally sensitive and indigenous practice and research [8]. As counsellors treating ethnic minorities with SUDs, social workers are encouraged to interrogate their own spirituality, as clients more often than not express their own spiritual needs during treatment services [61, 62].

It is not uncommon that group work offered by NPOs is generally facilitated by laypersons such as spiritual counsellors [8, 63, 64]. In some instances these would be trained clergy [63]; however, in most cases these would be recovering addicts [8, 51, 57] who have had some 'supernatural' experience. This is similar to approaches used in self-help groups such as Alcoholics Anonymous. The focus

of such programmes is that most of the group work interventions are on spiritual growth and life skills [8, 65]. For example, in a study conducted by carelse [8] that focused on ethnic minority groups in treatment for methamphetamine, all the participants reported on the important role played by religious clergy and recovering addicts. This is what they had to say:

> *We have two spiritual counsellors …They focus more on the spiritual things like the Christian principles.*

> *And then we have a lot of ministers and pastors, and … priests, since the organisation is a faith-based organisation. We do spiritual growth which is run by pastors.*

These narratives concur with studies conducted [50, 57, 63] that focused on professionals and laypersons' contention with issues of power, oppression and privilege in service delivery. These authors conclude that there must be differentiating functions of professionals such as social workers and laypersons such as recovering addicts in the helping relationship. As a general rule, training should be available for all people involved in services to people with SUDs including volunteers, in particular training on how to engage the service user's spirituality [60, 61]. Therefore it is imperative for clergy and recovering addicts in treatment in SUDs to have basic standards and knowledge with regard to spiritual intervention to avoid possible harm to clients. More importantly service providers will have to interrogate their own spirituality (however they perceive it) in order to engage meaningfully with the spirituality of others.

3.5 Spirituality and maintained sobriety

In pursuing a state of equilibrium, clients feel that it was important for them to take the first step of the 12-step programme [57, 62] and admit that they were powerless over SUDs and that their lives had become unmanageable. In particular, clients in the 12-step programmes believed that a power greater than themselves could restore their emotional and spiritual well-being [62] where spirituality and a connection to a higher power are pivotal to their recovery process. These are some of their perspectives in this regard from a study on the coping resources of a minority group of adults in a low socioeconomic community on the outskirts of Cape Town, South Africa [8]:

> *It brought me closer to my higher father and relying on him and to acknowledge that he took me out of, how can I say, I was lost totally.*

> *I believe it's prayer that God is opening for me. And I never prayed when I was using … my mind was all over the place but now I pray with sincerity and without any mind-altering.*

The clients' livid experiences are confirmed in the study by Miller and Rollnick [55] that explored the role of spirituality in the intervention outcomes after a 12-step programme. As Miller and Rollnick [55] points out, clients experienced an increased spiritual awareness and growth after completing the treatment programme. The findings also suggest that spirituality may have a positive effect on maintained sobriety if the person continues to engage in mindfulness strategies. In a study by Amaro and Black on the role of spirituality in helping Black women with histories of trauma and substance abuse, healing and recovery of participants also expressed more hope and motivation to maintain their sobriety because of their spiritual awareness and growth after their involvement in a programme incorporating mindfulness strategies linked to spirituality during treatment [35].

3.6 Spiritual complementary therapies

Treatment services for SUDs sometimes involve alternative therapies too [34, 37, 62]. For ethnic minorities in low socioeconomic community, alternative therapies such as reflexology are not common [8]. Participants could experience being overwhelmed with such unfamiliar strategies as one client indicated [8]: 'I could not believe that someone so decent touched me. Me, I am an addict. People normally treat us as dirty and filth, the low lives of society'. Therefore clients must be introduced to such new methods in a client-centred manner that respects their S&R and cultural believes.

The social worker's personal religiosity, training and sensitivity to the client's spirituality help in using an integrative approach that includes clients' alternative therapies [10, 20, 23, 64]. Therefore, educating and sensitising social workers in terms of S&R and alternative therapies are of paramount importance [23, 40, 44, 50, 55, 63, 65]. Ongoing training and intrinsic spirituality on the part of the social worker offering services to people with SUDs could be a catalyst when using an integrated approach [60, 63–65].

There is a growing body of literature on spiritual complementary or alternative therapies; however, there is a dearth of research of its efficacy for treating ethnic minorities with SUDs [?]. Still, an integrated body, mind and spirit approach to intervention in social work practice that is researched- and therefore evidence-based can be an advantage in treating such groups [62]. A combination of Eastern and Western philosophies as well as current research in integrated practice approach offering guidelines for assessment and intervention and not limited to spiritual beliefs appears to be a viable approach.

3.7 Spirituality as a foundation for restoring human dignity

The role of the social worker in any setting is to provide support and guidance. Participants in Carelse's study [8] reported that the counselling, interest and compassion from the social workers motivated them to stay in the programme and to pursue their recovery goals. They described the service provided as very good work, noting that all the things they had learnt would help to prevent relapse, to stay positive and to keep their focus on their recovery goals. Participants' views about the benefits of utilising social work services provided by the NPOs offering treatment to adults with SUDs from low socioeconomic backgrounds are summed up as follows:

The drugs strip you of all that [dignity] and I think that's a big part of a social worker's duty in individual counselling. They do very good work and even after I finished [the drug counselling programme] the one lady called and she wasn't even my therapist, and she called and followed up. She called to my mom's because she couldn't get a hold of me, how am I doing and that. And at that time, I relapsed already so I felt guilty … So that for me played a big role, the interest. And I think that's a major role; the compassion with which you do your work.

All the things you learn there and the chance to express yourself. The information is vital, what they [social workers] put in place, a plan to prevent relapse and I still have all my papers [literature/material on coping resources] at home. And the homework that they give you, it keeps you positive, it keeps you focused on your goal to stay clean. So that helps a lot.

I started praying again. I prayed Wednesday and Thursday and felt better spiritu-ally. Even though I'm not on the place, I know I won't fool myself to think that now that I am praying I am recovered. Friday a lady called me and said she's got a job

> *for me so everything is coming together. So things are starting to fall in place for me and I believe its prayer that God is opening doors for me.*
>
> *I never prayed when I was using, because I was constantly under the influence [of drugs] and I felt unworthy. Not that I feel worthy now but at least I now don't have drugs in my system. My mind is all over the place but I pray to make myself feel better. Now I pray with sincerity and without any mind-altering [drugs].*

The benefits of prayer and meditation seem to have developed the client's problem-solving techniques and efforts to manage triggers for relapse. Coping with stress and stressors such as in the case of SUDs involves deliberate efforts such as in mindfulness strategies, which in this study were prayer and meditation to combat and deter SUDs by influencing the environment and using the resources such as mindfulness strategies in the form of prayer and meditation [34, 35, 37, 62]. Therefore it can be deduced that maintained sobriety is largely dependent on the nature and scope of the treatment programme and more so when mindfulness strategies in a biopsychosocial-spiritual approach is embedded in treatment. Incorporating spirituality in the treatment programmes challenges clients to reflect on their quality of life, for example, learning new ways of dealing with SUDs enhances their self-worth and dignity as they gain higher levels of person: environment fit or a state of equilibrium.

4. Conclusion

There is a growing demand for integrated approaches to treating minority and marginalised people with SUDs. Such treatment requires a continuous process of interrogating theories and related approaches to suit clients' needs. Social work services have evolved from a generalist approach to a person-centred approach over the past 20 years. In this process, the spiritual dimension to persons with SUDs gained progressively more prominence. Currently, a biopsychosocial-spiritual approach has paramount importance for offering integrated and holistic treatment for ethnic minority persons with SUDs. Thus a biopsychosocial-spiritual approach is proposed particularly in the South African context where spirituality is ingrained in the culture and value systems of coloured people. This chapter highlighted the importance of an integrated eclectic approach and the feasibility of a biopsychosocial-spiritual model in treating SUDs in marginalised communities in South Africa. Lessons could be learnt from the experiences shared for integrating spirituality in SUDs in similar contexts. What is clear is that the value of a biopsychosocial-spiritual approach in substance abuse treatment in South Africa cannot be ignored. By no means, this is the only model that can be used with marginalised communities, but it is one that is emerging strongly in treating SUDs when working with such ethnic minorities. The value of spirituality as it relates to person-centredness, in treating SUDs in minority groups, is a topic worth pursuing for future research.

The inclusion of a person-centred approach and mindfulness strategies in treating SUDs should also be further investigated. Similarly, the Bachelor of Social Work (BSW) as well as continued professional development training should incorporate aspects of students' and practitioners' personal spiritual beliefs, the role this has on the professional relationship, as well as the impact of spirituality on the intervention process. Therefore it will be imperative that due diligence is given to the personal S&R beliefs (whether they believe in the transcendent, a higher power or not) of students and practitioners because it is as important as that of the clients that they serve.

The biopsychosocial-spiritual model is indeed a modern humanistic and holistic perspective that is truly person-centred and therefore worth perusing for treatment services with marginalised persons with SUDs, such as ethnic minorities.

Conflict of interest

The author declares no conflict of interest.

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References

[1] South African Community Epidemiology Network on Drug Abuse. Research Brief. Medical Research Council. [Internet]. 2017. Available from: http://www.mrc.ac.za/adarg/sacendu.htm [Accessed: 2017/08/12]

[2] Crisp C. Dual diagnosis: Substance abuse and mental health in an inpatient setting. In: Grobman LM, editor. Days in the Lives of Social Workers. 3rd ed. Harrisburg, PA: White Hat Communications; 2005. pp. 205-210. ISBN: 10: 0965365387

[3] South African History [Internet]. A history of Apartheid in South Africa. Available: https://www.sahistory.org.za/article/history-apartheid-south-africa [Accessed: 2019/07/16]

[4] Kirk JF. Making a Voice: African Resistance to Segregation in South Africa. 1st ed. New York: Routledge; 2018. 368 p 9780429499104

[5] Patel L. Social Welfare and Social Development. 2nd ed. Cape Town: Oxford University Press; 2015. 352 p

[6] Mangena F. African ethics through Ubuntu: A postmodern exposition. Africology: The Journal of Pan African Studies. 2016;**2**:66-80. Available from: http://www.jpanafrican.org/docs/vol9no2/9.2-6-Fainos.pdf [Accessed: 2019/07/20]

[7] De Lannoy A. Unpacking the Lived Realities of Western Cape Youth. Exploring the well-being of young people residing in five of the most deprived areas in the Western Cape Province. Available from: www.povertyandinequality.uct.ac.za/sites/default/files/image_tool/images/95/2018/Publications/Youth%20Well%20being%20WC_Research-report.pdf [Accessed: 2018/07/20]

[8] Carelse S. Social Work Services Provided by Non-profit Organisations to Adult Methamphetamine Uses – An Ecological Systems Perspective [Thesis]. Stellenbosch: Stellenbosch University; 2018

[9] Dreyer Y. Community resilience and spirituality: Keys to hope for a post-apartheid South Africa. Pastoral Psychology. 2015;**64**:651-662. DOI: 10.1007/s11089-014-0632-2

[10] Philips C. Spirituality in social work: Introducing a spiritual dimension into social work education and practice. Social Work Research. 2014;**26**:65-77. DOI: 10.11157/anzswj-vol26iss4id27

[11] Ruglass LM, Yali AM. Do race/ethnicity and religious affiliation moderate treatment outcomes among individuals with co-occurring PTSD and substance use disorders? Journal of Prevention & Intervention in the Community. 2019;**47**(3):198-213. DOI: 10.1080/10852352.2019.1603674

[12] Katerndahl DA. Impact of spiritual symptoms and their interactions on health services and life satisfaction. Annals of Family Medicine. 2008;**6**:412-420. DOI: 10.1370/afm.886

[13] Hutchison W. The role of religious auspiced agencies in the post-modern era. In: Meinert R, Pardeck J, Murphy J, editors. Postmodernism Religion and the Future of Social Work. Vol. 18. New York: The Haworth Press; 1998. pp. 55-69. DOI: 10.1080/15426432.1998.9960236

[14] Limb G, Hodge D. Developing spiritual lifemaps as a culture-centred pictorial instrument for spiritual assessments with native American clients. Research on Social Work Practice. 2007;**17**(2):296-304. DOI: 10.1177/1049731506296161

[15] Blakey JM. The role of spirituality in helping African American women with histories of trauma and substance

abuse heal and recover. Social Work and Christianity. 2016;**43**:40-59. ISSN: 1944-7779

[16] Dykes G, Carelse S. Spirituality. In: Van Breda A, Sekudu J, editors. Theories for Decolonial Social Work Practice in South Africa. Cape Town, South Africa: Oxford University Press; 2019. ISBN: 9780190721350.ch12

[17] Coady N, Lehmann P, editors. Theoretical Perspectives for Direct Social Work Practice: A Generalist-Eclectic Approach. 3rd ed. New York: Springer Publishing Company; 2016 . 469 p. ISBN: 13-9780826119476

[18] Norcross JC, Grencavage LM. Eclecticism and integration in counseling and psychotherapy: Major themes and obstacles. In: Dryden W, Norcross JC, Grencavage LM. Eclecticism and integration in counselling and psychotherapy: Major themes and obstacle. British Journal of Guidance and Counselling. 1989;**17**:227-247. DOI: 10.1080/03069888908260036

[19] Nuttall J. Imperatives and perspectives of psychotherapy integration. International Journal of Psychotherapy. 2002;**7**:249-264. DOI: 10.1080/1356908021000063169

[20] Saad M, De Medeiros R, Mosini A. Opinion. Are we ready for a true biopsychosocial-spiritual model? The many meanings of 'spiritual'. Medicine. 2017;**4**:1-6. DOI: 10.3390/medicines4040079

[21] King DE. Faith, Spirituality and Medicine: Toward the Making of a Healing Practitioner. Binghamton, NY: Haworth Pastoral Press; 2000. ISBN: 13-978-0789011152

[22] McKee DD, Chappel JN. Spirituality and medical practice. Journal of Family Practice. 1992;**35**:201, 205-208. Available from: https://europepmc.org/abstract/med/1645114 [Accessed: 20/07/20]

[23] Engel GL. How much longer must medicine's science be bound by a seventeenth century world view? Psychotherapy and Psychosomatics. 1992;**57**:3-16. DOI: 10.1159/000288568

[24] Slater L. Person-centredness: A concept analysis. Contemporary Nurse. 2006;**23**(1):135-144. DOI: 10.5172/conu.2006.23.1.135

[25] Connor JP, Haber PS, Hall WD. Alcohol use disorders. The Lancet. 2016;**387**(10022):988-998. DOI: 10.1016/S0140-6736(15)00122-1

[26] McNeil R, Kerr T, Pauly B, Wood E, Small W. Advancing patient-centered care for structurally vulnerable drug-using populations: A qualitative study of the perspectives of people who use drugs regarding the potential integration of harm reduction interventions into hospitals. Addiction. 2016;**111**(4):685-694. DOI: 10.1111/add.13214

[27] Zhao J, Gao S, Wang J, Liu X, Hao Y. Differentiation between two healthcare concepts: Person-centered and patient-centered care. International Journal of Nursing Sciences. 2016;**3**(4):398-402

[28] McCance T, McCormack B. The person-centred practice framework. In: Person-Centred Practice in Nursing and Health Care: Theory and Practice. Chichester, West Sussex, UK; 2016. pp. 36-62. Chap 3. ISBN: 8781118990575

[29] Borrell-Carrió F, Suchman A, Epstein R. The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. Annals of Family Medicine. 2004;**6**:576-582. DOI: 10.1370/afm.245

[30] White KL, Williams TF, Greenberg BG. The ecology of medical care. Bulletin of the New York Academy of Medicine. 1996;**73**:187-212. Available

from: bullnyacadmed01031-0195.pdf [Accessed: 2019/07/20]

[31] Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. Gerontologist. 2002;**42**: 24-33. DOI: 10.1093/geront/42.suppl_3.24

[32] Smith RL, Southern S. Integrative confusion: An examination of integrative models in couple and family therapy. The Family Journal. 2014;**13**:392-399. Available from: http://tfj.sagepub.com/content/13/4/392 [Accessed: 2019/07/15]

[33] Marcus MT, Zgierska A. Mindfulness Related Treatment and Addiction Recovery. New York: Routledge; 2012, 2012. ISBN: 13: 978 0415 69689 0

[34] Li W, Howard MO, Garland EL, McGovern P, Lazar M. Mindfulness treatment for substance misuse: A systematic review and meta-analysis. Journal of Substance Abuse Treatment. 2017;**75**:62-96

[35] Amaro H, Black DS. Moment-by-moment in Women's recovery: Randomized controlled trial protocol to test the efficacy of a mindfulness-based intervention on treatment retention and relapse prevention among women in residential treatment for substance use disorder. Contemporary Clinical Trials. 2017;**62**:146-152. DOI: 10.1016/j.cct.2017.09.004

[36] Turner T, Welsches P, Conti S. Mindfulness-Based Sobriety-a clinician's Guide for Addiction Recovery Using Relapse Prevention Therapy, Acceptance & Commitment Therapy & Motivational Interviewing. Canada: Raincoast Books; 2013. ISBN: 978 160882 854 8

[37] Bautista T, James D, Amaro H. Acceptability of mindfulness-based interventions for substance use disorder: A systematic review. Complementary

Therapies in Clinical Practice. 2019;**35**:201-207. DOI: 10.1016/j.ctcp.2019.02.012

[38] Holloway M, Moss B. Spirituality in Social Work. Basingstoke, Hampshire, UK: Palgrave McMillan; 2010. ISBN: 13 978 230 21924 3

[39] Koenig HG, King DE, Carson VB. Handbook of Religion and Health 2nd Ed. New York: Oxford University Press; 2012. 1192 p. ISBN: 9780195335958

[40] Furman L, Benson P, Grimwood C, Canda E. Religion and spirituality in social work education and practice at the millennium: A survey of UK social workers. British Journal of Social Work. 2004;**34**:767-792. Available from: http://www.jstor.org/stable/23720509 [Accesssed: 2019/07/20]

[41] Kissman K, Mauer L. East meets west: Therapeutic aspects of spirituality in health, mental health and addiction recovery. International Social Work. 2002;**45**:35-43. DOI: 10.1177/0020872802045001315

[42] Paul GL. Strategy of outcome research in psychotherapy. Journal of Consulting Psychology. 1967;**31**:109-119. DOI: 10.1037/h0024436

[43] Stansley MA, Bush AL, Camp ME, Jameson JP, Philips LL, Barber CR. Older adults' preferences for religion/spirituality in treatment for anxiety and depression. Aging and Mental Health. 2011;**15**(3):334-343. DOI: 10.1080/13607863.2010.519326

[44] Oxhandler HK, Pargament KI. Social work practitioners' integration of clients' religion and spirituality in practice: A literature review. Social Work. 2014;**59**:271-279. DOI: 10.1093/sw/swu018

[45] Giordano AL, Prosek EA, Stamman J, Callahan MM, Loseu S, Bevly CM, et al. Addressing trauma in substance abuse

treatment. Journal of Alcohol and Drug Education. 2016;**60**:55

[46] Heinz AJ, Disney ER, Epstein DH, Glezen LA, Clark PI, Preston KL. A focus-group study on spirituality and substance-user treatment. Substance Use & Misuse. 2010;**45**:134-153. DOI: 10.3109/10826080903035130

[47] Manuel JI, Yuan Y, Herman DB, Svikis DS, Nichols O, Palmer E, et al. Barriers and facilitators to successful transition from long-term residential substance abuse treatment. Journal of Substance Abuse Treatment. 2017;**74**: 16-22. DOI: 10.1016/j.jsat.2016.12.001

[48] Shorey RC, Gawrysiak MJ, Anderson S, Stuart GL. Dispositional mindfulness, spirituality, and substance use in predicting depressive symptoms in a treatment-seeking sample. Journal of Clinical Psychology. 2015;**71**:334-345. DOI: 10.1002/jclp.22139

[49] Nedelec JL, Richardson G, Silver IA. Religiousness, spirituality, and substance use: A genetically sensitive examination and critique. Journal of Drug Issues. 2017;**47**:340-355. DOI: 10.1177/0022042617693382

[50] Canda ER. Spiritual connections in social work: Boundary violations and transcendence. Journal of Religion & Spirituality in Social Work: Social Thought. 2008;**27**(1-2):25-33. DOI: 10.1080/15426430802113749

[51] Best D, Beckwith M, Haslam C, Alexander Haslam S, Jetten J, Mawson E, et al. Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). Addiction Research & Theory. 2016;**24**(2):111-123. DOI: 10.3109/16066359.2015.1075980

[52] Alcoholics Anonymous [Internet]. Alcoholics Anonymous 12-Step Recovery Programme. Available from: http://www.recovery.org/topics/ alcoholics-anonymous-12-step/ [Accessed: 2018/08/24]

[53] Gaine GS, La Guardia JG. The unique contributions of motivations to maintain a relationship and motivations toward relational activities to relationship well-being. Motivation and Emotion. 2009;**33**(2):184-202. DOI: 10.1007/s11031-009-9120-x

[54] Wagner CC, Ingersoll KS. Motivational Interviewing in Groups. New York: Guilford Press; 2012. 416 p. ISBN 9781462507924

[55] Miller WR, Rollnick S. Motivational Interviewing: Helping People to Change. 3rd ed. New York: Guilford Press; 2013. ISBN: 13 978-1609182274

[56] Hettema J, Steele J, Miller WR. Motivational interviewing. Annual Review of Clinical Psychology. 2005;**1**:91-111. DOI: 10.1146/annurev. clinpsy.1.102803.143833

[57] Ranes B, Johnson R, Nelson L, Slaymaker V. The role of spirituality in treatment outcomes following a residential 12-step programme. Alcoholism Treatment Quarterly. 2017;**35**:1, 16-33. DOI: 10.1080/07347324.2016.1257275

[58] White Paper on Health. National Health Institute. South Africa, Pretoria. 2017. Available from: https:// www.gov.za/sites/default/files/ gcis_document/201512/39506gon1230. pdf [Accessed: 2019/07/20].

[59] Carrington A. A spiritual approach to social work practice. In: Crisp BR, editor. Handbook of Religion, Spirituality and Social Work. London, UK: Routledge; 2017, 2017. DOI: 10.4324/9781315679853

[60] Hodge DR. Spiritual competence. In: Crisp BR, editor. Handbook of Religion, Spirituality and Social Work. 1st ed. London, UK: Routledge; 2017. 398 p. ISBN: 9781315679853

[61] Oxhandler HK, Giardina TD. Social workers' perceived barriers to and sources of support for integrating clients' religion and spirituality in practice. Social Work. 2017;**62**(4): 323-332. DOI: 10.1093/sw/swx036

[62] Lee MY, Leung PP. Integrative Body-Mind-Spirit Social Work: An Empirically Based Approach to Assessment and Treatment. New York, USA: Oxford University Press; 2018. ISBN: 97801 90458522

[63] Tan SY, Scalise ET. Lay Counselling, Revised and Updated: Equipping Christians for a Helping Ministry. Michigan: Harper Collins Christian Publishing; 2016. 410 p. ISBN-13: 978-0310524274

[64] Chatters LM, Taylor RJ, Woodward AT, Bohnert AS, Peterson TL, Perron BE. Differences between African Americans and non-Hispanic whites utilization of clergy for counseling with serious personal problems. Race and Social Problems. 2017;**9**(2):139-149. DOI: 10.1007/s12552-017-9207-z

[65] Ali OM. The imam and the mental health of Muslims: Learning from research with other clergy. Journal of Muslim Mental Health. 2016;**50**(1):46-61. DOI: 10.3998/jmmh.10381607.0010.106