

Effectiveness of Religious-Spiritual Group Therapy on Spiritual Health and Quality of Life in Methadone-treated Patients: A Randomized Clinical Trial

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Original Article

Abstract

Background: Spirituality is one of the most important factors that can contribute to the recovery of substance use disorder (SUD). The objective of this study is to evaluate the efficacy of the religious-spiritual group therapy on the spiritual health and the quality of life in methadone-treated patients.

Methods: This study was carried out in Qom City, Iran, in 2018. 72 methadone-treated patients were randomly selected and assigned in two groups: the experimental group (which received religious-spiritual therapy) and control group (which received no treatment). At the beginning of the study (pre-test), eight weeks after the start of the study (post-test), and three months after the start of the study (follow-up test), all participants completed the World Health Organization Quality of Life-BREF (WHOQOL-BREF) questionnaire and the Spiritual Well-Being Scale (SWBS). Participants in the experimental group received 8 sessions (90 minutes for each session) of spiritual and religious training, while the control group received no religious-spiritual intervention; it just was trained with general information on addiction. Data were analyzed using SPSS software and descriptive and inferential statistics methods.

Findings: The results of repeated measures analysis of variance (ANOVA) showed that there was no significant difference between the intervention and control groups in the pretest, but religious-spiritual training significantly increased spiritual health and the patients' quality of life ($P < 0.001$).

Conclusion: Religious-spiritual education can improve the quality of life and spiritual well-being in methadone-treated patients. The findings suggest that religious -spiritual education can be considered as an inexpensive, accessible, useful, and effective treatment for SUD treatment.

Keywords: Religious beliefs; Spirituality; Quality of life; Methadone; Health

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Introduction

Addictive behaviors and especially drug abuse remain as one of the most serious health threats.¹ According to a recent report, about 2.2 million Americans have criteria for opioid dependence.^{2,3} According to the latest figures provided by the United Nations Office on Drugs and Crime (UNODC), about two millions eight hundred thousand Iranians have become infected with addiction, and despite the extensive measures taken to prevent and reduce the use, the rate of drug abuse, dependence, and relapse remains high.^{3,4} Regarding the high relapse in drug users, it seems necessary to provide practical solutions to reduce relapses. Various factors can be effective in relapse probability, such as violations of emotional regulation, distress tolerance, resilience, emotional avoidance, impulsive behaviors, rumination, low self-efficacy, and spiritual emptiness in the phenomenon of returning to substance use.⁵ One of the most important factors in the substance use disorder (SUD) and its relapse is spiritual emptiness.⁶ Since 1983, considering the biological, psychological, social, and spiritual dimensions of mankind and determining the main effect of spirituality in the people's health, the World Health Organization (WHO) introduced the spiritual dimensions as the well-being and the quality of life, and also introduced its investigation in different countries.⁷ Moreover, in the SUDs, human beings with biological, psychological, and social dimensions are considered. Each of these dimensions can threaten the general health of the individual.⁸ Considering that spiritual well-being is at the center of this dimension, paying attention to it can have a significant effect on the general health. Therefore, spirituality as one of the human aspects of health care plays a significant role in treating SUDs.⁹

The results of the performed studies indicated that religious orientation and spirituality were related to the positive consequences of physical and psychological health. Kim and Seidlitz, by reviewing the studies, concluded that religion and spirituality were less related to narcotics and negative emotions, improving the quality of life, friendship, high self-esteem, and coping with life stress.¹⁰ Religion and spirituality have a negative relationship with high-risk behaviors such as drug abuse and smoking. Different aspects of

spirituality and religiosity are associated with decreasing depression, suicide, and mortality, also increasing longevity, marital satisfaction, well-being, happiness, and improving the function of the immune system. The combination of spiritual and religious interventions with psychological treatments can be effective in preventing mental and physical diseases.¹¹ On the other hand, research showed that opioid, alcohol, and sedation were related to low quality of life.¹² Physical and mental health in opioid dependents not only is lower than general population and physical patients, but also is equal to psychiatric disorders.¹³ Studies have also showed that drug abuse and opioid use were associated with lower quality of life.¹⁴⁻¹⁶ There is a great deal of evidence that higher spiritual quality is associated with higher quality of life and more successful treatment in opiate dependents.¹⁷

According to the studies, it can be said that spirituality is a key factor in the treatment and prevention of addiction, which can also increase the quality of life.¹⁸ The findings of Salmabadi et al. study¹⁹ showed that the religious orientation and the quality of life had meaningful relationship. Considering the emphasis of various studies on the multifactorial nature of substance abuse, a point to be considered in all studies is the importance and impact of spirituality and spiritual health on the pattern of drug use; so, there are many experts in the field of spirituality and spiritual care as the main nucleus of the prevention and treatment of addiction.²⁰

In most health-related studies, religion and spirituality have led to positive therapeutic outcomes²¹ and more research should be done on how spirituality affects the various aspects of recovery in SUDs. Spiritual health is considered as the fourth dimension of health accepted by the International Health Organization (IHO) and its member states, but the expression of the concepts and the application of this requires more effort in different societies.²² Religious, spiritual, and scientific advancements can be used both for diagnosis and treatment of disorders and diseases.²³ The inadequacy of the current treatment, the high cost of medical treatment, the severe cultural, economic, and social problems imposed on the community, the low number of research on spirituality-based therapies, and the welcome to spiritual therapy in reputable

scientific centers lead us to the need for such research.²⁴ Regarding the inadequacy of traditional psychiatric therapies for opiate dependents, and on the other hand, the effects of spirituality-based interventions on health status, and especially on addicted patients, it seems that spirituality-based intervention has a significant and beneficial effect on many dimensions of the theirs' life; it will also reduce anxiety and depression among them. It is also likely that this intervention will not only be a second and third level prevention, but also a first-line prevention among vulnerable groups. It not only prevents and/or treats depression and anxiety and improves the quality of life in the first place, but also it prevents the drug abuse and some psychiatric disorders in the long term.²⁵ Therefore, we aimed to investigate the efficacy of religious-spiritual group therapy on spiritual health and the quality of life in methadone-treated patients.

Methods

In a randomized study, 72 methadone-treated patients were randomly selected from methadone maintenance therapy (MMT) centers in Qom, Iran, and according to inclusion and exclusion criteria, control and experimental groups were included. The inclusion criteria were as follows: aged between 18 and 60 years, referral of a psychiatrist or physician according to the primary diagnosis of substance dependence based on the fifth revised edition of the Diagnostic and Statistical Manual of Mental Disorders-5th Edition (DSM-5), cycle degree, and filled out the consent form to participate in the study. The exclusion criteria included: using anti-psychotics, having severe disorders [psychotic disorders, organic brain disorders (OBDs)], having suicidal ideation (so that it was impossible to participate in the research), absence of more than two sessions of participation in other therapeutic programs at the same time, and having long-term dependence on several substances other than opiate at the same time. Patients in the two groups filled the WHO Quality of Life-BREF questionnaire (WHOQOL-BREF) and spiritual Well-being scale (SWBS) at the start of the study, eight weeks after the treatment sessions, and three months after the completion of the study. The experimental group received 8 sessions of

religious-spiritual group therapy, while the control group did not receive any psychological intervention. Both groups also received MMT. Data analysis of 63 patients in two groups was performed using SPSS software (version 21, IBM Corporation, Armonk, NY, USA). Chi-square test, t-test, and repeated measures analysis of variance (ANOVA) were used.

Demographic characteristics form: This form contained questions about demographic characteristics, including age, marriage status, education, and history of drug use.

Spiritual Well-Being Scale (SWBS): This scale was developed by Ellison.²⁶ There are 20 items and 2 sub-scales, 10 of them are about religious health and the others about existential health in a 6-point Likert scale, from completely disagree to fully agree. In negative questions, the score is reversed. The total spiritual health score is from 20 to 120. Spiritual health is divided into three levels: low (20 to 40), moderate (41 to 99), and high (100 to 120).²⁵ This questionnaire has a good reliability and credibility.²⁷ The reliability and validity of this scale were determined by Seyed Fatemi et al. through content validity in Iran.²⁸

WHOQOL-BREF: It is a 26-item questionnaire that measures the quality of overall and general life of a person. This scale was developed by a group of experts from the WHO in 1996 and adjusted by the 100 questions form. This questionnaire has 4 sub-scales and a general score. These sub-scales include physical health, mental health, social relationships, and environmental health. Initially, a raw score is obtained for each subscale, which must be converted to a standard score of 0 to 100 through a formula. A higher score predicts a higher quality of life.²⁹ Validity and reliability of this questionnaire were determined using interview with 1167 people from Tehran, Iran. They were divided into two groups: chronic and non-susceptible. The reliability of the retest for the sub-scales was as follows: physical health 0.77, mental health 0.77, social relation 0.75, and environmental health 0.84. Internal consistency was also calculated using Cronbach's alpha.³⁰

Ethical consideration: This clinical trial was reviewed and approved by the Vice Chancellor of Medical and Health Services Research Committee of Qom University of Medical Sciences (IR.MUQ.REC.1396.117).

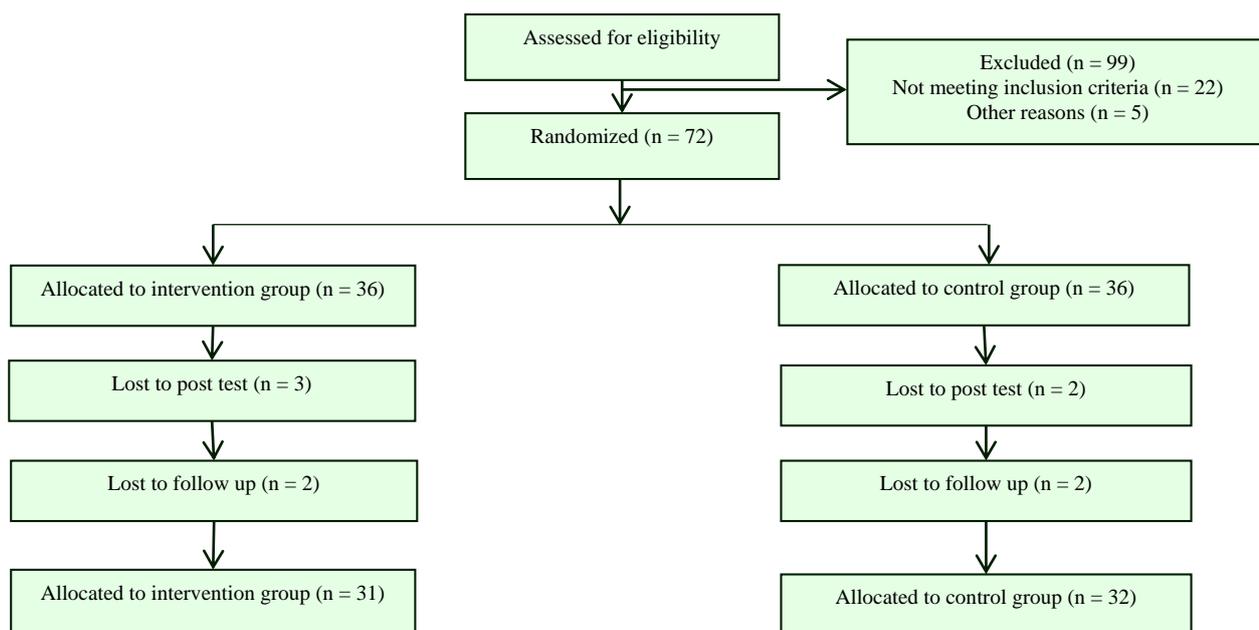


Figure 1. The CONSORT flow diagram of study

Each participant completed the informed consent form for participation in the study. Concerning the goals and the way of conducting sessions, patients were assured that their information would be kept as confidential. In addition, each participant was informed that they would be out of treatment if they did not want to continue attending treatment sessions.

Results

72 methadone-treated patients were studied. They

were assigned to two groups; 5 of them in the intervention group due to irregular presence and failure to complete the questionnaire during the follow up period and 4 in the control group due to failure to complete the questionnaire in the post-test and follow-up stages were excluded. Data of 63 subjects were analyzed (31 in the intervention group and 32 in the control group) (Figure 1).

According to table 1, there were no statistically significant differences in age, education, history of use, and job in intervention and control groups.

Table 1. Demographic characteristics of the participants

Variable	Status	Group		P
		Intervention	Control	
Age (year) [n (%)]	< 25	7 (22.58)	5 (15.62)	0.571
	25-35	15 (48.38)	17 (53.12)	
	> 40	9 (29.03)	10 (31.25)	
Age (year) (mean ± SD)	-	28.3 ± 5.04	29.7 ± 4.21	
Education	Under diploma	14 (45.16)	15 (46.87)	0.693
	Diploma	11 (35.48)	10 (31.25)	
	Above diploma	6 (19.35)	7 (21.87)	
History of use (year) [n (%)]	< 5	6 (19.35)	9 (28.12)	0.842
	3-5	13 (41.93)	12 (37.50)	
	> 5	12 (37.81)	11 (34.37)	
Job [n (%)]	Employed	24 (77.42)	23 (71.78)	0.923
	Unemployed	7 (22.58)	9 (28.12)	
Marital status [n (%)]	Married	23 (74.19)	22 (68.75)	0.613
	Single and divorced	8 (25.80)	10 (28.12)	

SD: Standard deviation

Table 2. The comparison of quality of life scores at pre-test, post-test, and follow-up in both groups

Variable	Pre-test		Post-test		Follow-up		P	
	Mean ± SD		Mean ± SD		Mean ± SD		Time	Time × group
Group	Intervention	Control	Intervention	Control	Intervention	Control		
Physical health	47.93 ± 2.19	45.65 ± 3.69	59.12 ± 3.48	45.22 ± 2.14	58.43 ± 2.16	44.47 ± 3.04	0.610	< 0.001
Psychological health	49.46 ± 2.24	48.72 ± 3.15	61.27 ± 3.41	49.02 ± 1.24	60.13 ± 2.13	48.28 ± 3.19	0.480	< 0.001
Social relationships	54.15 ± 3.21	53.69 ± 1.84	70.56 ± 3.52	53.48 ± 3.18	73.46 ± 3.19	51.85 ± 2.81	0.100	< 0.001
Environment	57.93 ± 2.15	57.21 ± 3.45	68.45 ± 3.14	56.62 ± 2.44	67.12 ± 2.10	55.74 ± 3.61	0.040	< 0.001
General quality of life	64.34 ± 4.15	65.57 ± 2.26	76.37 ± 2.11	64.52 ± 1.53	75.42 ± 3.36	64.16 ± 2.37	0.120	< 0.001

SD: Standard deviation

The repeated measures ANOVA was used to compare religious-spiritual and control groups regarding spiritual health and quality of life.

The mean and standard deviation (SD) of pre-test, post-test, and follow-up scores for the quality of life and its subscales are presented in table 2. The mean of total pre-test of quality of life in the intervention group was 64.34 ± 4.15 and 65.57 ± 2.26 in the control group. Differences in the scores of the two groups were not significant before the intervention. Mean score of posttest of quality of life in the intervention group was 76.37 ± 2.11 and in the control group was 64.52 ± 1.53. In the follow-up period, this rate in the intervention group was 75.42 ± 3.36 and in the control group was 64.16 ± 2.37. Also, changes in quality of life scores and its subscales in the post-test and follow-up period are presented in table 2.

A repeated measures ANOVA was used to compare the changes in spiritual health scores in three stages of evaluation. The findings showed that the mean score of spiritual well-being at posttest was 86.24 ± 1.78, the existential health subscales was 49.18 ± 3.67, and the religious health was 52.36 ± 5.24 in the intervention group, as compared to the control group (P < 0.05); these changes of scores in the follow-up phase, between

two groups, were significant (Table 3).

Discussion

Spiritual-based intervention can be used as one of the most effective ways to deal with and treat drug abuse disorders. However, few studies to date have been performed to assay the effectiveness of spiritual and religious-based interventions in SUDs. This result confirms the previous finding that showed the efficiency of spirituality and its interventions in the treatment of problems caused by drug abuse.^{18,25,31,32} As mentioned above, there is few researches about the effectiveness of religious-based interventions and spirituality in substance-dependent individuals. Mohammadi et al.²⁵ conducted a clinical trial on the efficacy of spiritual psychotherapy (using Yale's group therapy package) on 61 opioid-dependent patients referred to the National Center for Addiction Studies and two other private clinics. The results of this study showed that spiritual group therapy reduced psychological problems such as depression and anxiety; it also improved the quality of life and accelerated the negative trend of morphine test. Addicts who receive spiritual teachings have a more hopeful and positive

Table 3. The comparison of spiritual health scores at pre-test, post-test, and follow-up in both groups

Variable	Pre-test		Post-test		Follow-up		P	
	Mean ± SD		Mean ± SD		Mean ± SD		Time	Time × group
Group	Intervention	Control	Intervention	Control	Intervention	Control		
Religious well-being	41.32 ± 6.22	42.29 ± 3.92	52.36 ± 5.24	43.24 ± 3.24	51.27 ± 1.53	41.42 ± 5.13	0.490	< 0.001
Existential well-being	42.16 ± 3.15	41.72 ± 4.26	49.18 ± 3.67	42.11 ± 8.88	48.23 ± 2.35	41.69 ± 2.48	0.240	< 0.001
Spiritual well-being	74.27 ± 3.81	73.63 ± 4.84	86.24 ± 1.78	73.41 ± 2.38	84.28 ± 1.89	72.15 ± 2.16	0.030	< 0.001

SD: Standard deviation

attitude, which in turn can be effective in reducing depression and distress and increasing life satisfaction.¹⁷

On the other hand, spiritual training is effective in changing one's view of the disease and quality of life. These results are consistent with a research that showed the effects of spirituality and its training on increasing the level of hope and reducing depression.³¹ In addition, participation in group meetings helps its members to reduce their feelings of isolation and loneliness. They will experience new emotions through each other's support and enjoy sympathy with each other through this supportive system.

In a research study, Bamdad et al.³² reviewed the effect of spiritual care on 81 amphetamine-dependent patients admitted to the acute sections of the Razi Psychiatric Center of Tehran in a clinical trial. The intervention group received the spiritual care package for 40 days. The results of this study indicated that spiritual care was effective in the spiritual health of amphetamine-dependent people; it is proposed to be included in the health care programs for the promotion of mental health. The results of Heinz et al.¹⁸ showed the influence of religion and spirituality on positive therapeutic outcomes; and the promotion of spirituality with positive therapeutic outcomes is associated with the consumption of substances and the improvement of the spiritual dimension of the recipients. Heinz et al. also examined the religious-spiritual experiences and their relationship with the therapeutic outcomes of heroin and cocaine dependence. They reported that religious and spiritual activities had a positive impact on the recovery process.

Individuals involved in spiritual and religious activities have a higher level of spiritual health. Conflict strategies and spirituality-based problem-solving techniques appear to be adaptive in drug discontinuation and continuation of treatment. Through the management of stress and suffering, religion reduces the amount of drug use through some alternative methods.³³ With increasing spirituality and improving the spiritual dimensions, adaptive responses and progression are evident in the recovery from drug abuse.³⁴ Studies showed that religion could act as a protector against substance abuse by providing a

lifestyle and behavioral approach. It, as an internal source of energy, is a key factor in avoiding drug abuse. It can create a value-based system that is superior to all other values, including substance abuse. Therefore, according to the results of the studies, believing in religious beliefs can lead to reduction of drug intake. Significant negative correlation between religion and substance abuse has been mentioned in various studies. In this regard, the results of this study are consistent with other studies. This means religious beliefs are related to preventing and reducing drug use on the one hand, and increasing the satisfaction and the quality of life on the other hand.^{35,36}

Conclusion

The present clinical trial was done to evaluate the effectiveness of the religious-spiritual group therapy on spiritual health and the quality of life among patients undergoing methadone treatment. Our results indicated that the spiritual group therapy has been effective in promoting spiritual well-being and improving the quality of life of methadone-treated patients. In the intervention group, the therapeutic effects were maintained in the follow-up period in addition to the post-test. Due to the ineffectiveness of current treatments, the high cost of medical treatments, and the severe cultural, economic, and social problems which are imposed on society, there is a need for spiritual interventions because of the effectiveness and the acceptance of them in accredited scientific centers. Spiritual interventions can be used because of their effectiveness, usefulness, cost-effectiveness and availability. Since the results of this study are significant and noticeable, future researches are suggested to be done with larger sample size, also among women.

Conflict of Interests

The Authors have no conflict of interest.

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اثر بخشی گروه درمانی مذهبی - معنوی بر سلامت معنوی و کیفیت زندگی بیماران تحت درمان با متادون: کار آزمایی بالینی تصادفی

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مقاله پژوهشی

چکیده

مقدمه: معنویت از جمله عوامل بسیار مهمی است که می‌تواند به روند بهبودی اختلالات مصرف مواد کمک کند. هدف از انجام پژوهش حاضر، بررسی اثر بخشی گروه درمانی مذهبی - معنوی بر سلامت معنوی و کیفیت زندگی بیماران تحت درمان با متادون بود.

روش‌ها: این مطالعه در سال ۱۳۹۷ در شهر قم انجام شد. ۷۲ نفر از بیماران تحت درمان با متادون به صورت تصادفی انتخاب شدند و در دو گروه آزمایش (درمان مذهبی - معنوی) و شاهد (بدون درمان مذهبی - معنوی) قرار گرفتند. کلیه شرکت‌کنندگان پرسش‌نامه کیفیت زندگی (World Health Organization Quality of Life-BREF یا WHOQOL-BREF) و مقیاس سلامت معنوی (Spiritual Well-Being Scale یا SWBS) را در ابتدای تحقیق (پیش‌آزمون)، ۸ هفته (پس‌آزمون) و سه ماه (آزمون پیگیری) پس از شروع پژوهش تکمیل نمودند. شرکت‌کنندگان گروه آزمایش ۸ جلسه آموزش مذهبی - معنوی (هر جلسه ۹۰ دقیقه) را دریافت کردند؛ در حالی که گروه شاهد به جزء اطلاعات عمومی پیرامون اعتیاد، هیچ مداخله مذهبی - معنوی دریافت نکردند. داده‌ها با استفاده از آمار توصیفی و استنباطی در نرم‌افزار SPSS مورد تجزیه و تحلیل قرار گرفت.

یافته‌ها: بر اساس نتایج آزمون ANOVA، تفاوت معنی‌داری بین گروه‌های آزمایش و شاهد در پیش‌آزمون وجود نداشت، اما آموزش مذهبی - معنوی به طور معنی‌داری موجب ارتقای سلامت معنوی و کیفیت زندگی بیماران شد ($P < 0/001$).

نتیجه‌گیری: آموزش مذهبی - معنوی کیفیت زندگی و سلامت معنوی را در بیماران تحت درمان با متادون ارتقا می‌دهد. آموزش مذهبی - معنوی می‌تواند به عنوان یک برنامه درمانی ارزان‌قیمت، در دسترس، مفید و اثربخش در درمان اختلال مصرف مواد مورد توجه قرار گیرد.

واژگان کلیدی: باورهای مذهبی، معنویت، کیفیت زندگی، متادون، سلامت

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