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Cynthia Gibeau
PERCEPTION AND
QUALITY OF
LIFE: CONTRASTING
PERSONAL
FAITH BASED WELLNESS
AND THE TRADITIONAL
MEDICAL MODELS OF
CARE USED IN
ALCOHOL ABUSE AND
ADDICTION TREATMENT
PROGRAMS

ABSTRACT

This study explored the quality of care for those who suffer from alcohol and drug abuse. A presentation of the current traditional medical model focused on current research on the brain mechanism involved in alcohol addiction, as well as current treatments that are available.

It then presented three models based on personal faith, and supplied research on the efficacy of these models. A valid argument was made that the inclusion of a personal faith model in the treatment of those who suffer from alcohol abuse and addiction would provide a more positive outcome and helps provide more stability when an individual returns to their environment.

Finally, a model was developed for consideration for further research: the tradition medical model used in conjunction with a melded faith based model for treatment of alcohol abuse and addiction.

PERCEPTION AND QUALITY OF LIFE: CONTRASTING PERSONAL FAITH
BASED WELLNESS AND THE TRADITIONAL MEDICAL MODELS OF CARE
USED IN ALCOHOL ABUSE AND ADDICTION TREATMENT PROGRAMS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Masters of Social Work.

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2009

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CHAPTER 1

INTRODUCTION

Background of the Problem

For a substantial number of people in the United States, personal faith is an important part of their lives. The majority of adults in this country feel a need for personal faith growth throughout their lives with the rate of personal faith involvement remaining fairly constant from the mid-1960s through the turn of the century, Baker (2003). Personal faith, a deep sense of belonging, wholeness, of connectedness, and of openness to the infinite, has become recognized as a construct distinct from religiosity, with some intersecting belief ideation.

In recent years, the association between personal faith and therapeutic medicine has attracted considerable attention among researchers and practitioners (Anandarajah & Hight, 2001). Research findings indicate that many patients believe their personal faith has a significant role in their lives, that there is a positive relationship between personal faith and treatment outcomes. Patients have indicated, via quality of life questionnaires, their desire for the medical community to recognize their personal faith as part of their overall treatment. Over 70% of patients would like their physicians to include personal faith concept themes in their treatment, but only 10 to 20 percent of doctors discuss these issues with their patients (Anandarajah & Hight, 2001). Support for the integration of personal faith into medical practice and therapeutic counseling has grown as a result of these findings. About 50 medical schools presently

provide curricula dealing with an individual's personal faith and medicine, (Puchalski & Larson, 2002).

To coincide with this involvement, the issue of personal faith based wellness in counseling has received increased awareness due to the recent attention focused on health promotion, wellness, and the ability to cope among the chronic alcohol abuse and addiction population (Baker, 2003; Miller, 2003; Miller & Thoresen, 2003). It is important to note, however, that some coping behaviors can be negative in that they lead to destruction of self and others. This is evident when alcohol is used as a coping mechanism. Others coping mechanisms, however, are positive in that they become life enriching, growth stimulating, and character building, for example: meditation, participation in Dialectical Behavior Therapy "DBT", and yoga. The integration of a personal faith concept in developing coping styles has been positively connected to various aspects of mental and physical health (Gorsuch, 1995).

Alcoholism, also called dependence on alcohol, is a chronic relapsing disorder that is progressive and has serious detrimental health outcomes. Alcoholism is a chronic, a potentially fatal disease, that affects an individual's work, family, and physical environment. The development of alcoholism is characterized by frequent episodes of intoxication, preoccupation with alcohol, loss of control in limiting alcohol intake, and emergence of a negative emotional state in absence of the alcohol (Rivera, 2000).

The following are some alarming statistics regarding alcohol abuse released by the National Center of Addiction and Substance Abuse at Columbia University (2005):

- American youth who begin drinking before the age of 15 are four times more likely to become alcoholics than young people who do not drink before the age of 21.
- The 25.9% of underage drinkers who are alcohol abusers and alcohol dependent drink 47.3% of the alcohol that is consumed by all underage drinkers.
- Every year, 1,400 American college students between the ages of 18 and 24 die from alcohol related accidents and injuries, including motor vehicle accidents.
- In 2004, 16,694 deaths occurred as a result of alcohol related motor vehicle crashes. The amount was approximately 39% of all traffic fatalities.
- Alcohol dependence and alcohol abuse cost the United States an estimated \$185 billion in 2005.

Alcohol is the most common drug of choice for substances abusers; it is legal, readily available and economical. However, heroin, cocaine, methamphetamines, club drugs such as Ecstasy, GHB, and LSD, although not as prevalent are still the source of work, relational, and physical problems in an

addicted person's life. Today a new source of addiction and abuse needs to be considered: the increasing abuse and misuse of prescription drugs.

Although alcohol abuse and addiction disorders are increasingly recognized as a chronic relapsing condition that often spans decades and require multiple courses of treatment, 60% of the people with lifetime alcohol abuse and addiction disorders do eventually reach a state of sustained abstinence (Dennis, Foss, & Scott, 2007).

Using a personal faith based program is nothing new in the treatment of alcohol abuse and addiction; the 12-step program of Alcoholics Anonymous has been an integral part of many treatment plans. Using one's personal faith within therapeutic counseling sessions is new, and is proving to be a positive recourse for patient and therapist in promoting understanding, a "safe" atmosphere, and a strong patient – therapist connection.

Personal faith based wellness can be defined as "a continuing search for meaning and purpose in life; an appreciation for depth of life, the expanse of the universe, and natural forces which operate it; a personal faith system" (Meyers, 2000). Although treatment professionals involved in counseling and therapeutic management have agreed for quite some time that personal faith based wellness plays a major role in alcohol abuse and addiction recovery, investigations on the effects of personal faith and personal faith based wellness - as completely divorced from religiosity - are just beginning (Foskett, Marriott, & Wilson-Rudd,

2004). There are still populations that have not been fully recognized for their potential in improving their health through the use of personal faith based wellness counseling techniques, in particular among those suffering from chronic alcohol abuse and addiction (Rose, Westefeld, & Ansley, 2001).

Clinical Experience with Individuals diagnosed with Alcohol Abuse & Addiction

Interest in the concept of combining personal faith based concepts and the traditional medical model of treatment of an individual diagnosed with alcohol abuse issues comes from this author's own clinical experience in working with substance abuse patients as part of my recent internship at The Brattleboro Retreat in Brattleboro, Vermont.

My experience working at The Retreat in the Intensive Outpatient Program (IPO) and the Hospital Outpatient Program (HOP) consisted of processing intakes, treatment, and discharge planning for individuals who had recently undergone detoxification for substance abuse, either alcohol or drugs. The majority of these individuals were also dual diagnosed with co-occurring mental illnesses as well. Notably working with these individuals, I would refer to prior intake documentation and found that the question of personal faith was either left blank or was noted "none". Yet during therapy sessions and group discussions they often mentioned places, feeling, and thoughts that they utilized to calm themselves, relieve anxiety, and enable them to sleep. I found that when this

personal faith was explored with the patient it became a tool that the patient utilized in times of anxiety and cravings. I shared this finding with the treatment team and received positive feedback, many stating that they would explore this area with their patients in the future.

The objective of this study will be to investigate the use of personal faith based wellness in counseling to aid in recovery, improvement or development of coping skills for those who abuse substances and alcohol. By reviewing the available literature in depth, a model for application of personal faith counseling will emerge that can be recommended for future testing and examination. The database of this study is derived from the available literature. Although faith based wellness counseling has wide application, the focus of this thesis, centers on a limited range of populations – specifically, patients suffering from alcohol abuse and addiction. The idea is that personal faith based wellness may help such persons gain or regain a sense of wellbeing that goes beyond that of the traditional medical model, which focuses primarily on physical illness. The variables and measures included in the model will be those that have been found to be most useful in previous investigative research studies concerning personal faith based wellness in relation to health-promotion behaviors.

The thesis statement is: “Practitioners who include an individual’s personal faith in the treatment of their patients who suffer from alcohol abuse and

addiction have a more positive outcome than those who utilize a traditional medical model of treatment.”

Research Questions

As based in the overview of the problem and thesis statement presented above, a major research question has been formulated: *What are the key elements of successful personal faith based wellness rehabilitation programs, versus those of the traditional medical models of treatment in helping selected populations with recovery, improvement, or ability to cope and thus become productive members of society?* From this primary question, several important sub questions emerge. These may now be stated as follows:

1. What are the components of personal faith based wellness counseling and the traditional medical model in terms of techniques focused on recovery, improvement or development of coping skills?
2. Can a therapeutic counseling model be developed which incorporates the components of personal faith based wellness with the tradition medical model, that is predictive of overall health-promoting behaviors, and assist improvement and perception of quality of life?

Definition of Terms

Several common terms will be uniquely used in this study. The following are defined to convey the meaning that is intended within this body of

research:

Health Responsibility: This term is defined as paying attention to and accepting responsibility for one's own health, and educating oneself about health (Mechanic & Cleary, 2000). It also refers to exercising informed consumerism when seeking professional assistance. Waite, Hawks, and Gast (1999) report a positive relationship between personal faith well-being, health behaviors, and health responsibility.

Health-Promoting Behaviors: This designation refers to a multidimensional pattern of self-initiated actions and perceptions that serves to maintain or enhance the level of wellness, self-actualization, and fulfillment of the individual (Berger & Walker, 1997).

Traditional medical model: At the present time the mainstream model of illness is biomedical in nature. This approach focuses on the physical aspects of illnesses and treatment consists of stabilizing body systems and controlling the illness via pharmacologic means. The medical model also relies on current research to gain understanding and adapt treatment. The medical model does not focus on the patient's wishes and the patient is often not consulted on the course of treatment chosen (Aggleton & Chalmers, 2000).

Personal faith based wellness: A continuing search for meaning and purpose in life in the form of the adoption of a personal faith system. Components include connecting (feeling harmony, wholeness, and connection

with the universe), and developing (maximizing wellness by searching for a meaning and purpose in life).

Personal faith: This term is best defined by Shafranske and Gorsuch (1984) as “a deep sense of belonging, of wholeness, of connectedness, and of openness to the infinite” (p.233).

Substance Abuse: While there is no universally accepted definition of this term as applied to alcohol abuse and addiction, it generally refers to the excessive use of alcohol leading to abuse and addiction. According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* as published by the American Psychiatric Association (2000), such behavior is characterized by the use of a mood or behavior-altering substance in a maladaptive pattern. This leads to clinically significant behavioral impairment as, for example, inability to attend school or work, failure to fulfill social obligations, and/or use in places in which it is physically dangerous to do so or in ways which end in legal problems.

Religiosity: A devotion to an organized, specific set of beliefs and worship usually focused on a higher power outside oneself, while striving to adhere to its tenets.

Assumptions

Several important assumptions underlie the design and methods that will be used in this study: These may be listed as follows:

1. It is assumed that behavior is meaningful, can be understood, and can

be changed when practitioners incorporate components of an individual's personal faith in their therapeutic approach. However, change is a multifaceted complex phenomenon with numerous antecedents. It is composed of many dynamic variables in people and their environment. Its precise determination and measurement is difficult when only selected components are examined.

2. Individuals can influence their own health and life by behaviors that are associated with growth in feelings of personal faith. Some behaviors increase the severity and duration of illness and addictions. Others can be accepted as health-promoting behaviors since they enhance health and life, increase longevity, and make life fuller and more meaningful. It is assumed that growth in feelings of personal faith and behavior change rests within the individual, but the relationship is positive.
3. It is also assumed by this researcher that the documents, reports, journal articles, and research that have been included in the present study are representative of the majority of the literature reflective of the relationship between personal faith based wellness and recovery, improvement, or the development of coping skills among selected populations, namely those who are suffering from alcohol and substance abuse.

Limitations

Similar to other types of studies, several important limitations are also associated with a descriptive study such as the present investigation. These may be listed as follows

1. This study will only look at behavior change and perceived health status, self-efficacy, personal faith based wellness, and recovery or coping ability from alcohol abuse and addiction. Representative findings of the study are limited to the amount of data and research that were identified through the literature review. The study does not pretend to be an exhaustive compendium; rather, it is a representative sample.
2. In addition, limitations exist in using data from research studies already completed. Since the research was conducted by many individuals, results may differ in conclusions, findings, perceptions of change in behavior, and use of personal faith in counseling. In other words, the variables of interest in this study were measured in different studies in one way and at one point in time, they could lead to different results if studies from different approach at other times and other places.
3. Some studies have different definitions of the relationship between personal faith based wellness and preventive behaviors. The research may interpret wellness behavioral change for an example,

Dialectical Behavioral Therapy, from a traditional medical model rather than from a personal faith based wellness health-promoting perspective.

Significance of the Research

Personal faith based wellness, health and health-promotion are major concerns in today's society, given the significant increase in substance and alcohol abusive behaviors in recent years (Brome, Owens, Allen, & Vevaina, 2000; Leigh, Bowen, & Mariatt, 2005). Most researchers believe that many abusive behaviors could be reduced in severity, and positive coping behaviors can be acquired, by simply practicing a healthier lifestyle after acquiring a sense of wellness that goes beyond that of the traditional medical model which focuses primarily on physical components of illness (Brome et al., 2000; Miller, 2003).

Numerous empirical studies were found that examined determinants of health-promoting behaviors among populations such as the elderly, adolescents, women, minority groups, and lower socioeconomic individuals who suffer from substance and alcohol abuse. But no studies were found that identified components of a personal faith based wellness model in conjunction with the traditional medical model, and then created a compilation of supportive health-promoting studies as related to those particular populations. In summary, few studies were found by this researcher that specifically examined recovery, improvement, and the development of coping skills in relation to feelings of an

individual's personal faith growth through the employment of a personal faith based wellness counseling program and model. The exceptions to this are the 12-step program of Alcoholics Anonymous (AA) which includes a personal faith component not specific to any formal religious belief but in recognition of an individual's personal faith.

This investigation will extend the knowledge base concerning correlates of personal faith based wellness counseling, recovery, and health-promoting behavior by identifying components of a personal faith based wellness model. Results of this investigation may also support an existing model. This evidence will be an addition to the theoretical base of knowledge necessary for the generation and modifications of personal faith in counseling in terms of behavior modification related to health.

Facilitation of further research in personal faith based wellness counseling is another area that this study will impact.

This research also shows significant differences when economics of health care delivery are considered. Knowledge and understanding of human behaviors as impacted by personal faith based wellness counseling can be used by professional counselors to intervene effectively in motivating and supporting health-promoting behaviors. This, in turn, will lead to increased levels of health, decreased levels of relapses, and the development of related health problems, decreasing overall health care expenditures.

Organization of the Study

Chapter 1 serves to introduce the present study. It discussed the topic of concern, the background and significance of the problem, and the purpose. It also presents research questions, definitions of terms that were unique to the study, limitations, and assumptions.

Chapter 2 focuses on the research method and concept behind the study. Included in this section is a detailed examination of the theoretical orientation underlying the wellness approach to therapeutic counseling.

Chapter 3 presents the toll that alcohol abuse and addiction takes on the micro, (an individual), meso, (the community), and macro, (society). It presents statistics data on how overwhelming the effects of alcohol abuse and addiction are. What the costs are not only in dollars, but in lives affected.

Chapter 4 provides an overview of the traditional medical model of physical illness focusing on ongoing research and its implementation as well as current medical practices in the treatment of alcohol abuse and addiction and recovery.

Chapter 5 provides an overview of the faith-wellness model and reviews studies on personal faith in counseling. Also included are discussions on recovery from and coping with alcohol abuse and addiction.

Chapter 6 provides a model of personal faith based wellness as a basis for gaining or regaining overall wellness that can be used for future study. This

serves to integrate other components of wellness and the traditional medical model, thus making personal faith based wellness central to wellness in all other areas of life.

CHAPTER 2

CONCEPTS AND RESEARCH METHODS

Introduction

The initial chapter of this study provided the background of the problem of concern; defined terms uniquely used in the study, and listed the important research questions. It was noted that the purpose of this study is to examine the use of personal faith based wellness in counseling for those with alcohol abuse and addiction problems in terms of recovery, and to identify one or more models – perhaps a combination - that can be used in future studies for assessment purposes. The purpose of this section of the study is to present the research concept and discuss the inclusion of the theoretical framework of personal faith in treatment. This chapter also includes a discussion of the method that will be used to present and analyze the collected data, and the theoretical framework to which the following subsections are devoted.

Research Concept Theoretical Framework

The most important conceptual issue of this investigative research is to identify the relationship and the many ways in which personal faith is linked to health. The theory behind the present analysis relates to personal faith based wellness, and the hypothesis of the study proposes that including personal faith in therapy provides a more positive outcome. As previously noted, the thesis statement is that practitioners who include personal faith considerations in their

treatment of patients, in conjunction with the traditional medical model, – especially those with alcohol abuse and addiction problems – have a more positive outcome in terms of recovery, improvement, and ability to use coping skills. Before this study can link the relationship between personal faith and health, however, it is first necessary to make a distinction between personal faith and religion to outline the theoretical framework, and to describe the various aspects of personal faith growth, health behaviors, and personal faith therapy and evaluation.

Theoretical Framework

Personal Faith versus Religion

Personal faith factors are basically concerned with individual subjective experiences which are often shared with others, whereas religious dynamics center on prescribed beliefs, rituals, practices, with social institutional characteristics and features (Foskett et al., 2004; Miller & Thoresen, 2003). Personal faith has meaning to individuals when it refers to the transcendent dimension outside of material existence (Baker, 2003). While this dimension cannot be controlled, it can definitely be experienced (Miller & Thoresen, 2003). Personal faith does not necessarily involve the practice of a religion or a specific belief in a higher power. Religion, however, is defined by boundaries which are necessitated by the specific organization in question. In this context, religion can be considered to be an organized and structured search for that which is

considered divine. While personal faith beliefs can be a part of religious belief, personal faith can exist outside institutionalized religion. Religion and personal faith are not the same, but can co-exist.

Many people experience personal faith feelings through their religion and/or their own private relationship with a higher power. Some experience personal faith in nature or via music and the arts, or through a system of values and ethics or by the pursuit of science. Regardless, individuals who are very religious might have particular personal faith experiences such as feeling close to the divine, as well as mystical epiphanies. The personal faith based wellness model recognizes that such subjective experiences are associated with emotional health, and occasionally with deeply compassionate transformations of personality (Miller, 2003).

Personal faith has been defined in the literature as the relationship between body, mind, and emotions that allows people to be positively and creatively connected to themselves, to others, and to the surrounding world (Baker, 2003; Jankowski, 2000). It can exist within the individual and it is not necessary to believe it is somewhere outside the body or on a higher level (Kus, 1995). The impact of personal faith has an indirect impact to the outside world in the context of increased self-esteem, ability to make choices, and ability to take life responsibilities. The relationship of body, mind, and emotion within one's self

shapes the ability to relate to others, and to the personal faith power in the universe; however that power is conceived (Kus, 1995).

The importance of personal faith in human life is increasingly recognized, but is defined and interpreted in many different ways due to different frames of reference (Moberg, 2002). Frames of reference are based on philosophical systems of belief that may conflict with one another regarding the attributes of personal faith health and disease. Frequently, signs of personal faith based wellness agreeable to some groups are unsuitable to others with diverse values. All measurements of personal faith are complicated by an unavoidable reductionism. Scales meant to be universal thus experience many faults. According to Moberg (2002), adopting universal measures hinders meaningful collection of verifiable data.

Moreover, the validity of research regarding the relationship of health outcomes to personal faith is endangered by the lack of theoretical distinctions between religion and personal faith in the literature (Frey, Daleman, & Peyton, 2005). Traditional definitions of personal faith have tended to emphasize the ecclesiastical, and/or elements related to the soul (Fisher, Francis, & Johnson, 2000). Current research regarding personal faith assumes broader definitions incorporating all dimensions of human life (Fisher et al., 2000). The distinction between personal faith and religion must be made clear before presenting a model of personal faith based wellness that supports a universal, interdisciplinary

definition of personal faith that includes both religious and nonreligious viewpoints. Personal faith is a complicated multidimensional aspect of human understanding. It has cognitive, experiential, and behavioral dimensions. The cognitive elements comprise the search for significance, purpose, and truth together with ethics, faith, and morality that provide guidance for living (Sulmasy, 1999; Craigie & Hobbs, 1999; Anandarajah & Hight, 2001). The experiential elements include a sense of hope, internal peace, comfort, love, connectedness, and sustenance. These are part of one's inner resources. They provide the capability of giving and receiving personal faith love, and the kinds of connections experienced with the self, the community, the environment, and nature (Anandarajah & Hight, 2001; Sulmasy, 1999), as well as conceptions of a higher power, values, and/or cosmic consciousness. The manner in which an individual externally expresses personal faith beliefs and internal personal faith conditions evidences itself in terms of behaviors and actions.

Hodge (2003) examined the correlation between personal faith/religion and human maturity in terms of psychological health attainment as an adult. Variables included in the investigative study were the role of meaning in life, having a transcendent purpose, inherent values, and participation in a personal faith community. This researcher found a significant connection between personal faith and psychological health as an adult.

In contrast with personal faith based wellness, personal faith distress and crisis occur when people cannot find meaning in their lives, or lack hope, love, peace, comfort, strength and connectedness; or when there is a conflict between their values, faith, and life events (Anandarajah & Hight, 2001). This personal faith crisis can have a harmful impact on physical and psychological well being; physical ailments, death, and disasters often generate personal faith distress in patients, relatives and those in the role of caretakers.

Personal Faith Growth and Health Behaviors

Personal faith can be defined as follows: "...that which is personal faith is defined in diverse ways, usually as distinct from material reality as experienced by the physical senses. That which is personal faith is generally understood to transcend ordinary physical limits of time and space, matter and energy." (Miller & Thoresen, 2003). Personal faith growth is an individual's concern with increased development of inner resources achieved by transcending, going beyond who and what he or she is. There is a correlation between personal faith well-being and health behaviors that are discussed in a plethora of research reporting observer-determined health status, but much of this work is disease or illness oriented. Self-rated determinations of health status usually are oriented toward well being and the perception of wellness. This indicates that the self-rating method of health appraisal has a distinct advantage over other methods

when health promotion, rather than disease or illness, is the focus (Berger & Walker, 1997).

A research study examined subjects who were predominantly white, female subject, aged 25 or younger in the workplace setting using self-rated determinations of health status, the HPLPII instrument (Health Promoting Lifestyle Profile scale). It measured the frequency of self-reported health behaviors using a 52 item assessment for determining personal faith. Three of the HPLPII's six sub-scales (personal faith growth, health responsibility, and interpersonal relations) reflect the multidimensional definition for personal health and personal faith and were thus determined to be the more appropriate instrument for evaluative purposes. Of the group of participants in the study, 60% claimed they experienced personal faith growth, and almost all acknowledged that they attended church once in a while, with 14.5% attending church on a monthly basis (Waite et al., 1999).

The researchers concluded from their analysis that there was a moderate to small relationship between the psychosocial variable of personal faith health and health-promoting behaviors. However, a strong correlation was found when personal faith health sub-scales were combined into a composite measure and correlated to the composite health-promoting behaviors measure ($r = .665$). The general findings in the study indicated a number of interesting findings:

- women scored higher than men with respect to the personal faith health scores ($p = .0342$),
- white-collar workers scored higher than blue-collar workers with respect to the personal faith health scores ($p = .0731$),
- Subjects over age 26 scored slightly higher than those 26 or younger with respect to the personal faith health scores ($p = .0678$).

Unhealthy behaviors including the abuse of alcohol and substances (especially related to prescription drug misuse), depression, and life stresses have also been linked positively with lack of personal faith. Boswell, Kahana, and Dilworth-Anderson (2006), in their examination of healthy lifestyle behaviors and personal faith in older adults, found that unhealthy behaviors, stress, and depression significantly and negatively impacted feelings of well being. Hartz (2005), agreed, further noting that personal faith, healthy lifestyle behaviors, and mental health were strongly associated. The literature supports the relationship that personal faith based wellness overall has been empirically and theoretically inversely associated depressive symptoms. It is important to explain that despair and depression have been diagnosed and defined by the American Psychiatric Association (2000) as a mental illness and is measured in terms of severity of symptoms. Depression is a common component found in those who abuse alcohol and substances. It is unclear whether the alcohol and drugs are

responsible for the depression or/and the individual is attempting to self medicate with alcohol and drugs to relieve the depressive symptoms.

An additional link was found between personal faith and alcohol abuse and addictions, although few studies were found that specifically separated personal faith from religion. In general, however, there is agreement among addiction treatment professionals and counselors where personal faith plays a positive role in recovery from alcohol abuse and addiction (Hartz, 2005; Miller, 2003; Swinton, 2001; Waite et al., 1999). A search of the literature could find only a few treatment programs that directly address personal faith aspects of addiction. The most advocated and recognized of these was the 12-Step meetings of Alcoholics Anonymous (AA). Attendance in this entire particular program has been found to show a consistent relationship to abstinence from alcohol in recovering people as well as a marked decrease in the recidivism rate (Tonigan, Connors, & Miller, 2003). It is important to explain that personal faith is understood as a fundamental factor in both the development of and recovery from alcohol abuse and addiction within AA organizations.

Personal faith Therapy and Personal faith Evaluation

Personal faith therapy is defined by Anandarajah and Hight (2001) as acknowledging and responding to the multidimensional manifestation of personal faith health care provided by counselors and therapists. This therapeutic

approach includes compassion, listening, and encouraging reasonable hope, but usually does not include any mention of a higher power or formal religious beliefs and practices. Aspects of personal faith counseling may include praying, meditation, and spending time in natural habitats, among other strategies.

Although general personal faith therapy may be provided by any qualified health care worker, expert personal faith counseling often requires advanced study of personal faith, association with a particular theology, and the ability to resolve conflict. If possible it should be offered by an individual with an educational background in this area. Personal faith assessment should be part of the individual's overall initial assessment and should be included in the treatment planning focused on the patient's recovery.

A study has indicated that the stress-reducing impact of religious belief, personal faith, and wellness lifestyle changes on a correlation study of chronic alcohol abuse had a positive and lasting effect. Researchers used path analysis to evaluate the correlations in a stress suppressor and a distress deterrent model. Analysis revealed no suppressor effects but many distress deterrent relationships. Personal faith, physical exercise, and a healthy diet all added to greater feelings of health for those who were chronic alcohol abuse study participants. It was recommended that further research be performed to increase understanding of the dimensions of personal faith and the role in coping versus adaptation (Boswell, Kahana, & Dilworth-Anderson, 2006).

An increasing number of research studies indicate that mindfulness, thought to be an aspect of personal faith, and might be successful in treating a range of medical problems, such as chronic pain, depression, stress, and anxiety, all common co-occurring issues in alcohol abuse and addiction. (Leigh, Bowen, & Marlatt, 2005). Nevertheless, there are not many valid and reliable assessments of mindfulness. Leigh and colleagues (2005) investigated the following related variables: (a) the reliability and validity of an innovative measure of mindfulness, the Freiburg Mindfulness Inventory (FMI); (b) the correlation between mindfulness and personal faith, and (c) the correlation between mindfulness and/or personal faith and alcohol/tobacco use by college students ($N=196$). The study authors concluded that their findings supported the reliability of the FMI, while indicating that personal faith and mindfulness might be separate phenomena. Moreover, tobacco use and binge-drinking were negatively correlated with scores on personal faith. As personal faith scores rose drinking and smoking declined. Therefore, personal faith might be correlated with reduced use of these substances. In contrast, there was a positive correlation between mindfulness and smoking and drinking. The researchers recommended further investigation of this unexpected finding.

Brome, Owens, Allen, and Vevaina (2000) investigated personal faith and its relationship to the following healthy psychological outcomes among Black females in recovery from alcohol misuse: (a) positive self-concept and coping

style; (b) positive family attitudes, such as family climate and feelings about parenting; and (c) satisfaction regarding social support. Administering the Personal Faith Well-Being Scale to measure personal faith, the study authors used the median split method to divide a sample of 146 Black females in recovery from alcohol misuse into high and low personal faith groups. The study results revealed that females in the high personal faith group expressed a more positive self-concept, dynamic coping style, attitudes toward family climate, and parenting than females in the low personal faith group. Furthermore, the high personal faith group expressed greater contentment with their quality of life.

Summary

This chapter endeavored to provide delineation between personal faith and religiosity. It focused on the research method and concept behind selected studies. Included in this chapter is a detailed examination of the theoretical orientation underlying the personal faith wellness approach to therapeutic counseling.

CHAPTER 3

THE TOLL OF ALCOHOLISM

Alcohol abuse and addiction knows no societal, racial, economic or geographical borders. It can be found in every aspect of human existence.

Alcohol abuse and addiction takes its toll on an individual (micro), community (meso), and societal (macro) functioning. In this chapter I will present information on what these tolls are, in the lives of those affected, in the costs to society, and in the overwhelming of the treatment program resources that are available.

In Lives

Alcohol abuse and addiction are complex illnesses characterized by intense, uncontrollable drug cravings along with compulsive drug seeking and use that persists even in the face of devastating consequences. Alcohol abuse and addiction increases a person's risk for a variety of other mental and physical illnesses. Those related to a drug-abusing lifestyle and those resulting from the toxic effects of the alcohol itself on the body. Additionally a wide range of dysfunctional behaviors resulting from alcohol abuse and addiction can interfere with normal functioning in the family, the workplace, and the broader community, (National Institute on Alcohol Abuse and Addiction, 2007).

Alcohol is the most widely abused psychoactive drug in the United States

today, due to its legality, low cost, and societal acceptance. Alcohol can be consumed in various liquid forms: beer, malt liquor, wine, hard liquor (distilled spirits), and grain alcohol.

It takes the average drinker's body one hour to metabolize one drink. As the amount of alcohol consumed exceeds the body's ability to metabolize it, the user's blood alcohol concentration (BAC) increases, and he or she begins to feel the effects of alcohol intoxication. As one's BAC continues to increase, the user will experience successively higher levels of intoxication (University of Maryland, 2006).

According to the National Survey on Drug Use, (2009), alcohol use has been shown to be concurrent with other illicit drugs; this poses a serious public health concern. Alcohol users are more likely than their counterparts who did not use alcohol to use illicit drugs – 13.9 percent versus 3.8 percent.

Short-Term Effects of sustained alcohol abuse and addiction are (University of Maryland, 2006):

- Slowed reaction times and reflexes
- Poor motor coordination
- Blurred vision
- Slurred speech
- Lowered inhibitions and increase risk behavior
- Lowered reasoning ability, impaired judgment

- Memory loss
- Confusion, anxiety, restlessness
- Slowed heart rate, reduced blood pressure
- Heavy sweating
- Nausea and vomiting
- Coma
- Death from respiratory arrest.

A person who consistently uses alcohol over a period of time will develop a tolerance to the effects of drinking and will progressively drink more alcohol to achieve the same effects, growing in their dependence and their addiction.

Over time heavy drinking can cause permanent damage to the user's body and brain. The physical damage caused by sustained alcohol abuse includes (University of Maryland, 2006):

- Liver damage-cirrhosis
- Heart damage – coronary disease, high blood pressure
- Brain damage – lower cognitive abilities, destruction of brain cells
- Mental disorders – increased aggression, antisocial behavior, depression, and anxiety
- Damage to sense of balance – causing injuries from falling
- Bone damage – osteoporosis

- Pancreas damage
- Cancer – pancreas, liver, breasts, colon, rectum, mouth, pharynx, and esophagus.
- Sexual problems – reduced sperm count
- Menstrual difficulties – decreased fertility, early menopause
- Birth defects
- Drinking during pregnancy – low birth weight, risk for Fetal Alcohol Syndrome.

There has been a correlation between the age an individual first starts drinking alcohol and the development of dependence on alcohol. Persons reporting first use of alcohol before age 15 were more than 5 times more likely to exhibit the symptoms of alcohol dependence or abuse than those who reported using alcohol at age 21 or older (16% versus 3%) (NSDUH Report, 2004). The longer the exposure to alcohol abuse, the more likely it is that an individual will develop symptoms of long term abuse (see list above).

In Costs

Alcohol drains the United States economy 185 billion dollars per year, or 686 dollars per capita for every man, woman, and child living in the United States. Healthcare costs alone from alcohol-related problems amount to more than 26 billion dollars annually, (Marin Institute, 2006).

These figures indicate a level of severity, but they only represent two of

the statistics relating to the abuse of alcohol. Some others are noted from the Marin Institute (2006):

- Twenty-five to forty percent of all patients in U.S. general hospitals (excluding maternity and intensive care) are being treated for complications of alcohol-related problems.
- Annual health care expenditures for alcohol-related problems amount to 22.5 billion dollars.
- Untreated alcohol problems waste an estimated 186.4 billion dollars per year in health care, business, and criminal costs.
- Health care costs related to alcohol abuse are not limited to the user. Children of alcoholics who are admitted to the hospital average 62 percent more hospital days and 29 percent longer stays.
- Alcohol use by underage drinkers results in 3.7 billion dollars a year in medical care costs due to traffic crashes, violent crimes, suicide attempts, and other related consequences. The total cost for use by underage youth is 52 billion dollars.
- Alcohol related car crashes are the number one killer of teens. Alcohol use is also associated with homicides, suicides, and drowning – the next three leading causes of death among youth.

The cost of treatment programs is a source of debate among the

legislators; however the cost to parents, children, and families is immeasurable. Dollars and cents cannot measure the toll alcohol abuse and addiction takes on those whose lives have been touched by alcoholism.

Treatment Outlook

The ultimate goal of alcohol abuse and addiction treatment is to enable an individual to achieve lasting abstinence. According to the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use in 2006, 23.6 million persons aged 12 and older needed treatment for an illicit drug or alcohol abuse (9.6 percent of the persons aged 12 and older). Of these only 2.5 million or 10.8 percent of those who needed treatment received it in a specialty facility. Of those admitted 39.7 percent were for alcohol and another substance.

According to the National Institute on Drugs Abuse (2008), about 59 percent were white, 21 percent were African-American, 14 percent were Hispanic or Latino, and another 2.3 percent were Alaska Native or American Indian, and 1 percent is Asian/Pacific Islander. The other 2 percent fell into the "other" category. Untreated alcohol abuse and addiction add significant costs to families and communities, including those related to violence and property crimes, prison expenses, court and criminal costs, emergency room visits, healthcare utilization, child abuse and neglect, lost child support, foster and welfare costs, reduced productivity, and unemployment.

Scientific research has shown that treatment can help many people

change destructive behaviors, avoid relapse, and successfully remove themselves from a life of alcohol abuse and addiction. Recovery is a long term process and frequently requires multiple episodes of treatment. The key principles in the formation of an individualized, effective, treatment program are (NIDA, 2008):

- No single treatment is appropriate for all individuals. Culture, race, and individuals preferences must be considered.
- Treatment must be readily available and within an individual's ability to pay.
- Effective treatment attends to multiple needs of the individual, not just his or her drug addiction.
- An individual's treatment plan must be assessed often and modified to meet the person's changing needs.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Cost covered for virtually all effective treatments for addictions.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
- Treatment does not need to be voluntary to be effective.

Detoxification, followed by medication and behavioral therapy, are usually the first steps in treatment. Education in relapse prevention and establishing

family and community supports within the individual's environment then follow.

One of the most recognized supports within an individual's community is Alcoholics Anonymous, (AA). AA's 12-step program and peer support have proven very effective in maintaining sustained abstinence.

CHAPTER 4

TRADITIONAL MEDICAL MODEL

Introduction

This chapter focuses on the traditional model for the treatment of alcohol abuse and dependence currently used within the medical field. The chapter will first focus the neurobiology of alcohol abuse and addiction and then on the current research being conducted in neurobiology to understand what part our brain plays in abuse, addiction, and drug seeking behaviors. Secondly the chapter will focus on the current supports the medical field provides in the form of help with detoxification and medication to help an individual obtain and sustain abstinence in his or her environment.

Medical Definition of Alcoholism

The journal of the American Medical Association defines alcoholism as a “primary, chronic disease characterized by impaired control over drinking, preoccupation with the drug alcohol despite adverse consequences, and distortions in thinking” (Morse & Flavin, 1992).

Addictive behavior associated with alcoholism is characterized by compulsive preoccupation with obtaining alcohol, loss of control over consumption, and development of tolerance and dependence, as well as impaired social and occupational functioning. Like other addictive disorders, alcoholism is characterized by chronic vulnerability to relapse after cessation of

drinking. To understand the factors that compel some individuals to drink excessively, alcohol research has focused on the identification of brain mechanisms that support the reinforcing actions of alcohol, and the progression of changes in neural function induced by chronic ethanol consumption that lead to the development of dependence. More recently, increasing attention has been directed toward the understanding of neurobiological and environment factors in susceptibility to relapse, (Weiss & Porrino, 2002).

Genetics of Alcoholism

The risk of developing alcoholism depends on many factors, including genetics and the environment. Those with a family history of alcoholism are more likely to develop it themselves; however, many individuals have developed alcoholism without a family history of the disease. Since the consumption of alcohol is necessary to develop alcoholism, the prevailing attitudes towards alcohol in an individual's environment affect their likelihood of developing the disease. Current evidence indicates that in both men and women, alcoholism is 50-60% genetically determined, leaving 40-50% for environmental influences, (Dick, & Bierut, 2006). Environmental influences are varied and can range from the role alcohol plays within the home to peer pressure, and to self medication when the inability to cope arises.

Neurobiology and Alcoholism

To understand the factors that compel some individuals to drink

excessively, alcohol research has focused on the identification of brain mechanisms that support the reinforcing actions of alcohol and the progression of changes in neural function induced by chronic ethanol consumption that lead to the development of dependence. More recently increased attention has been directed toward the understanding of neurobiological and environmental factors in susceptibility to relapse, (Weiss, Friedbert, & Porrino, 2002).

Excessive drinking can lead to impairment of cognitive function and structural brain changes. The latter can be studied using human autopsy material and/or animal models.

Translational studies (the combined use of human subjects and animal experimentation) on the effects of alcohol on the human brain are being conducted. Human studies provide a full depiction of the consequences of chronic alcohol exposure, but they are limited by ethical consideration for experiments involving controls of relevant variables. Animal models, on the other hand, can distinguish components of the addiction processes but cannot fully represent the human condition. Together, studies in humans and animals have provided support for the involvement of specific brain structures over the course of alcohol addiction, including (Zahr, & Sullivan, 2008). The following areas of the brain are currently the focus of the addiction process by researchers:

- Prefrontal cortex – executive functioning, decision making
- Basal ganglia – initiates voluntary movement

- Amygdala – involved in fear and emotion
- Hippocampus – plays a role in learning and memory
- Cerebellum – movement control center
- Hypothalamic-pituitary – adrenal axis – implicated in anxiety and affect disorders.

Recent research focusing on brain arousal, reward, and stress systems is accelerating our understanding of the components of alcohol dependence and contributing to the development of new treatment strategies. A major goal of basic research on alcoholism is to understand the neural underpinnings of alcohol use, and to define the pathological progression to alcohol dependence

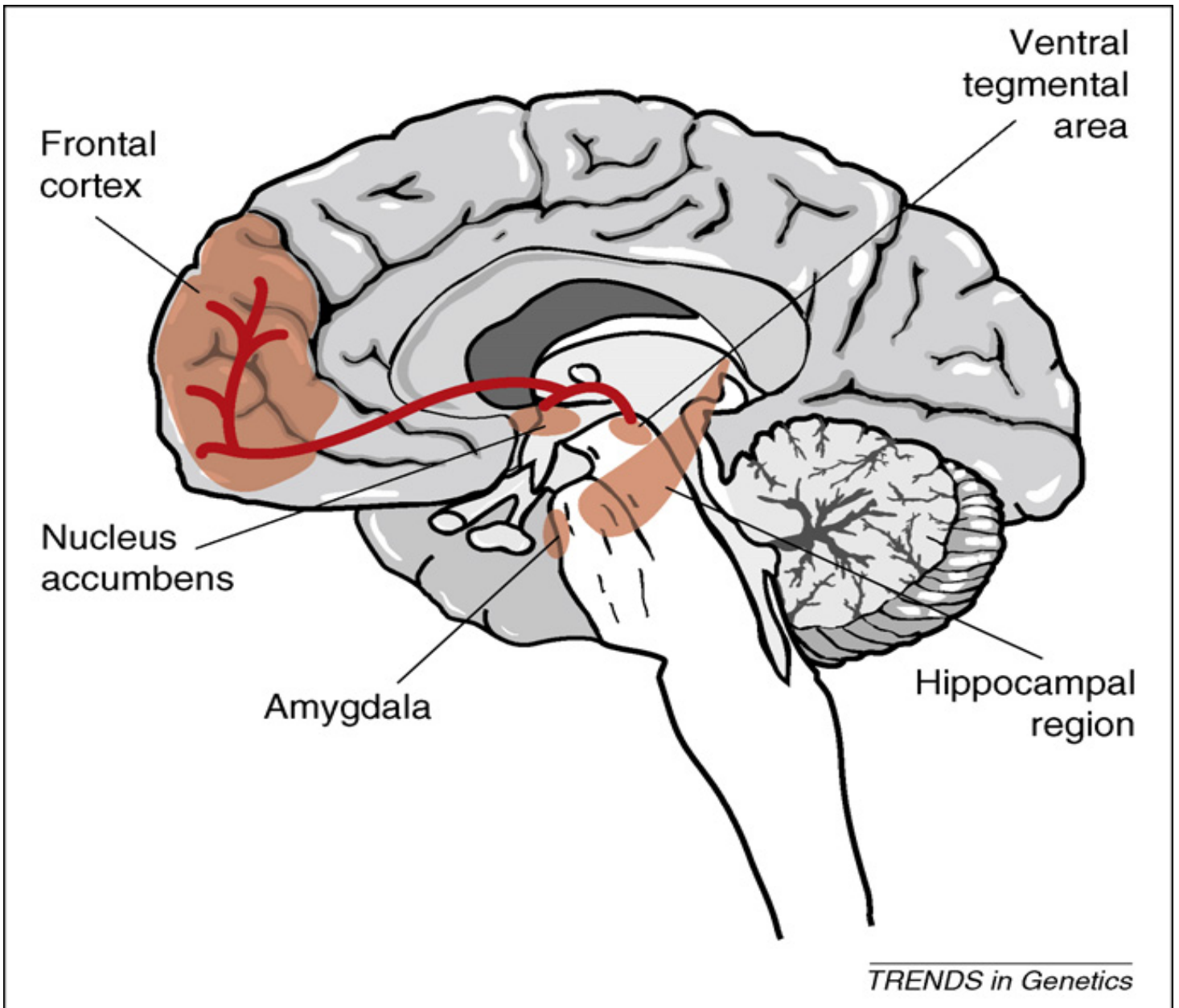
The positive reinforcing effects of alcohol generally are accepted as important motivating factors in alcohol drinking behavior in the early stages of alcohol use and abuse. The mesolimbic dopamine pathway is the neural system which plays a central role in the reward circuits of the brain, those circuits provide the positive reinforcement felt by the consumption of alcohol (See figure 1 on page 41). Dopamine is a neurotransmitter (brain messenger) primarily involved in this mesolimbic system. When alcohol is consumed dopamine is released and a feeling of pleasure is felt. Unfortunately, as this system adjusts to the amount of alcohol consumed, it takes more consumption of alcohol to achieve the same dopamine reaction, leading to tolerance abuse and dependence (Gilpin, & Koob, 2008).

This system, the mesolimbic dopamine pathway, is also involved in arousal and stress, and along with other brain systems is currently the focus of brain research to further elucidate its connection with alcoholism.

Effects of Alcohol on Children's Brains – Prenatally

Children prenatally exposed to alcohol can suffer from serious cognitive deficits and behavioral problems, associated with alcohol-related changes in brain structure. Neuropsychological studies have identified deficits in learning and memory as well as in executive functioning both in children with fetal alcohol syndrome and in children with less severe impairments. Both groups of children also exhibit problem behaviors, such as alcohol and drug use, hyperactivity, impulsivity, and poor socialization and communication skills. Brain imaging studies have identified structural changes in various brain regions of these children. These regions include the basal ganglia, corpus callosum, cerebellum and hippocampus and may account for the cognitive deficits. Functional brain imaging has also detected changes in alcohol-exposed children indicative of deficits in information processing and memory tasks (Mattson, Schoenfeld & Riley, 2005).

Figure 1: Mesolimbic pathway of the brain.



Determination of Severity of Problem

The diagnosis, heritability, etiology (genetic and/or environmental factors), pathophysiology, and response to treatments (adherence or relapse) of drug dependence were found to have a genetics component along with personal choice and environmental factors. This provided further evidence that drug (including alcohol) dependence is an organic chronic medical illness (McLellan, Lewis, O'Brien & Kleber, 2000).

Physicians use various tools in screening a patient who they determine might have an alcohol abuse or addiction problem. Some of the following screening tools are used for this purpose:

The CAGE questionnaire is the most commonly used screening used to indicate that a problem with alcoholism may exist. It asks the following questions (Ewing, 1984):

- Have you ever felt you needed to Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt Guilty about drinking?
- Have you ever felt you needed a drink first thing in the morning (Eye opener) to steady your nerves or to get rid of a hangover?

The Alcohol Dependence Data, Questionnaire is a more sensitive diagnostic test than the CAGE test. It helps distinguish a diagnosis of alcohol

dependence from one of heavy alcohol use.

The Michigan Alcohol Screening Test (MAST) is a screening tool for alcoholism widely used by courts to determine the appropriate sentencing for people convicted of alcohol-related offenses.

The Alcohol Use Disorders Identification Test (AUDIT) is a screening questionnaire developed by the World Health Organization. This test is unique in that it has been validated in six countries and is used internationally.

The Paddington Alcohol Test (PAT) was designed to screen for alcohol related problems among those attending Accident and Emergency departments.

Treatment Options

Treatment options differ due to individual choice, economics (those with insurance or means and those without), geographic location, and severity of the addiction. Those with the financial means usually go to a facility such as the Betty Ford Clinic where they receive individualized treatment and anonymity. If an individual has insurance or limited economic means they usually go to facility such as the Brattleboro Retreat, where I recently interned. There they go through a detoxification process, receive individualized and group counseling and can be given pharmaceutical drugs to ease symptoms and promote abstinence. Some individuals are coerced into detoxification through our legal system after committing offences related to the use of alcohol, and others seek treatment because of a family or work problem that has arisen from their alcohol abuse

and/or addiction; and others go through treatment in hopes of taking control of their lives again.

Some individuals foolishly try to detoxify from alcohol on their own.

Alcohol detoxification differs significantly from most other drugs in that it can be directly fatal.

Five percent of cases of acute (long-term alcohol consumption) alcohol withdrawal episodes experience delirium tremens, also known as “DT’s”. Of these five percent, 35% will be fatal if untreated and 5-15% if treated (National Library of Medicine, 2008). Delirium tremens’ symptoms can range from confusion, disorientation, agitation, and hallucinations, usually visual. Other symptoms include severe autonomic instability, fever, tachycardia, and hypertension.

All alcohol detoxification should be done in a medical setting.

Pharmacology

Medications are usually the next step in treatment. They provide a stabilizing effect as well as a support in maintaining abstinence. The following are currently the drugs approved by the FDA for that purpose:

Disulfiram (Antabuse): causes a severe adverse reaction when someone taking the medication consumes alcohol.

Naltrexone (Revia and Depade): suppresses the euphoric feeling; users experience sluggish and sedative effects of the alcohol consumed, rather than the usual stimulative effect.

Acamprosate (Campral): reduces the physical distress and emotional discomfort usually experienced when alcohol use is discontinued.

The use of these drugs has been shown to be highly effective in combination with counseling in helping individual achieve and sustain abstinence (National Association of State Alcohol Addiction Directors, 2001).

Chapter Summary

In this chapter I have presented the traditional medical model for the treatment of alcohol abuse and addiction. First, the focus was on the neurobiology of alcohol abuse and addiction, and then on the research being conducted to identify the neurobiology of the disease.

In this chapter the focus was on the present research conducted on understanding the neurobiological mechanisms that support the reinforcing actions of alcohol and the progression of changes in neural function induced by chronic alcohol consumption that leads to the development of dependence. Areas of the brain were discussed, namely the arousal, reward, and stress systems and their role in the development of new treatment strategies.

Next, was a discussion on the effects of alcohol abuse and addiction of an unborn child whose mother drinks alcohol during her pregnancy.

Finally, presented were treatment options currently used in the detoxification, maintenance, and long term abstinence were presented as well as the medical implications of the treatment process.

The medical model is an important part of the treatment plan, supporting individuals through detoxification and treatment as well as providing the needed support when they return to their environment.

However, this model is not always accepted by those who are suffering from alcohol abuse and addiction. Some examples are; for personal reasons, (denial of the existence of a problem), religious, (Christian Scientist who use prayer and do not use medical interventions), and those who have little or no trust in the medical establishment as a whole.

The medical model is an important tool in an alcoholic's recovery and should be available to all who wish to use it, regardless of sociological or economic standings.

CHAPTER 5

PERSONAL FAITH BASED WELLNESS MODELS

Introduction

In general, the personal faith based wellness models are an orientation toward health care that pays attention to the many non-medical factors and variables that affect an individual's health and well being (Breuleux, 2005). According to this model, the health care provider considers many alternatives for preventing and curing chronic conditions, such as alcohol and substance abuse. This includes improving overall health, and the development of coping ability skills. Specifically, the following principles are embodied by the personal faith based wellness model:

1. The health care provider offers an impartial, suitable application of personal faith based wellness practices that rely on evidence-based therapy in the treatment setting;
2. The health care provider endorses a cross-disciplinary orientation to client care, based on informed consent and sustained decision making between the health care provider and the client;
3. The personal faith based wellness models create a foundation for interaction and cooperation between the conventional medical model and complementary therapies, with the chief aim of promoting optimal health and wellbeing.

4. The personal faith based wellness approach endorses the development and application of professional standards for wellness therapy across medical disciplines.

Models of Faith Based Wellness

The personal faith based wellness models implies that medical intervention is only one element involved in restoring their overall wellbeing. It emphasizes the inclusion of positive therapy such as use of support systems, recognition of patient strengths, and promotion of health, dealing with the reason for symptoms and natural therapy, personal faith, and feeling healthy as motivation for the health care client (Armentrout, 1993).

From the perspective of distinct fields of study, Howden (1992) and Westgate (1996) independently developed similar models of the general theory of personal faith based wellness.

From the perspective of counseling, Westgate (1996) examined research in counseling, psychology, and medical wellness literature. These elements were identified from seven major publications (Banks, 1980; Chandler, Holden, & Kolander, 1992; Meyers, 2000) that had extensively investigated and discovered elements of what constituted personal faith based wellness in counseling research. In summary, the four major concepts identified by Howden (1992) included the following: (a) The purpose and meaning of life, (b) internal resources, (c) transcendence, and (d) positive interconnectedness.

Briggs, Apple, and Aydlett (2004) offered precise definitions with examples of the four elements of personal faith based wellness. First, according to these scholars, the meaning and purpose of life is described as a search for or involvement in activities and/or associations that increased feelings of personal importance, optimism, and motivation for living. Next, internal resources referred to reliance upon one's own inner strength and self-direction, attaining peace with the uncontrollable via an inner sense of peace, and turning inward for direction (Howden, 1992). Transcendence means going beyond the individual ego (Maslow, 1971) as well as changing one's main emphasis from self to that of other people and the wider world (Chandler et al., 1992). Finally, positive interconnectedness referred to affirmative feelings of connection to one's self, others, and all life forms with the possible inclusion of a deity (Howden, 1992).

Anandarajah and Hight (2001) also support a universal, interdisciplinary definition of personal faith. They assert that personal faith is a complicated multidimensional aspect of human understanding; it has a cognitive, experiential, and behavioral dimensions. The cognitive elements comprise the search for significance, purpose, and truth together with ethics, faith, and morality that provide guidance for living (Craigie & Hobbs, 1999; Anandarajah & Hight, 2001). The experiential elements encompass a sense of hope, love, connectedness, internal peace, comfort, and sustenance. These attributes are part of one's inner resources, the capability of giving and receiving various concepts love, and the

kinds of associations and connections experienced with one's self, the community, the environment and nature (Anandarajah & Hight, 2001). The element of behavior refers to the manner in which an individual externally expresses personal faith beliefs and internal personal faith conditions.

Heaton, Schmidt-Wilk, and Travis (2004) make a distinction between pure personal faith and applied personal faith. Pure personal faith is a silent, limitless, inner experience of pure self-awareness, lacking thought and emotion. Applied personal faith conceptualizes the area of measurable applications and results that emerge from the inner experience of pure personal faith conceptualization. On the other hand, Jankowski (2002) believes personal faith consist of three dimensions. These may be listed as follows:

1. The cognitive,
2. The metaphysical,
3. The relational.

The cognitive element incorporated in this model refers to one's existential values and beliefs. The metaphysical component, on the other hand, includes the region of personal faith experiences beyond the individual's ability for rational knowledge. Finally, the relational area concerns the sense of connectedness among individuals, nature in general, and the cosmos itself. Pargament (1997) adds the specific definition of personal faith as locating, preserving, and transforming the sacred aspect in one's life.

Empirical Research

The movement toward compassion and connectedness in personal faith based wellness models used for the treatment of alcohol abuse and addiction has been investigated in a number of research studies. For example, in their research on personal faith as incorporated in personal faith based wellness model within medical practice found that it would benefit from using the HOPE question as a practical tool for personal faith assessment. Anandarajah and Hight (2001) found that personal faith is a complicated multidimensional aspect of human understanding. Most addiction treatment programs incorporate a cognitive, experiential, and behavioral dimension. The experiential elements of personal faith encompass a sense of hope, love, connectedness, internal peace, comfort, and sustenance. These attributes are part of one's inner resources and the kinds of associations and connections experienced with oneself and the community that aid addicts in seeking treatment, sustaining abstinence, and completing treatment. (Anandarajah & Hight, 2001).

Fisher and colleagues (2000) advocated evaluation of personal faith based wellness in terms of four domains of health involving one's self, community, environment, and belief in a higher power. They supported this perception of personal faith based wellness with data gathered from 311 teachers in the United Kingdom. From this data, they developed The Personal faith Health in Four Domains Index (SH4DI). This instrument offers a general

index of personal faith health and differentiates among the following four distinct personal faith based wellness viewpoints:

- Personalists: one intra-relates with oneself with regards to meaning, purpose, and values of life.
- Communal: inter-personal relationships between self and others relating to morality and culture.
- Environmental: the notion of unity or connectedness with the environment.
- Transcendental: relationship of self with some-thing or some-One beyond the human level that involves faith toward, adoration of and worshipping of the source of Mystery of the universe.

The Role of the Medical Practitioner in Personal Faith Based Wellness Models

Medical doctors can start to integrate an individual's personal faith in the following three ways (Meyers, 2000):

- Conducting and reviewing scientific research regarding the connection between personal faith and wellness.
- Evaluating the patient's personal faith concepts and diagnosing whether personal faith is assisting or hampering with feelings of shame or guilt, within a patient's recovery from alcohol abuse and addiction.

- Including the patient's personal faith in their treatment plan and discussing the inclusion with the patient.
- Being conscious and open to the inclusion of any personal faiths derived from a cultural and/or racial source.

Challenges of Integration

It is not easy to provide integration of a patient's various beliefs systems due to the dependence on beliefs within their cultures, race, and life experience, it can, nonetheless, be achieved by working with the patient in an open minded, accepting manner. A critical element in the process is the requirement that the health care provider understands his or her own personal faith, values, and biases in order to stay patient-centered and tolerant when treating the personal faith needs of their patients. The need to be nonjudgmental is particularly important when the values of the patient differ from those of the doctor. An overwhelming concern of counselors incorporating personal faith into their therapy is that some practitioners lacking appropriate training might inflict their own values on their clients without carefully evaluating the case (Purdy & Dupey, 2005). For instance, a religious counselor might erroneously advocate his or her own religious beliefs while trying to help a nonreligious, but personal faith individual.

When an individual is experiencing difficulty their flow of personal faith energy might be blocked, interfering with effective functioning. For instance, if a

client is experiencing an emotional crisis, his or her personal faith oriented energy becomes focused upon the immediate crisis, draining energy from other life tasks. At this point, the individual might become aware that he or she does not have the personal faith tools to deal with the issues involved in the crisis, such as the death of a loved one, the termination of a relationship, the unexpected loss of a job, or the onset of disease. This is a pivotal period in which an individual might turn to alcohol to cope. Moreover, as a result of the crisis, the client might not be caring for his or her physical health or might have failed to continue to enjoy nature. In such a case, other life tasks and personal faith elements are abandoned or unnoticed.

Strategies

An additional strategy to assist clients to examine their personal faith involves requesting them to describe what personal faith signifies for them as individuals, and to reflect on other interpretations of personal faith. The aim of this strategy is to assist clients to broaden their view of personal faith to supply alternative methods for developing personal faith in them and in their journey through life. On the other hand, constructing meaning from mortality is extremely difficult for most human beings. Normally, people begin to think about what related health issues, resulting from chronic alcohol abuse, have meaning for them only when until they become an issue effecting their lives.

One approach that can be used by the counselor is requesting a client to reflect on whom they would turn to for help and support in recovery. Many individuals suffering from alcohol abuse and addiction have isolated themselves; some have alienated friends and family. The goal in this case is to help them identify the possible consequences of continued alcohol abuse as well as the resources available to them to achieve abstinence and recovery of their health.

Personal Faith in Counseling

First, many people experience personal faith feelings through their religion or their own private relationship with a higher power. On the other hand, some individuals experience personal faith in nature or via music and the arts, or by a system of values and ethics or the pursuit of science. Individuals who are very religious might have particular personal faith experiences such as feeling close to the divine as well perhaps involving mystical epiphanies. The personal faith based wellness model recognizes and addresses these kinds of subjective experiences that are often associated with emotional health, and occasionally with deeply compassionate transformations of personality (Miller, 2003).

Second, personal faith based wellness models can address and help resolve personal faith distress problems as well. In contrast with personal faith based wellness, personal faith distress, and a crisis can transpire when people cannot find meaning, hope, love, peace, comfort, strength and connectedness or when there is a clash between their values/faith and incidents in their life

(Anandarajah & Hight, 2001). Alcohol abuse and addiction with resulting physical ailments frequently generate personal faith anguish in patients and their relatives. Learning to cope is an important part of the healing and recovery process. Personal faith incorporated within therapy can help in acknowledging as well as responding to the multidimensional manifestation of personal faith beliefs, including those related to a cultural or racial practices, that health care providers may observe in their clients and their relatives. This therapeutic orientation encompasses compassion, being there, listening, and encouraging reasonable hope, while it might not include any mention of higher power or religion it can and should include the personal faith of their patient such as: praying, meditation, interpreting scripture, attending religious services, religious artifacts, specific cultural norms, listening to music, hiking, spending time in natural habitats, etc. These are important components in bringing about both coping and healing.

Third, personal faith based wellness models - through their concentration on general personal faith assessment should be the method used by healthcare providers to identify a client's personal faith needs in relation to medical therapy; however, expert personal faith assessments frequently requires comprehension and assistance with particular theology and conflicts. If possible such counseling should be offered by an individual with an educational background in this area, such as individuals trained to be Clinical Pastoral Education (CPE) chaplains.

The discussion above only provides a few of the more important reasons for the selection of personal faith based wellness models to create the compilation present in this chapter. After the compilation is created to organize and summarize studies related to component classifications, studies are placed within the appropriate category, followed by a summary discussion for each. These data are used to answer the questions and hypotheses posed in the first chapter. Also included are discussions on recovery from and coping with alcohol and substance abuse.

Methodological Considerations

Koenig, McCullough, and Larson (2001) believe that part of the problem with assessments in the use of personal faith as a coping behavior stems from the use of the method itself as chosen by researchers to assess subject perceptions and beliefs. They identify three types of assessment methods: ask open-ended questions, provide a list of different coping strategies and then ask subjects to choose those that have been most helpful, and directly ask patients whether they use religion to cope with health problems. Of these, providing a list is the preferred manner and technique because it provides subjects with a bit more information about what types of coping strategies are of interest to the researchers and also gives respondents permission to acknowledge other personal faith based coping methods – those that are not considered to be mainstream - if they have been found to be helpful.

According to Koenig (1994), personal faith and religious faith promotes the mental health of individuals, especially those who are aging and begin to suffer from physical challenges resulting from a lifetime of chronic alcohol abuse and addiction. Not only does faith provide hope for change and healing, it also represents a model for overcoming human suffering. Koenig (1994) adds that a focus on interpersonal relationships, a supportive community, promise of an afterlife, seeking forgiveness of oneself and others, and a sense of control reflect positive cognitive perspectives and emotional states that are conducive to individual adjustment .

Personal Faith in Counseling

Reported in the literature and further noted by Stanard, Sandhu, and Painter (2000), there is an accumulation of much evidence in recent years that personal faith assumes an important role in treating both psychological and medical conditions, thus it has become an important topic for counselors. "Assessment can assist both the counselor and client in obtaining a better understanding of the role of personal faith in the issues that bring the client to counseling and in designing treatment interventions appropriate for resolution of those issues" (p. 204). Hill and Pargament (2003) agree, adding that personal faith and religious measures of coping are stronger predictors of outcomes of stressful situations than traditional, generic measures of religiosity (e.g., frequency of prayer, frequency of attendance at religious services, and religious

salience). They also concluded from their study that general personal faith and religious beliefs/practices have to be translated into specific forms of coping when individuals are faced with stressful life events such as chronic alcohol abuse and addiction combined with any related illness, for example. It is these specific coping methods that appear to have the most direct implications for an individual's health during such stressful conditions.

Hill and Pargament (2003) further caution, however, that while the dimensions and categories of personal faith have been identified and measured, adequate volumes of research robustly connecting personal faith and health is still lacking. They point out that "Unfortunately, much of the conceptual and empirical work from the psychology of religion has not been well integrated into research on the connection between religion, personal faith and health" (p. 64) Levin (2002) agrees, noting the importance of exploring the personal faith-healing connection in his work on faith, health, and cultural/racial specific beliefs.

Clearly, personal faith coping has emerged in the literature as an important strategy for dealing with a broad range of health concerns, ranging from alcohol abuse and addiction, resulting disabilities and terminal illness. The studies described briefly above indicate that personal faith is frequently used during times of medical or psychiatric illness. Of interest is the fact that the use of personal faith among all populations, young and old, increases with the severity of the life stress or illness in question. This would indicate that the

human trend is to turn increasingly toward personal faith as a means of recovery or coping as chronic alcohol addiction progresses. It has also been shown that increased personal faith provides a significant moderating effect on depression resulting from addiction. In fact, personal faith has become a way of being for many addicts in dealing with stress and depression.

A study conducted by Delaney (2005), whose participants had chronic alcohol abuse and addiction was conducted with the purpose of developing, assessing, and improving the psychometric attributes of the Personal Faith Scale (SS). Its goal was to further assist personal faith used in therapy. Delaney (2005) administered the SS to 240 adults with chronic alcohol abuse and addiction. From his assessment of the data, the researcher concluded that his study results could help facilitate the incorporation of personal faith in health care treatment. Moreover, they could offer a transformative vision for the nursing profession and a method of obtaining optimal health outcomes and abstinence rates, allowing patients to move toward compassion and connectedness to self and others.

The investigative research briefly described above only examined a few of the many studies that have used components of personal faith based wellness models to assess individuals with various illnesses resulting from alcohol abuse and addictions. Time allocated for the present research and length restrictions make it impossible to adequately cover the various model components as applied

to patient's conditions. However, the studies that have been included in the discussion above clearly display a positive pattern of benefit. When applied to individuals or groups with illness resulting from alcohol addiction and abuse, positive findings result. In summary, using the components of personal faith based wellness models serves to improve attitudes, feelings of control and self-worth, and purpose, thereby leading to increased coping skills and sometimes to better overall health.

Components of Personal Faith based Wellness Models and Application

By reviewing the available literature in depth, it was believed by this researcher that a model for application would emerge – one that could be recommended for future testing and examination. Before such a model can be recommended, however, it is first necessary to summarize the major components of personal faith based wellness models that currently exist in order to answer the study's research questions, as posed in the initial portion of the research. Studies related to the use of major components of personal faith based wellness models in counseling situations need to then be reorganized and summarized under each individual category in a comprehensive, usable format.

. The major categories of therapy, as supported in the available literature, include the following: meaning and purpose in life, inner resources, transcendence, and positive interconnectedness (Briggs et al., 2004; Chandler et al. 1992; Howden, 1992; Ingersoll, 1994; Myers et al., 2000; Westgate, 1996).

These have been specifically identified to include the following:

- meaning, purpose in life,
- belief in a universal force
- faith
- positive inter-connectiveness
- capability of giving and receiving personal faith
- transcendent beliefs and/or experiences that may include a sense of a higher power.

In addition, there are four domains of health involved in the personal faith based wellness models. These involve one's self, community, environment, and higher power (Fisher et al., 2000). The domains, however, are not being taken into consideration at the present time.

Table 1 on the following page provides a compilation of studies using the major categories of personal faith based wellness models to assess patient populations. The Purdy and Dupey's (2005) model was chosen for its inclusion of major categories of a holistic, personal faith based wellness model that were fluid in their vision of the spirit . Westgate's (1996) model, especially the positive interconnectedness that refers to affirmative feelings of connection to self, others, and all life forms, was selected because of the way it reflects personal faith in its best definition. Anandarajah and Hight's (2001) were chosen for its category - the capability of giving and receiving personal faith love.

This will be further discussed in the following chapter when a new model of personal faith based wellness – one that combines the more important model elements and is driven by the situational environment - is proposed

It is also important to explain that each investigation that relates to a major category is listed under that category heading. Thus, each study is placed in an appropriate category. Studies include date of publication and a brief note of findings related to the variables within the category. These data provide the information to answer the research questions as presented and discussed in the following section.

Table 1

*Major Components of Personal Faith based Wellness model for Counseling
Therapy*

Model Category (Dimension)	Research Studies (Publication Date)	Illness/Addiction or Disability
Belief in universal force (religious orientation)	Brome et al. (2000) Gorsuch (1995)	Alcohol abuse Alcohol abuse
Purpose/meaning of life	Miller (2003)	Alcohol abuse
Faith	Arnold (2003) Brome et al. (1991) Tonnigan et al. (2003)	Alcohol abuse Alcohol abuse Alcohol abuse
Positive inter- connectedness (closeness to Higher power)	Delaney (2005) Koenig (1994) Westgate (1996)	Illness/addiction Aging disability/ Alcohol abuse Alcohol abuse
Transcendence	Levin (2002) Miller (2003)	Illness/addiction Addiction
Capability of giving/receiving Personal faith	Arnold (2003) Leigh et al. (2005) Resnick et al. (2005)	Alcohol abuse Subst. abuse Alcohol abuse

Self-efficacy

One of the benefits of personal faith based wellness consultation is increased self-efficacy. In other words, those who seek personal faith direction in the form of this type of consultation experience more positive outcomes because their feelings of self efficacy (i.e., the belief that one is capable of acting or performing in a certain way) increase. This is best explained by the classic theory of Bandura (1986) that; an individual's belief in his or her capacity affects what courses of actions that are chosen. How much effort will be mustered in a given endeavor, and how long will that person will continue in the face of obstacles and failures? It also influences changes in thought patterns of the self-aiding form and how much stress individuals will allow them to experience in coping (Bandura, 1986). Thus, when perception of self efficacy improves, regardless of the situation, coping skills and health behaviors improve.

It is important to explain that the self-efficacy mechanism plays a central role in human agency – that is, the individual's psychosocial functioning. How individuals behave and the emotional reactions they experience within treatment and recovery is elements of this functioning. Bandura explains that "Thought affects action through the exercise of personal agency. People use the instrument of thought to comprehend the environment, to alter their motivation, and to structure and regulate their actions. The experiences flowing from their

actions, in turn, affect the nature of their thought” (Bandura, 1986).

But the strength of self-efficacy determines the extent of the individual’s coping effort (Bandura, 1986). If people have strong efficacy expectations, they will keep working at a task against great odds and in the face of many obstacles – especially recovery from alcohol abuse and addiction which has a high incidence of relapse. If they have weak expectations, they will quickly give up the task when difficulties arise. Increased feelings of personal faith improve their motivation to continue forward.

Techniques used in Counseling, a Comparison

There are a number of techniques that can be employed by counselors and practitioners. The more important of these include the following: (Meyers, 2000)

- use open-ended questions, example, body language and tactile clues and/or overtly ask questions,
- administration of survey questionnaires,
- conduct one-on-one interviews,
- patient journaling
- administer previously published and validated personal faith scales (ones that include model components listed above),
- focus group discussions/forums, and
- small group counseling

Myers (2000) suggests the practitioner or counselor follow a four-step procedure. The first step is to introduce the model to the client and include a life span focus in the application of the model. Next, the practitioner or counselor should conduct a formal or informal assessment, as based on components of the selected model. The third step is application of intentional interventions of selected model components to enhance wellness feelings. The fourth step is to evaluate progress, then schedule a follow-up. Upon the findings of the follow-up, the four steps may be again repeated. Practitioners should also review their notes and findings before sessions. This serves to clarify counselor and patient expectations, as well as to gauge progress and permit the practitioner to address difficulties under controlled conditions.

The personal faith based wellness model, on the other hand, regards each patient as an individual whose perspectives and desires are critical to treatment (Borsay, 2000). It does not advocate evidence-based practice for effective treatment. Because this model pays attention to many variables that affect health and well being, the healthcare provider can consider many options for addressing alcohol abuse and resulting chronic or terminal disease, improving health, and/or developing coping ability skills to deal with addiction and resulting health issues (Breuleux, 2005). The personal faith based wellness model creates a foundation for interaction and cooperation between the practitioner and

the client, encourages feelings and expression of personal faith, and emphasizes cognitive, metaphysical, and relational therapy. Also consideration for the expression of an individual's personal faith practices (particularly those related to cultural and racial diversity) must be addressed. It has been explained that the cognitive element involves the individual's existential values and beliefs. The metaphysical refers to personal faith experiences, the relational pertains to the sense of connectedness among the self, others, the wider community, and nature in general. The personal faith concept aspect of the treatment plan helps the patient locate, preserve, and transform the personal faith aspects in his or her life (Pargament, 1997).

Personal faith based wellness practitioners begin by evaluating the patient's personal faith and diagnosing personal faith distress. It is necessary to know whether personal faith variables are assisting or hampering patient healing. Once this is determined, the counselor can include personal faith in the treatment of their patients. Thus therapeutic intervention includes attention to a client's personal faith when making suggestions about prevention, medical therapy, and treatment. Fundamentals of universal personal faith therapy are integrated into the customary medical interaction between doctor and patient.

To better identify the dissimilarities between the traditional medical model and personal faith based wellness model approaches, a table was constructed. Table 2 on the following page provides this information. As indicated, the steps

used by the health provider when applying the traditional medical model approach versus the personal faith based wellness approach are detailed.

Table 2

*Approach Differences: Traditional medical model vs. Personal faith based wellness model**

<u>Medical Approach</u>	<u>Personal faith based wellness Approach</u>
Assess biomedical aspects of condition (anatomical, bio-chemical, physiological malfunction)	Assess personal faith and personal faith distress before assessing patient illness/addiction condition.
Uses illness orientation to health care that emphasizes the structure and function of the body.	Uses orientation toward health care that emphasizes many factors affecting health, including personal faith needs
Patient not involved in decision making or treatment selection	Patient completely involved in decision making and treatment
Focus on specific condition (addiction)	Focus on whole person (internal/ external) personal faith and addiction
Customary medical interaction trust between doctor and patient	Fundamentals of universal personal therapy are integrated into customary medical interaction.
Doctor's uses medication as a basis for treatment	Therapeutic intervention includes patient's personal faith as important part of treatment in conjunction with pharmacology.
Health care providers do not need to understand their personal faith, values or biases when treating patients	Health care providers need to understand their personal faith, values, biases in order to stay patient-centered and tolerant
Does not incorporate personal faith In treatment planning	Incorporates the dimension of personal faith in treatment planning, counseling therapeutic help

*compiled from a number of different studies

Chapter Summary

The purpose of this chapter was to provide additional literature regarding the role of personal faith in counseling, more importantly, identifying components from personal faith based wellness models, and to create a compilation of these models. It was noted that the personal faith based wellness models recognize subjective experiences of personal faith that are generally associated with addiction, related to emotional and physical health, behavioral changes, alleviation of resulting medical issues, and occasionally with deeply compassionate transformations of personality (Miller, 2003).

The first section provided additional studies and research that used personal faith based wellness model components to assess alcohol abuse and addiction populations or to evaluate components of the model itself via the use of alcohol addiction populations. The majority of these studies investigated one or more of the following categories (components): the belief in a universal force, the need to find meaning and purpose in life, making meaning of death, and general feelings associated with personal faith. All studies attested to the increase of positive attitudes, improvement in coping skills, and improvement in health behaviors among those individuals who acquired or already had greater feelings of personal faith. While the additional studies review was quite limited, the general findings from the thirteen studies included in the review were quite conclusive. When aspects of personal faith were applied to individuals or groups

with mental illness and/or addictions and substance abuse, positive findings result.

The second major section of this chapter identified important components of personal faith based wellness models and provided a compilation – that is, a listing of studies that supported the various categories. The compilation lists the researchers, date of publication, and type of population addressed. It was explained that Purdy and Dupey's (2005) major categories of a holistic personal faith based wellness model were those selected for inclusion in a revised model. This revised model also included elements from Westgate's (1996) model, and Anandarajah and Hight's (2001) category - the capability of giving and receiving personal faith.

The compilation represents a combination of categories (dimensions) from three personal faith based wellness models. Each is interrelated to the other. In the model proposed in the following chapter of this study, a revised personal faith based wellness model takes into consideration the overarching or driving influence of alcohol abuse and addiction treatment and supported recovery.

It must also be taken into consideration that the inclusion of personal faith in counseling would not be welcomed by all. For some, personal faith is considered a private matter. They would not be receptive to personal faith's inclusion outside their realm of personal experience. In these cases, a counselor must be respectfully conceded to their patient's wishes.

CHAPTER 6

CONCLUSION, RECOMMENDATIONS, AND DISCUSSION

Introduction

Previous portions of the present research presented modular components of the study. This chapter combines these separate modules into a unified whole. It provides a modified personal faith based wellness model – one that incorporates both the traditional medical model of treatment and a compilation of the personal faith based wellness models into a modified model that can be used in conjunction with the traditional medical model providing a more comprehensive treatment program.

Recommendations for further study are provided. Recommendations focus on suggestions for future studies of a similar nature, as well as on areas of concern deemed important in the light of the modified model.

Modified Model Presentation

This section of the concluding chapter provides a modification of the personal faith based wellness model that can be used as a basis for gaining or regaining overall wellness when integrated with the traditional medical model. This model can provide the basis for future study. The model serves to present an integration of a modified personal faith based wellness model with those of the traditional medical model of medical treatment for individuals diagnosed with alcohol abuse and addiction.

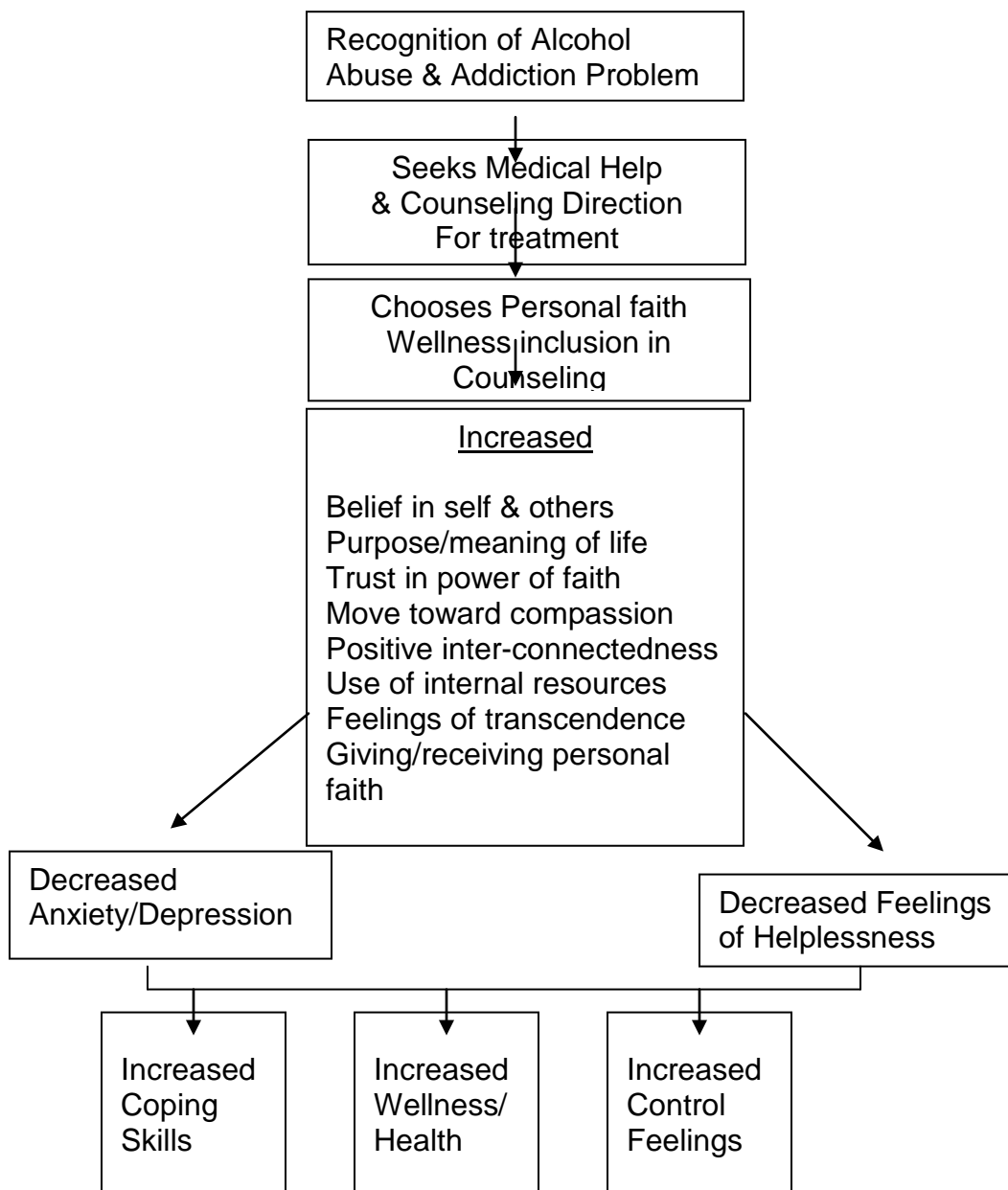
Components (categories or dimensions) of this modification include a combination of those from the models developed by three former researchers (Anandarajah & Hight 2001; Purdy & Dupey, 2005; Westgate, 1996) Figure 2, on the following page, presents the modified model that is suggested by the findings of this study for personal faith based wellness counseling resulting in behavioral changes leading to recovery from and sustained, long term absence from alcohol abuse and addiction.

As noted in the flowchart diagram, the first step is the recognition of the alcohol abuse and addiction problem and the need to seek treatment. This then leads to a personal decision to use personal faith based wellness model in conjunction with traditional medical treatment. As a result of this decision, an individual may experience increased feelings about one or more of the following: belief in self and others; purpose/meaning of life; trust in the power of faith; positive inter-connectedness with self, others and the community at large; use of internal resources in acquiring; feelings of transcendence; and giving as well as receiving personal faith.

Decreased feelings of helplessness, powerlessness, depression, and anxiety are some of the effects the patient will experience as a result of acquiring more positive feelings of personal faith. Acquisition of these, in turn, will increase coping skills and feelings of control, in addition to changes in the patient's wellness and health behaviors and feelings. The modified model thus provides

a flow from top to bottom – that is, from realizing the need to seek treatment, making a choice to include the aspect of personal faith as a treatment tool used in conjunction with medical treatment, and ultimately feelings of increased coping abilities.

Figure 2: Modified Model for Personal faith based wellness Counseling



Conclusions

On the basis of the findings from the literature review analysis and development of an integral personal faith based wellness model, the present research investigation has reached several important conclusions. First, this researcher agrees with conclusions reached by Hill (2003) regarding the need to discover more about the distinctive contributions of personal faith and well-being. According to Hill (2003), such discovery can be achieved “through measures of personal faith more conceptually related to physical and mental health” (p80). According to the findings of this study, more discoveries can be achieved through the application of a personal faith based wellness model that flows from one stage to another, rather than those that are presented as static components.

It was also concluded from the present in-depth review that personal faith based wellness is indeed a complex topic, especially as pertains to developing a personal faith based wellness consultation model. Although this study has only been able to provide a somewhat broad treatment of the topic, nevertheless it was found that model development must start with identification of the need of the patient to seek treatment. The patient, doctors, and counselors must work in coordination in order to provide a treatment plan that reflects the wishes, strengths, and availability of the patient and his/her environment. The patient's preferences must be considered and valued in this process. Treatment must flow seamlessly from one stage to the next, from medical intervention, to

counseling, to environment supports. Subsequently, it was explained how an integral model can be used to organize that flow while showing what precipitates and drives the need for personal faith based wellness counseling. A model such as the one suggested in this study will allow counselors and health care providers to assist patients to find meaning, balance, and satisfaction in their lives, especially when facing such adverse circumstances as alcohol abuse and addiction.

Findings from the present study also lead to the conclusions that, similar to the views and research of Myers (2000), personal faith based wellness models serve to both enhance and provide remedial intervention. As best explained by Myers (2000), it is through the use of such models that “counselors can assist clients in the process of assessing their wellness ...and in developing wellness plans to facilitate positive growth and change across the life span” (p. 262).

Recommendations

In an effort to apply the findings of the study and the modified personal faith based wellness model, the following recommendations have been formulated:

1. The author of the present investigative study recommends exploring in more detail, the motivational and behavioral change aspects of personal faith based wellness counseling models that

are based on specific techniques or psychotherapeutic theories, such as cognitive or humanistic theories. Where possible, empirical, rather than theoretical research would be most desirable and would further add to the existing body of knowledge concerning models and processes of personal faith counseling. This would also assist counselors who incorporate personal faith, practitioners, and health care providers in their day-to-day work with patient counselees, especially those experiencing, multiple relapses in chronic alcohol abuse and addiction.

2. Additional research is also needed to determine the most effective strategies for change to enhance wellness with respect to each dimension (component) of the personal faith based wellness model. In addition, the interactions of dimensions of personal faith based wellness needs to be identified to determine which has an impact on another. Such studies were not found during the literature search for the present investigation. As recommended by Myers (2000), the influence of culture, race, and gender also needs to be investigated in relation to the application of the stages of any proposed personal faith based wellness model. Assessing differences and similarities among groups and individuals from different countries as well as those present in our population, would

provide new insights about the influence of age, gender, race, and culture.

3. Although studies included in the present research strongly support the positive effects of personal faith based wellness counseling for those suffering from alcohol abuse and addiction, when used in conjunction with the traditional medical model of treatment, more research needs to be conducted to support this finding. Thus, it is recommended that future research conduct follow-up studies, but on a broader scale with regard to the amount of research reviewed, sample size and diversity of sample group. This would almost certainly yield greater insight and perhaps an even closer convergence with the findings of the present research. Such future investigation may also serve to further validate the findings of this study.
4. Another potential area for research is to apply the modified personal faith based wellness model on a specific population, age, or culture and administer a published personal faith scale, assess the results in relation to the severity of the alcohol abuse and addiction, and then empirically evaluate the results. Such a study would serve to support the motivational orientation of the modified model. Such research would provide further insight to personal

faith counselors about the appropriate counseling direction to use with clients.

5. There are also several areas of future research that would advance understanding of resilience and development of coping skills.

Empirical longitudinal studies of patient populations suffering from alcohol abuse and addictions should be conducted to determine how life stressors affect individuals, families, and/or groups over time. It would also be of interest to compare individuals versus groups in terms of resilience and coping ability after receiving personal faith based wellness counseling. Further study is also recommended on differences in facing families based on factors of ethnicity, race, geography, gender, and religious affiliation, and the similarities or differences with which these groups express resilience, undertake behavioral change, and learn to deal with illness/disability problems in their everyday lives.

6. Finally, it is recommended that counselors assess their own feelings about various components of the proposed model before applying it to clients. Concepts of hope, change, forgiveness, and reconciliation have the same definition of all people, regardless of the philosophical approach of the model and whether or not the model advocates separation or integration of personal faith and

psychology. Counselors must first understand their own feelings and views before they can influence the views and progress of others.

Discussion

The purpose of this study was to support the inclusion of personal faith wellness counseling in conjunction with the current medical model of treatment by those involved in support and care of individual's suffering from alcohol abuse and addiction. I believe this study presents a valid argument for its inclusion.

It is also important to note the medical model provided insight into ongoing research into the neurobiology of alcohol abuse and addiction. Discovering the biological causes and maintenance of continued alcohol abuse in the face of negative consequences would be an important step in providing pharmaceutical support as well as medical interventions into the disease of alcoholism.

Social workers, as well as others in the helping field, would benefit from further study and training of personal faith inclusion in their treatment of individuals with substance abuse issues. All too often in the field of mental health a person's faith, whether tied to an institutional practice, cultural or racial in origins or a belief system unique unto its own, has been ignored by practitioners. It is time that we recognize that this personal faith is a tool to use in the "healing process" within a therapeutic setting. This exclusion may be a "safe" way for a practitioner to proceed, but it is costly to our patients. This tool

(personal faith) can provide our patients with crucial support during a time of transformation, especially during the restructuring of their thoughts and habits that abstinence can involve.

Each of these models separately and thus in conjunction, may not be acceptable to some for various personal reasons, however; there are many who would benefit from the model I have proposed in this chapter that uses the traditional medical model in conjunction with a personal faith model of care.

I have witnessed the hopelessness that is all too common in chronic alcohol abuse and addiction. I have encountered patients many of whom have experienced multiple relapses. I believed when I started this study and I still believe at its conclusion, that the inclusion of their personal faith in their treatment in conjunction with the current tradition medical model would make a positive difference in their treatment outcome.

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