Brazilian Journal of Psychiatry
bjp
Revista Brasileira de Psiquiatria

Braz J Psychiatry. 2023 May-Jun;45(3):274-279
doi:10.47626/1516-4446-2022-2984
Brazilian Psychiatric Association

SPECIAL ARTICLE

Guidelines for integrating spirituality into the prevention and treatment of alcohol and other substance use disorders

Alexandre de **Rezende-Pinto**, Alexander **Moreira-Almeida**

Núcleo de Pesquisas em Espiritualidade e Saúde, Faculdade de Medicina, Universidade Federal de Juiz de Fora, Juiz de Fora, MG, Brazil.

Alcohol and other substance use disorders are complex problems with multiple variables and determinants, requiring a multidimensional approach to prevention and treatment. A robust body of research shows that religiosity and spirituality (R/S) play a prominent role in these disorders; however, how to apply this knowledge remains unclear. We present practical guidelines on how to integrate R/S into substance use prevention and treatment in an ethical, evidence-based manner. These guidelines have been endorsed by prominent academic leaders in these topics and by health associations affiliated with the three major Brazilian religions. The integration of R/S is part of a respectful, person-centered, interdisciplinary approach, which imposes neither religious beliefs nor secular worldviews. The most critical interventions include collecting a history of spiritual and religious beliefs, practices, and experiences and evaluating how these may be used positively in treatment. It is also essential that health professionals are encouraged to value and respect the R/S of patients, and that religious groups recognize that professional and technical interventions can make a valuable contribution to preventing and treating these disorders.

Keywords: Spirituality; prevention; treatment; alcohol; substance use

Introduction

Religiosity and spirituality (R/S) can play an important role in the prevention and treatment of alcohol and other substance use disorders. It is crucial to keep in mind that these elements are complementary, and one should never overlook the importance of multidisciplinary treatment within the health system.

Particular care must be taken to avoid imposing religious or secular worldviews. R/S may be unimportant to many patients, and this must be respected. Any approach should be person-centered, which may entail taking a history of spiritual and religious beliefs, practices, and community, their relevance (if any) to that specific person, and how they can be used positively in treatment.

The interaction between the multidisciplinary, professional approach and recognition of the importance of R/S should be a two-way street. This means that health professionals should appreciate and respect patients' R/S in the same way that religious groups should recognize that technical and professional measures make a valuable contribution to prevention and recovery.

The use, misuse, and dependence of alcohol and other drugs and the bio-psycho-socio-spiritual dimensions

Disorders caused by the use, misuse, and dependence of alcohol and other drugs are becoming more and more of a public health problem. According to the Global Burden of Disease Study, the use of alcohol, for example, constitutes one of the main risk factors for the morbidity and mortality worldwide, and its consumption was the leading risk factor for mortality in 2016 in the 15 to 49 age group, being directly responsible for 10% of all deaths.[1]

The problems arising from the use of alcohol and other substances are complex and caused by a multitude of factors: biological (e.g., genetic predisposition, innate tolerance), psychological (e.g., impulsivity, novelty-seeking, and low self-esteem), social (e.g., living in an environment where substance use is rife), and spiritual (e.g., the loss of existential meaning, regarding oneself as a sinner and being banished by God). Thus, finding protective factors against substance use continues to represent a major challenge, as is finding socially attainable, cost-effective, evidence-based interventions that can contribute to addressing and treating these issues.

Correspondence: Alexandre de Rezende-Pinto, Rua Célia Marcos de Freitas, 120/1501, CEP 36025-060, Juiz de Fora, MG, Brazil.
E-mail: rezendepinto@yahoo.com.br
Submitted Nov 30 2022, accepted Jan 16 2023.

How to cite this article: Rezende-Pinto A, Moreira-Almeida A. Guidelines for integrating spirituality into the prevention and treatment of alcohol and other substance use disorders. Braz J Psychiatry. 2023;45:274-279. http://doi.org/10.47626/1516-4446-2022-2984

One review study demonstrated that a problematic pattern of alcohol use accompanied by clinically significant impairment or suffering is present in around 14% of American adults over the course of a year; however, only 8% of these individuals reported utilizing some form of treatment.[2]

Therefore, an effective approach to the treatment and prevention of problems related to substance use needs to consider all of the abovementioned aspects as part of a bio-psycho-socio-spiritual approach.

The aim should be to reduce negative factors and increase positive ones in each of these four dimensions of the individual. Unfortunately, often only one of these dimensions is tackled, to the detriment of the others – whether by emphasizing the use of medication alone, or only psychotherapy or social aspects, or focusing solely on spiritual aspects. Here, we shall address aspects related to R/S, but the fundamental importance of the other aspects for effective treatment and prevention must always be borne in mind.[3] There has been a growing recognition that aspects of R/S are important variables in understanding the etiology and treating substance-use disorders.[4] Recently, the International Society of Addiction Medicine (ISAM) published a guideline reviewing the evidence and introducing recommendations on how spirituality can be incorporated into the study and clinical practice of substance-use disorders.[5] The state government of Minas Gerais, Brazil, has included R/S as a prevention and treatment factor in its *Plano Mineiro*, or Intersectoral Plan for the Care/Treatment and Prevention of the Use/Misuse of Alcohol, Tobacco and other Drugs (Plano Mineiro Intersetorial de Cuidados/Tratamento e Prevenção do Uso/Abuso de Álcool, Tabaco e outras Drogas).[6] The present guideline stems from the *Plano Mineiro* and expands on it, notably concerning guidance on practical application. It is based on the best available evidence. It has been endorsed by many Brazilian and international academic leaders in substance use, the interface between spirituality and mental health, and by associations of health professionals representing the three major Brazilian religious denominations (see the Endorsements section).

The role of religiosity and spirituality (R/S) in substance use, misuse, and dependence

Definitions of R/S have been widely debated. For the purposes of these guidelines, we define spirituality as the ''relationship or contact with a transcendent realm of reality that is considered sacred, the ultimate truth or reality'' and religion as the ''institutional or communal aspect of spirituality, as a shared set of beliefs, experiences and practices related to the transcendent and the sacred.''[7]

R/S is an important human dimension, with 84% of the world's population and 92% of Brazilians reporting a religious affiliation. In Brazil, 83% consider religion to be very important to their lives and more than a third attend a religious service at least once a week.[8] Thousands of studies have shown the importance of R/S for physical and mental health. Overall, individuals with higher levels of R/S have higher levels of wellbeing and quality of life, as well as lower rates of depression, all-cause mortality, suicide, and substance use/misuse.[7,9]

One of the most consistent findings has been the strong association between higher levels of R/S and lower use/misuse of alcohol and other drugs. Around 85% of the 278 studies into the relationship between R/S and alcohol consumption, and more than 80% of those 185 concerning the use of other drugs, found that R/S provided a protective effect.[10] Interestingly, around 70% of the abovementioned studies were carried out on adolescents, university students, and young adults, the age groups with the highest risk of initiating – and developing problems related to – substance use. Two studies conducted in Brazil may be used as an example: in a sample of 12,000 university students, those who had no involvement with R/S were twice as likely to have used licit or illicit drugs, within the previous month, than those with R/S involvement.[11] Out of more than 500 inpatients with crack dependence, having had greater R/S involvement between the ages of 15 and 17 halved the chances of developing a severe craving, of starting use before the age of 18, and of incarceration.[12] In a large U.S. study, adolescents' religious attendance and prayer/meditation were significant predictors of lower licit and illicit substance use after 8-14 years of follow-up.[13] Thus, R/S has consistently shown itself to be an important protective factor in the general population concerning the use/misuse of alcohol and other drugs.

The factors through which R/S may act, resulting in less use/misuse of substances, include giving meaning to life and suffering, optimism, appreciation of the body as a divine gift, emphasis on family structure and coexistence, social support, interactive groups, provision of models of socialization in which substance use is absent, an explicit condemnation of the use of substances, involvement in voluntary work, and the practice of prayer, meditation, and R/S readings.[10,12]

There is also consistent evidence of the role of R/S in the treatment and recovery of people with problems resulting from substance use. In a study of patients with crack-cocaine dependence cared for at an Alcohol and Drugs Psychosocial Care Center III (Centro de Atenção Psicossocial de Álcool e outras Drogas [CAPS AD III]), higher levels of R/S were associated with greater self-efficacy for abstinence and longer periods of abstinence throughout life.[14] Twelve-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) possess pronounced spiritual aspects. A fundamental element of this approach is the premise of the existence of a ''Higher Power'' and the search for a ''spiritual awakening'' through the 12 steps, which involve prayer and meditation. A recent Cochrane review of 27 studies and 10,565 individuals showed that participation in AA is as effective as than the most effective psychotherapies (such as cognitive-behavioral and motivational interview therapies), or even more so, obtaining 21% higher abstinence rates after 1 year.[15] The most recent American Psychiatric Association (APA) guideline for the treatment of alcohol use disorder included 12-step therapy among the evidence-based treatments.[16]

The positive impact of mutual help groups on public health can be very high. For example, a study carried out with 39,089 people in the United States found that 9.1% had recovered from drug and alcohol problems. Of those who overcame the problem after seeking some form of help, 45.1% participated in mutual-help groups, 27.8% received professional help, and 21.8% attended recovery support services (including religious services). In other words, most of those who recovered did so by looking to mutual help and recovery groups, which usually incorporate aspects of R/S.[17]

Therapeutic communities (TCs) are a further example of the use of R/S resources in the treatment of substance-related disorders, as they normally use the 12-step model and very often have a connection with religious institutions. Though limited, there is some evidence that TCs may be effective as a psychosocial engagement, particularly for patients with severe dependence, who are inured to the approaches adopted by outpatient clinics.[18]

Considering the high prevalence of R/S in the population and its well-established impact on health, various professional associations have recommended the inclusion of R/S in prevention and treatment,[19] including the World Psychiatric Association (WPA)[20] and the Brazilian Society of Cardiology (BSC).[21] R/S should be addressed by health professionals, regardless of their religious or antireligious position. The key point is that the approach should focus on the patient, i.e., what matters is the patient's values, beliefs, and wellbeing. The goal is to identify and stimulate the positive aspects of people's R/S, which should be done in combination with the other biopsychosocial factors.[7]

Some core guidelines for the ethical, evidence-based integration of R/S into the prevention and treatment of substance use/misuse have been developed and are available.[5,7,19,20,22-25] The examples provided below are based on the R/S characteristics of the majority of the Brazilian population,[8] but in practical application should always be adapted to the sociocultural peculiarities and R/S of whichever individual or group is the focus of the approach.

Core guidelines for ethical, evidence-based incorporation of R/S into the prevention and treatment of substance use/misuse

Collecting the patient's spiritual history – identifying the patient's R/S resources (practices and beliefs that he/she holds and groups in which he/she participates) that may help with prevention or treatment

The most well-established application of R/S in daily clinical practice is the taking of a spiritual history. The spiritual history should gather information about patients' R/S, their life experiences, and determine what role R/S plays in their current problems.[26] FICA is a brief questionnaire that takes just 3-5 minutes to complete and is helpful for clinical practice in general.[27] Below are some practical examples of questions to explore the four R/S aspects covered by FICA (Box 1).

The professional must observe an open-minded, non-dogmatic approach, with genuine interest and respect for patients' beliefs, values, and experiences. Moreover, the patient may be asked to explain how his religious community sees the problem he is experiencing and how this may influence – positively or negatively – the way he copes with difficulties.[28]

In the case of non-spiritual patients, instead of focusing on spirituality, the professional can ask how the patient copes with the disease, what gives meaning and purpose to his/her life, and what cultural beliefs might impact his treatment. In these cases, it is also worth exploring potentially negative experiences that might have driven the patient away from R/S.[19]

Encouraging the use of positive R/S resources that the patient (in the case of treatment) or people in general (in the case of prevention) possess

It is essential that the approach focuses on the patient – in other words, what matters are the patients' values, beliefs, and wellbeing.[19] Professionals should not use their position to proselytize spiritual or secular worldviews; they must always respect and be sensitive to the spiritual

Box 1 FICA Questionnaire

F – Faith/belief
- Do you consider yourself religious or spiritual?
- Do you have spiritual or religious beliefs that help you cope with problems? If not, what gives you meaning in life?

I – Importance
- What importance does spirituality have in your life?
- Has your spirituality ever influenced you in coping with stress or health problems?
- Do you have any particular belief that might affect medical decisions or your treatment?

C – Community
- Are you part of a religious or spiritual community?
- Does it give you support, and if so, how?
- Are communities like churches, temples, centers, or support groups important sources of support?

A – Action in treatment
- How would you like me, as your healthcare professional, to address the question of religiosity and spirituality in your treatment?

and religious beliefs and practices of their patients and their patients' families and caregivers.[5] The focus is to help the patient bring their habits (including drinking) into line with their goals and values, which requires them to be aware of what their goals and values are and how they can be achieved.[29]

The information obtained from the spiritual history will help determine the therapeutic approach. If R/S beliefs and practices, as well as the support of the religious group, are or have been useful to help the patient cope with stressful situations, then it is appropriate to encourage or support them.[30] For example, prayer is often referred to as helpful in coping with drug cravings.[31] In this sense, for many patients, meditation, reading, watching programs, or listening to R/S-related music may also be useful coping tools.[30] Beliefs about the meaning of life and suffering, along with hope, self-value, forgiveness, and self-forgiveness based on R/S, are also frequently reported by patients.

From a more community-based perspective, attending religious meetings (mass, prayer groups, etc.) and engaging in volunteer work may provide a social support network and social interaction models not based on the use of alcohol or other drugs, not to mention they can frequently provide role models of people who have overcome substance use.[28]

There is consistent evidence from systematic reviews of randomized clinical trials that R/S beliefs and practices can be integrated into psychotherapy, generating good results and good acceptance by patients, including those with substance use problems.[32,33] One such R/S strategy that could be incorporated is the question of cognitive distortions and dysfunctional beliefs, using religious arguments acceptable to the patient. For example, the Christian patient who may feel forsaken by God and who finds it impossible to rehabilitate himself may reflect on the parable of the prodigal son or lost sheep. Forgiveness, hope, gratitude, and generosity may also be cultivated through daily religious practices. Support may also be given to positive, religious coping strategies, such as trying to find God's teachings in the problems/challenges faced, a collaborative posture ("I will do my best and leave the rest to God"), asking forgiveness for one's mistakes, etc.[30]

Bio-psycho-socio-spiritual approach to the individual, using approaches from all of these dimensions

For more effective treatment and prevention, all available, effective resources must be used.

- Biological: medication (when required), healthy diet, physical activity, etc.
- Psychological: psychotherapy, psychoeducation, etc.
- Social: encouragement of family and social relationships and healthy leisure activities
- Spiritual: supporting the use of positive R/S resources that the individual may possess.

Partnership with R/S based community resources (e.g., AA, NA, sobriety pastoral care services, support groups, etc.) as one aspect of a comprehensive approach to treatment

In parallel with conventional treatment, patients should be encouraged to take part in mutual help groups.[16]

Two-way partnership with R/S communities: 1) identify patients with substance use problems and refer them to health services for treatment; and 2) welcome and support patients being treated in the health services

Spiritual aid would also help patients being treated in the community or in hospitals.

Religious beliefs may conflict with treatment prescribed by professionals. For instance, some patients may feel that resorting to conventional treatment might be an admission of having little faith. Moreover, the individual might believe that God does not care for him and that he is being punished – so-called negative religious coping. Individuals may feel angry at or wronged by God. There is evidence showing that people who face spiritual struggles are more likely to experience problems with alcohol consumption.[34] Patients who are going through one of these religious or spiritual conflicts may be referred to chaplaincy services or pastoral care, the aim being to provide the most suitable counseling.[3] On occasions, a patient might mention a certain antagonism of his religious leaders toward medical or psychological treatment. In these cases, and with the patient's consent, it may be important to contact the religious leader, not with a confrontational approach, but inviting him to work together for the patient's benefit.[35]

Problems with substance use can push individuals away from their families and communities. Thus, religious leaders should strive to make patients feel welcome in their communities of faith, creating an atmosphere of openness and inclusion. Leaders of religious communities are very often the first point of contact for individuals or families who are struggling with substance use.

It is equally important that religious leaders create strategies for reducing or eliminating the stigma concerning treatment for substance use disorders and generate more acceptance by the community. Creating channels for religious leaders to refer those suffering from such disorders for treatment, in parallel with the approach and support they receive in their religious group, is paramount.[36]

Partnership with religious communities (churches, spiritist centers, temples, mosques, sacred spaces, synagogues, etc.) in campaigns to prevent and encourage the treatment of problems associated with the use of alcohol and other drugs, especially in areas/populations at most significant risk

Development of spirituality and involvement in religious communities can be included in campaigns as effective

strategies for reducing the risk of use/misuse of alcohol and other drugs.[7]

Partnerships should be established with religious groups that work with vulnerable (e.g., unhoused) populations to facilitate referral for treatment. One partnership with religious communities in prevention campaigns and encouragement to seek treatment, for example, was inspired by the very successful experience of campaigns to prevent infant malnutrition and dehydration developed by the Children's Pastoral (Pastoral da Criança), a Catholic program for infant development.[37]

Inclusion of patients' R/S-related content in treatment and recovery programs for substance use disorders, available through the Unified Health System (Sistema Único de Saúde – SUS), including individual and group sessions and workshops available through the Psychosocial Care Network (Rede de Atenção Psicossocial), preventive approaches in primary health care, and treatment in basic health units, outpatient mental health clinics, and inpatient psychiatric units

Scientific evidence has demonstrated the benefits of incorporating R/S into psychotherapy, with efficacy comparable to that of conventional approaches, as well as additional effects in terms of psychological and spiritual welfare for patients interested in the subject. R/S-related content can be incorporated into individual or group strategies such as motivational interviews, relapse prevention techniques, and clinical or psychotherapy visits.[30]

Endorsements

Institutions

Brazilian Association of Christians in Science (Associação Brasileira de Cristãos na Ciência – ABC^2) (Brazil); Brazilian Evangelical Christian Alliance (Aliança Cristã Evangélica Brasileira) (Brazil); Brazilian Spiritist Medical Association (Associação Médico Espírita do Brasil – AME-Brasil) (Brazil); Sobriety Pastoral (Pastoral da Sobriedade) (Brazil).

Individuals

Ageu Heringer Lisboa. Psychologist, Co-Founder and Past President of the Corps of Christian Psychologists and Psychiatrists (Corpo de Psicólogos e Psiquiatras Cristãos – CPPC) (Brazil); Alan Fung, MD, ScD, FRCPC. Co-Chair, World Psychiatric Association (WPA) Section on Religion, Spirituality and Psychiatry, Vice-Chair, American Psychiatric Association (APA) Caucus on Spirituality, Religion and Psychiatry, University of Toronto and Tyndale University (Canada); Antônio Geraldo da Silva, MD, PhD. President of the Brazilian Psychiatric Association (ABP), University of Porto School of Medicine (Portugal); Bruno P. Mosqueiro, MD, PhD. Chair of the ABP Section on Spirituality, Secretary of the WPA Section on Religion, Spirituality, and Psychiatry (Brazil); Christopher C. H. Cook, MD, PhD, FRCPsych. Emeritus Professor of Spirituality, Theology & Health, Durham University, Chair, Spirituality & Psychiatry Special Interest Group, Royal College of Psychiatrists (UK); Felix Henrique Paim Kessler, MD, PhD. Associate Professor of Psychiatry, Federal University of Rio Grande do Sul (Universidade Federal do Rio Grande do Sul), Chief, Addiction Psychiatry Service, Hospital de Clínicas de Porto Alegre, member of the Center for Drug and Alcohol Research (Centro de Pesquisa em Álcool e Drogas) (Brazil); Frederico D. Garcia, MD, PhD. Associate Professor, Department of Mental Health (Departamento de Saúde Mental), Federal University of Minas Gerais (Universidade Federal de Minas Gerais) (Brazil); Harold G. Koenig, MD. Professor of Psychiatry and Behavioral Sciences, Director, Center for Spirituality, Theology and Health at Duke University (USA); Homero Vallada, MD, PhD. Associate Professor of Psychiatry, University of São Paulo (Universidade de São Paulo) (Brazil); John R. Peteet, MD. Associate Professor, Department of Psychiatry, Harvard Medical School, USA, Past Chair, APA Caucus on Spirituality, Religion and Psychiatry (USA); Jorge Alberto Costa e Silva, MD, PhD. Past President of the Brazilian Academy of Medicine (Academia Brasileira de Medicina) (2017-2020), Past President of the WPA, Past Director of the Mental Health Department of the World Health Organization (WHO) (Brazil); Jorge Jaber, MD. Director, Jorge Jaber Clinic (Brazil); Kenneth I. Pargament, PhD. Professor Emeritus, Department of Psychology, Bowling Green State University (USA); Marc Galanter, MD. Research Professor of Psychiatry, New York University (USA); Robert Cloninger, MD, PhD. Professor Emeritus of Psychiatry, Washington University School of Medicine (USA); Ronaldo Laranjeira, MD, PhD. Professor of Psychiatry, Federal University of São Paulo (Universidade Federal de São Paulo – UNIFESP) (Brazil); Tyler J. VanderWeele, PhD. Professor of Epidemiology, Department of Epidemiology, Harvard T. H. Chan School of Public Health, Director, Human Flourishing Program, Harvard University (USA); Uriel Heckert, MD, PhD. Professor of Psychiatry (retired), Federal University of Juiz de Fora (Universidade Federal de Juiz de Fora), Co-Founder and Past President, CPPC (Brazil); Zila Sanchez, PhD. Associate Professor of Epidemiology, UNIFESP (Brazil).

Acknowledgements

We express our gratitude to the following colleagues who made very useful suggestions to earlier versions of these guidelines: Alan Fung, Bruno P. Mosqueiro, Christopher C. H. Cook, David Hathaway, Frederico Garcia, John R. Peteet, Kenneth I. Pargament, Robert Cloninger, and Tyler J. VanderWeele.

Disclosure

The authors report no conflicts of interest.

References

1 GBD 2016 Alcohol Collaborators. Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet. 2018;392:1015-35.

2 Kranzler Hr, Soyka M. Diagnosis and pharmacotherapy of alcohol use disorder: a review. JAMA. 2018;328:815-24.
3 Oliveira FHAO, Rezende-Pinto A. Psiquiatria e espiritualidade: em busca da formulação bio-psico-socio-espiritual do caso: aplicações práticas. HU Rev. 2020;44:447-54.
4 Cook CC. Addiction and spirituality. Addiction. 2004;99:539-51.
5 Galanter M, Dermatis H, Post S, Sampson C. Spirituality-based recovery from drug addiction in the Twelve-Step fellowship of Narcotics Anonymous. J Addict. 2013;7:189-95.
6 Governo do Estado de Minas Gerais, Secretaria de Estado de Desenvolvimento Social, Subsecretaria de Políticas sobre Drogas [Internet]. Plano mineiro intersetorial de cuidados/tratamento e prevenção do uso/abuso de álcool, tabaco e outras drogas. Belo Horizonte; 2021.
7 Moreira-Almeida A, Mosqueiro BP, Bhugra D. Spirituality and Mental Health Across Cultures – Evidence-Based Implications for Clinical Practice. New York: Oxford University Press. 2021. https://social.mg.gov.br/images/SUPOD/Plano-Mineiro-Intersetorial-2021.pdf
8 Moreira-Almeida A, Pinsky I, Zaleski M, Laranjeira R. Envolvimento religioso e fatores sociodemográficos: resultados de um levantamento nacional no Brasil. Arch Clin Psychiatry. 2010;37:12-5.
9 Moreira-Almeida A, Lucchetti G. Panorama das pesquisas em ciência, saúde e espiritualidade. Cienc Cult. 2016;68:54-7.
10 Koenig HG, King DE, Carson VB. Handbook of religion and health. 2nd ed. New York: Oxford University Press; 2012.
11 Gomes FC, Andrade AG, Izbicki R, Moreira-Almeida A, Oliveira LG. Religion as a protective factor against drug use among Brazilian university students: a national survey. Braz J Psychiatry. 2013;35:29-37.
12 Rezende-Pinto A, Moreira-Almeida A, Ribeiro M, Laranjeira R, Vallada H. The effect of religiosity during childhood and adolescence on drug consumption patterns in adults addicted to crack cocaine. BJPsych Open. 2018;4:324-31.
13 Chen Y, Vanderweele TJ. Associations of religious upbringing with subsequent health and well-being from adolescence to young adulthood: an outcome-wide analysis. Am J Epidemiol. 2018;187:2355-64.
14 Ely A, Mosqueiro BP. Religiosity/spirituality, motivation and self-efficacy in the treatment of crack users. Arch Clin Psychiatry. 2021;48:36-44.
15 Kelly JF, Humphreys K, Ferri M. Alcoholics Anonymous and other 12-step programs for alcohol use disorder. CDSR. 2020;3:CD012880.
16 Reus VI, Fochtmann LJ, Bukstein O, Eyler AE, Hilty DM, Horvitz-Lennon M, et al. The American Psychiatric Association practice guideline for the pharmacological treatment of patients with alcohol use disorder. Am J Psychiatry. 2018;175:86-90.
17 Kelly JF, Bergman B, Hoeppner BB, Vilsaint C, White WL. Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. Drug Alcohol Depend. 2017;181:162-9.
18 Smith LA, Gates S, Foxcroft D. Therapeutic communities for substance related disorder. CDSR. 2006;1:CD005338.
19 Tostes JSR, Pinto AR, Moreira-Almeida A. Religiosidade/espiritualidade na prática clínica: o que o psiquiatra pode fazer? Rev Debates Psiquiatr. 2013;3:20-6.
20 Moreira-Almeida A, Sharma A, Rensburg BJ, Verhagen PJ, Cook CCH. Posicionamento da Associação Mundial de Psiquiatria sobre espiritualidade e religiosidade em psiquiatria. Rev Debates Psiquiatr. 2018;8:6-8.
21 Précoma DB, Oliveira GMM, Simão AF, Dutra OP, Coelho OR, Izar MCO, et al. Updated cardiovascular prevention guideline of the Brazilian Society of Cardiology – 2019. Arq Bras Cardiol. 2019;113:787-891.
22 Costa M, Siqueira J, Resende PHC. Psicoterapia integrada à espiritualidade. HU Rev. 2020;44:481-9.
23 Oliveira VHA, Souza MHF. Espiritualidade da criança e do adolescente na prática clínica. HU Rev. 2020;44:461-8.
24 Casaletti C, Pereira FMT, Leão FC. Coleta de uma história espiritual: fundamentos para uma prática profissional culturalmente sensível. HU Rev. 2020;44(4):455-60.
25 Saad M, Medeiros R, Peres MFP. Assistência religiosa-espiritual hospitalar: os ''porquês'' e os ''comos''. HU Rev. 2020;44:499-505.
26 Moreira-Almeida A, Koenig HG, Lucchetti G. Clinical implications of spirituality to mental health: review of evidence and practical guidelines. Braz J Psychiatry. 2014;36:176-82.
27 Lucchetti G, Bassi RM, Lucchetti AL. Taking spiritual history in clinical practice: a systematic review of instruments. Explore. 2013;9:159-70.
28 Vanderweele TJ, Balboni TA, Koh HK. Invited commentary: Religious service attendance and implications for clinical care, community participation, and public health. Am J Epidemiol. 2022;191:31-5.
29 Moreira PAS, Inman RA, Cloninger CR. Virtues in action are related to the integration of both temperament and character: comparing the VIA classification of virtues and Cloninger's biopsychosocial model of personality. J Posit Psychol. 2022;17:858-75.
30 Costa A, Moreira-Almeida A. Religion-adapted cognitive-behavioral therapy: a review and description of techniques. J Relig Health. 2022;61:443-66.
31 Sanchez ZM. As práticas religiosas atuando na recuperação de dependentes de drogas: a experiência de grupos católicos, evangélicos e espíritas [Tese de Doutorado]. São Paulo: UNIFESP; 2006.
32 Worthington EL, Hook JN, Davis DE, McDaniel MA. Religion and spirituality. J Clinical Psychol. 2011;67:204-14.
33 Gonçalves JPB, Lucchetti G, Menezes PR, Vallada H. Religious and spiritual interventions in mental health care: a systematic review and meta-analysis of randomized controlled clinical trials. Psychol Med. 2015;45:2937-49.
34 Krause N, Pargament KI, Hill PC, Ironson G. Spiritual struggles and problem drinking: are younger adults at greater risk than other adults? Subst Use Misuse. 2018;16:808-15.
35 Koenig HG. Spirituality in patient care. Why, how, when, and what. 2nd ed. Philadelphia: Templeton Foundation Press; 2007.
36 American Psychiatric Association Foundation. Mental health: a guide for faith leaders. Arlington: American Psychiatric Foundation; 2016.
37 Schumann C, Stroppa A, Moreira-Almeida A. The contribution of faith based health organisations to public health. Int J Psychiatry. 2011;8:62-4.