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Religious Beliefs, Treatment Seeking, and Treatment Completion among Persons with Substance Abuse Problems

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Original Article

Abstract

Background: Religious beliefs can assist with the success of treatment in persons with substance abuse problems by providing social support, confidence, and hope.

Methods: As such, a secondary analysis using 2013 National Survey on Drug Use and Health (NSDUH), of 20219 participants with self-identified illicit substance use problems was conducted. Survey was weighted bivariate and multivariate regression analysis was used to adjust for potential confounders.

Findings: Approximately, 15.0% of the study sample were between ages of 18-25 years and 71.5% were Non-Hispanic Black, 11.3% were Non-Hispanic White, and 12.1% were Hispanic. About 10.3% had less than a high school education, 28.0% graduated high school, 30.0% had some college education, and 32.0% were college graduates. Only 1.3% reported receiving substance abuse treatment in the past 12 months and 5.4% perceived a need for substance abuse treatment in the last 12 months. 65.0% reported that religious beliefs were an important part of their life and 62.5% reported that their religious beliefs influenced their decision making. After adjustment for sociodemographic factors, both the importance of religious beliefs and the influence of religious beliefs on decision making were associated with increased odds of having treatment [odds ratio (OR) = 1.56, 95% confidence interval (CI): 1.14-2.14 and OR = 1.51, 95% CI: 1.11-2.05, respectively]. However, there was no association between the importance of religious beliefs or the influence of religious beliefs on decision making and perceived need for substance abuse treatment.

Conclusion: These findings suggest that religious beliefs may be an important determinant in receiving treatment among substance abusers and also have implications for exploration of faith-based and faith-placed interventions.

Keywords: Religious; Substance-related disorders; Treatment

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Introduction

Several national surveys show that over half of Americans identify that religion is a very important part of their life and although the percentage of persons who believe in God has decreased over time, 80% of American still report believing in God and approximately 9% of those who do not believe in God, report belief in some higher power or spiritual force.[1] Given the lack of consensus regarding the definition of the core constructs of religiousness and spirituality and the overlapping aspects, most studies either use the terms interchangeably or together. Moreover, several studies have shown a favorable influence on several health outcomes[2,3] such as mortality, cardiovascular disease (CVD),[4] cancer,[5] and substance abuse.[6]

Several studies show that religiousness or religiosity may have a powerful role in the prevention of substance abuse and several theoretical arguments exist. There is consistent evidence that religiosity and spirituality are negatively related to alcohol, tobacco, and illicit substance use.[7-11] The processes and mechanisms through which different aspects of religiosity and spirituality influence health are still under study and several have been proposed through psychological processes or the provision of social support.[12,13]

Moreover, inquiries into the role of religiosity and spirituality in facilitating successful addiction treatment have been fairly new. It is largely unknown if religiosity influences an addict's decision making regarding seeking treatment, initiating treatment, and completing a treatment program. As such, the purpose of this study was to examine the relationship between religious beliefs and the influence of religious beliefs on decisions and perceived need for treatment and receiving treatment for substance abuse in the past 12 months among a self-identified sample of persons with illicit substance use problems.

Methods

A secondary analysis using the 2013 National Survey on Drug Use and Health (NSDUH), of 20219 participants with self-identified substance abuse problems defined as ever having used illicit drugs was conducted. NSDUH is a repeated cross-sectional national survey conducted by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA).[14] The target population is a nationally representative noninstitutionalized sample of the United States (US), aged 12 years and older. Approximately, 67500 persons are surveyed annually via face-to-face interviews. The purpose of the survey is to obtain data on national prevalence and patterns of substance abuse and mental disorders. An independent multistage probability sampling design was used to sample household residents from 50 states in addition to the District of Columbia. Data were collected via in-person interviews in participants' homes. Detailed information about the survey methods is published elsewhere.[14]

Measures: The outcome variables in this study were having received treatment for substance abuse problems in the past 12 months and perceived need of substance abuse treatment in the past 12 months. The main explanatory variables were the importance of religious beliefs and influence of religious beliefs in decision making, respectively. Participants were provided with these statements: "Your religious beliefs are a very important part of your life" and "Your religious beliefs influence how you make decisions in your life". Participants were instructed to indicate their level of agreement ranging from "strongly disagree" to "strongly agree" on a 4-point Likert-type scale. Participants who selected either "agree" or "strongly agree" were categorized as persons for whom religious beliefs were important and as persons whose decisions were influenced by their religious beliefs, respectively. Covariates included gender, age, race, education, marital status, employment, poverty status, and total household income.

Descriptive and summary statistics to describe sample demographic characteristics were calculated using Stata software, Release 11 (Stata Corporation, College Station, TX, USA). Survey was weighted bivariate and multivariate regression analyses were conducted for each religious exposure variable and each treatment outcome variable. Multivariate models included age, race, gender, education, marital status, employment, poverty level, and total family income. Additional multivariate models were constructed eliminating total family income, but there was no difference in the results.

Results

Table 1 shows the descriptive statistics for the sociodemographic, religious, and treatment variables.

Table 1. Descriptive statistics of the study sample, adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

Variables	n (%)†
Needing illicit drug treatment in 12 months	
Yes	1781 (5.4)
No	18438 (94.6)
Receiving illicit drug treatment in 12 months	
Yes	412 (1.3)
No	19807 (98.7)
Religious beliefs are important	
Yes	12515 (65.4)
No	7704 (34.6)
Religious beliefs influence decisions	
Yes	11569 (62.5)
No	8650 (37.5)
Race	
White	13198 (71.5)
Black	2516 (11.3)
Hispanic	2805 (12.1)
Other	1700 (5.1)
Gender	
Women	10215 (46.5)
Men	10004 (53.5)
Age (year)	
18-21	4408 (7.3)
22-25	5473 (8.6)
26-34	3350 (18.9)
35-49	4288 (27.7)
50 and above	2700 (37.5)
Education	
Incomplete high school	2897 (10.3)
High school	6140 (27.9)
Some college	6409 (29.6)
College graduate and above	4773 (32.2)
Marital status	
Currently married	6395 (49.4)
Widowed/divorced/separated	2375 (18.7)
Single or never married	11449 (31.9)
Employment	
Employed full time	10592 (56.8)
Employed part time	3941 (15.5)
Unemployed	1822 (5.8)
Other	3864 (21.9)
Poverty level (% of federal poverty threshold)	
100% at the poverty level	4439 (13.8)
100%-199% at the poverty level	4436 (17.8)
200% or more at the poverty level	11344 (68.4)
Total family income	
Less than $20000	5062 (16.6)
$20000-$49999	6580 (29.2)
$50000-$74999	3160 (17.3)
$75000 and more	5417 (36.9)
Total sample	20219 (100)

†Weighted percentages

As shown, 53.5% of the respondents were men and 71.5% were Non-Hispanic White. Almost half of the sample were currently married and employed full time. 68% were 200% or more at poverty level and approximately 37% reported total family income of $75000 or more. 65% reported that religious beliefs were important, while 62.5% stated that religious beliefs influenced their decisions. 5.0% of the participants reported needing treatment in the past 12 months, while only 1.3% reported receiving treatment in the past 12 months.

In the bivariate analysis, there were statistically significant differences in age, education, marital status, employment, and poverty level by receipt of treatment in the past 12 months as shown in table 2.

In the multivariate model examining the association between the importance of religious beliefs and reporting receiving treatment in the last 12 months, after adjustment for race, gender, age, education, marital status, employment, poverty level, and family income, persons who stated that religious beliefs were important had 1.56 times the odds of reporting receiving treatment in the past year compared to persons who indicated that religious beliefs were not important [odds ratio (OR) = 1.56, 95% confidence interval (CI): 1.14-2.14] (Table 3). The OR for each age category increased for the first two age categories of 22-25 and 26-34 years and then decreased for the age categories of 35-49 and 50 years and above. Compared to those aged 18-24 years, respondents aged 26-34 years had 2.78 times the odds of reporting receiving treatment in the past 12 months. Non-Hispanic Blacks were 50.0% less likely to report receiving treatment compared to Non-Hispanic Whites. Compared to men, women were 31.0% less likely to report receiving treatment. Compared to college graduates, persons who did not complete high school, high school graduates, and those who completed some college education had increased odds of reporting receiving treatment, with the strength of association decreasing with each increment in education (OR = 3.20, 95% CI: 1.58-6.45; OR = 2.49, 95% CI: 1.31-4.73; OR = 2.24, 95% CI: 1.19-4.20). In addition, compared to respondents that were currently married, those who were widowed, divorced, separated, or single or never married had higher odds of reporting receiving treatment in the past 12 months (OR = 3.92, 95% CI: 2.27-6.76 and OR = 4.50, 95% CI: 2.72-7.44).

Table 2. Bi-variate relationship between socio-demographic and economic characteristics with receiving illicit drug treatment among adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

Variables	Illicit drug treatment received in past year				Chi-square	P
	No		Yes			
	n (19807)	%	n (412)	%		
Religious beliefs are important						
Yes	12262	98.5	253	1.5	3.10	0.078
No	7545	98.9	159	1.1	3.10	0.078
Religious beliefs influence decisions						
Yes	11342	98.6	227	1.4	1.38	0.241
No	8465	98.8	185	1.2		
Race						
Whites	12910	98.7	288	1.3	0.15	
Blacks	2473	98.6	43	1.4	0.926	
Hispanics	2757	98.5	48	1.5		
Other	1667	98.8	33	1.2		
Gender						
Female	10038	98.8	177	1.2	1.93	0.165
Male	9769	98.5	235	1.5		
Age (year)						
18-21	4301	97.8	107	2.2	14.78	< 0.001
22-25	5330	97.8	143	2.2		
26-34	3270	97.7	80	2.3		
35-49	4232	98.8	56	1.2		
50 and above	2674	99.4	26	0.6		
Education						
Incomplete high school	2783	96.9	114	3.1	18.72	< 0.001
High school	5993	98.4	147	1.6		
Some college	6279	98.6	130	1.4		
College graduate and above	4752	99.6	21	0.4		
Marital status						
Currently married	6349	99.7	46	0.3	48.05	< 0.001
Widowed/divorced/separated	2318	98.3	57	1.7		
Single or never married	11140	97.4	309	2.6		
Employment						
Employed full time	10457	99.4	135	0.6	19.16	< 0.001
Employed part time	3852	98.1	89	1.9		
Unemployed	1739	94.9	83	5.1		
Other	3759	98.0	105	2.0		
Poverty level (% of federal poverty threshold)						
100% at the poverty level	4285	96.7	154	3.3	22.30	< 0.001
100%-199% at the poverty level	4322	97.9	114	2.1		
200% or more at the poverty level	11200	99.3	144	0.7		
Total family income						
Less than $20000	4889	96.8	173	3.2	20.12	< 0.001
$20000-$49999	6447	98.5	133	1.5		
$50000-$74999	3106	98.9	54	1.1		
$75000 and more	5365	99.5	52	0.5		

Similarly, in the investigation of the relationship between the influence of religious beliefs on decisions and receipt of treatment after adjustment for potential confounders persons who reported that religious beliefs influenced their decisions had 1.51 times the odds of reporting receiving treatment in the past 12 months compared to their counterparts. In this multivariate model Non-Hispanic Blacks were 49% less likely to report receiving treatment compared to their Non-Hispanic White counterparts. Similar statistically significant associations between age education marital status and employment were observed as shown in table 4.

Table 3. Odds ratios (OR) and confidence intervals (CI) for the logistic regression estimates for the relationship between religious beliefs as important and receiving illicit drug use related treatment among adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

Covariates	Illicit drug treatment received in past year			
	Unadjusted models		Adjusted model	
	OR	95% CI	OR	95% CI
Religious beliefs are important				
Yes vs. No	1.32	0.97-1.80	1.56**	1.14-2.14
Race				
Whites	1.00	-	1.00	-
Blacks	1.11	0.70-1.77	0.50**	0.30-0.84
Hispanics	1.17	0.68-2.02	0.70	0.39-1.24
Other	0.95	0.43-2.05	0.64	0.29-1.37
Gender				
Female vs. Male	0.80	0.58-1.10	0.69*	0.49-0.97
Age (year)				
18-21	1.00	-	1.00	-
22-25	1.04	0.73-1.47	1.79**	1.24-2.58
26-34	1.07	0.73-1.57	2.78***	1.81-4.28
35-49	0.56**	0.36-0.87	1.87*	1.14-3.06
50 and above	0.25***	0.14-0.44	0.70	0.36-1.36
Education				
Incomplete high school	7.98***	4.16-15.32	3.20***	1.58-6.45
High school	4.11***	2.23-7.59	2.49**	1.31-4.73
Some college	3.56***	1.90-6.68	2.24*	1.19-4.20
College graduate and above	1.00	-	1.00	-
Marital status				
Currently married	1.00	-	1.00	-
Widowed/divorced/separated	5.11***	2.95-8.85	3.92***	2.27-6.76
Single or never married	7.70***	5.06-11.71	4.50***	2.72-7.44
Employment				
Employed full time	1.00	-	1.00	-
Employed part time	3.32***	2.24-4.92	2.96***	1.92-4.55
Unemployed	9.34***	5.85-14.92	5.23***	3.11-8.80
Other	3.52***	2.37-5.23	3.70***	2.42-5.68
Poverty level (% of federal poverty threshold)				
100% at the poverty level	4.54***	3.16-6.52	1.25	0.64-2.43
100%-199% at the poverty level	2.82***	1.88-4.21	1.18	0.68-2.05
200% or more at the poverty level	1.00	-	1.00	-
Total family income				
Less than $20000	7.03***	4.37-11.32	1.43	0.66-3.10
$20000-$49999	3.32***	2.01-5.48	1.21	0.69-2.14
$50000-$74999	2.27**	1.31-3.95	1.50	0.86-2.63
$75000 and more	1.00	-	1.00	-

*P < 0.050, **P < 0.010, ***P < 0.001
OR: Odds ratio; CI: Confidence intervals

There was no statistically significant association observed between the importance of religious beliefs and perceived need for treatment (OR = 1.01 95% CI: 0.84-1.19). Similarly, there was no statistically significant association observed between the influence of religious beliefs on decisions and perceived need for treatment (OR = 1.09 95% CI: 0.92-1.29).

Discussion

In this sample of persons with self-identified substance abuse problems, both the importance of religious beliefs and the influence of religious beliefs on decisions were statistically significantly associated with receipt of substance abuse treatment in the past 12 months.

Table 4. Odds ratios (OR) and confidence intervals (CI) for the logistic regression estimates for the relationship between religious beliefs influence decision and receiving illicit drug use related treatment among adults aged 18 or older who ever used illicit drug, National Survey on Drug Use and Health (NSDUH), 2013

Covariates	Illicit drug treatment received in past year			
	Unadjusted models		Adjusted model	
	OR	95% CI	OR	95% CI
Religious beliefs are important				
Yes vs. No	1.20	0.88-1.63	1.51**	1.11-2.05
Race				
Whites	1.00	-	1.00	-
Blacks	1.11	0.70-1.77	0.51**	0.30-0.84
Hispanics	1.17	0.68-2.02	0.70	0.40-1.25
Other	0.95	0.43-2.05	0.63	0.29-1.35
Gender				
Female vs. Male	0.80	0.58-1.10	0.70*	0.50-0.98
Age (year)				
18-21	1.00	-	1.00	-
22-25	1.04	0.73-1.47	1.78**	1.24-2.58
26-34	1.07	0.73-1.57	2.77***	1.80-4.26
35-49	0.56**	0.36-0.87	1.85*	1.13-3.04
50 and above	0.25***	0.14-0.44	0.68	0.35-1.32
Education				
Incomplete high school	7.98***	4.16-15.32	3.26***	1.62-6.58
High school	4.11***	2.23-7.59	2.53**	1.33-4.80
Some college	3.56***	1.90-6.68	2.26*	1.21-4.25
College graduate and above	1.00	-	1.00	-
Marital status				
Currently married	1.00	-	1.00	-
Widowed/divorced/separated	5.11***	2.95-8.85	3.92***	2.28-6.74
Single or never married	7.70***	5.06-11.71	4.50***	2.71-7.38
Employment				
Employed full time	1.00	-	1.00	-
Employed part time	3.32***	2.24-4.92	2.99***	1.94-4.61
Unemployed	9.34***	5.85-14.92	5.19***	3.08-8.75
Other	3.52***	2.37-5.23	3.72***	2.42-5.70
Poverty level (% of federal poverty threshold)				
100% at the poverty level	4.54***	3.16-6.52	1.28	0.66 2.49
100%-199% at the poverty level	2.82***	1.88-4.21	1.20	0.69-2.07
200% or more at the poverty level	1.00	-	1.00	-
Total family income				
Less than $20000	7.03***	4.37-11.32	1.40	0.65-3.02
$20000-$49999	3.32***	2.01-5.48	1.22	0.69-2.15
$50000-$74999	2.27**	1.31-3.95	1.50	0.86-2.62
$75000 and more	1.00	-	1.00	-

*P < 0.050, **P < 0.010, ***P < 0.001
OR: Odds ratio; CI: Confidence intervals

The ORs were almost identical. Our findings align with the model of Longshore et al.[15] that demonstrated the importance of religious beliefs on drug treatment research. Our study additionally suggests that one's religious beliefs may also influence the decision to initiate treatment and treatment-seeking behaviors. However, in our study, we were unable to determine if one's religious beliefs influences the acceptability of a specific treatment program to a person with substance abuse problems.

The current study highlights the potential importance of addressing religious beliefs and behaviors in substance abuse counseling. The integration of religious beliefs into substance abuse counseling presents several considerations for care

providers and substance use disorder (SUD) intervention planners. One of the cornerstones of behavioral intervention is evidence-based theory. Because definitions of religiosity and spirituality vary widely and beliefs about the connection to substance abuse behavior, even more so, there has traditionally been difficulty grounding religious interventions within the framework of a health behavior model. To address this gap, Neff and MacMaster[16] proposed a spiritual behavior change model which comprised of concepts from the Theory of Reasoned Action (TRA), the Health Belief Model (HBM), and Social Learning Theory. Notably, the Neff and MacMaster's model differs from the Transtheoretical Model (TTM)[17] (one of the most often-cited health behavior theories for addictions), noting that while TTM provides perspective on the behavior change process, it does not comprehensively address the mechanisms underlying those processes.[17] Understanding the process of spiritual development in the path of substance abuse treatment and recovery may be a critical step in effective treatment planning.

Another key consideration for providers is how different spiritual and religious frameworks do and do not align with the disease model of addiction (DMA) and medication-assisted treatment (MAT) strategies. The DMA is not without critisism.[18] Nonetheless, the model has many champions, and MAT strategies align well with the DMA. A qualitative study by van der Meer and Nappo[19] of three different religious groups' substance abuse programs noted that some religious sects exclusively promoted prayer as an intervention and eschewed the use of MAT. Other religions in the study either supported or were open to a combination of prayer and MAT.[19] Chu and Sung[20] study of substance abuse treatment counselors' philosophies indicated that counselors in faith-based programs were less likely to ascribe to the disease paradigm of addiction. Providers should be very aware of the potential friction between religious beliefs, DMA, and MAT, particularly if program participants have either been prescribed MAT by other health care providers or seek the option to explore medication therapies as part of their treatment plans.

Finally, another important issue for providers and patients is the assessment of religious beliefs as salient individual protective factors. Persons who place greater value on their religious beliefs may benefit more than others from integrating religion into their treatment plans. The 10-item Treatment Spirituality/Religiosity Scale (TSRS) developed by Lillis et al.[21] shows promise as the basis of a practical measurement tool. The TSRS was developed with a specific focus on SUD treatment environments and administered as a subscale of the Community-Oriented Programs Environment Scale (COPES).[21] The authors suggest that the easily scored scale could assist providers in determining patient preferences for spirituality/religiosity (S/R) content in treatment programs. While the TSRS has notable limitations (e.g., lack of differentiation between spirituality and religiosity and specific references to Judeo-Christianity), an adapted religiously-inclusive version could have great utility in helping to improve participant-program fit.[21]

Conclusion

Considering the current study's findings and the above considerations, care providers may want to develop some sensitivity to patients' religious beliefs and consider the opportunities and challenges of incorporating these beliefs in treatment programming. As patients seek meaning, purpose, and forgiveness to chart the course toward sobriety, religious beliefs may emerge as the guiding principle on their journeys.

Limitations: One limitation of this study is that the group reporting ever use of illicit drugs may consist of current users, recreational users, and past users. As such, the substance abuse-related problems may be chronic problems resulting from past substance use among persons who are no longer using illicit drugs. Persons who may not be currently using illicit drugs may be more likely to have completed treatment and as such, may have a unique perspective on the long-lasting effects of their past illicit drug use. Another limitation is the inability to explore the influence of engagement of religious practices or involvement across the life course. It may be important to look at the change in religious beliefs over time rather than at one point in time.

Conflict of Interests

The Authors have no conflict of interest.

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Authors' Contribution

Conceptualized the research, wrote, reviewed and edited the manuscript: KBR; contributed to writing, reviewing, and editing of the manuscript: NW; contributed to the conceptualization of the research, reviewing, and editing of the manuscript: KC; conducted the data analysis and reviewed the manuscript: MH.

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اعتقادات مذهبی، جستجوی درمان و تکمیل درمان در افرادی دارای مشکلات سوء مصرف مواد

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مقاله پژوهشی

چکیده

مقدمه: اعتقادات مذهبی می‌تواند با ایجاد حمایت اجتماعی، اعتماد و امید، به موفقیت درمان در افرادی که دارای مشکلات سوء مصرف مواد هستند، کمک کند.

روش‌ها: به همین منظور، یک آنالیز ثانویه با استفاده از بررسی ملی در مورد مصرف مواد و بهداشت ۲۰۱۳، از ۲۰۲۱۹ شرکت‌کننده با مشکلات خودشناسایی شده مصرف مواد غیر قانونی انجام شد. بررسی دو متغیره وزن‌دهی گردید و از روش تحلیل رگرسیون چند متغیره جهت تعدیل متغیرهای مداخله‌گر بالقوه استفاده شد..

یافته‌ها: حدود ۱۵ درصد از نمونه‌های مطالعه در سنین ۱۸ تا ۲۵ سال بودند و ۷۱/۵ درصد از افراد سیاه‌پوست غیر لاتین‌تبار، ۱۱/۳ درصد سفیدپوست غیر لاتین‌تبار و ۱۲/۱ درصد لاتین‌تبار بودند. حدود ۱۰/۳ درصد تحصیلات کمتر از دبیرستان داشتند، ۲۸/۰ درصد فارغ‌التحصیل دبیرستان بودند، ۳۰/۰ درصد تحصیلات آکادمیک تکمیل نشده داشتند و ۳۲ درصد فارغ‌التحصیل دانشگاه بودند. فقط ۱/۳ درصد گزارش کردند که در ۱۲ ماه گذشته درمان سوء مصرف مواد دریافت کرده‌اند و ۵/۴ درصد نیز در ۱۲ ماه گذشته نیاز به درمان سوء مصرف مواد داشتند. ۶۵/۰ درصد عنوان نمودند که اعتقادات مذهبی بخش مهمی از زندگی آن‌ها را تشکیل می‌دهد و ۶۲/۵ درصد گزارش کردند که اعتقادات مذهبی‌شان در تصمیم‌گیری آن‌ها تأثیر داشته است. پس از تعدیل عوامل جمعیتی- اجتماعی، هم اهمیت اعتقادات مذهبی و هم تأثیر اعتقادات مذهبی بر تصمیم‌گیری با افزایش احتمال درمان همراه بود. (۲/۱۴- ۱/۱۴ :Confidence interval (CI) ۹۵ درصد، ۱/۵۶ = Odds ratio (OR) و ۲/۰۵- ۱/۱۱ :CI، ۹۵ درصد، ۱/۵۱ = OR). با این حال، هیچ ارتباطی بین اهمیت اعتقادات مذهبی یا تأثیر اعتقادات مذهبی بر تصمیم‌گیری و نیاز درک شده به درمان سوء مصرف مواد وجود نداشت.

نتیجه‌گیری: اعتقادات مذهبی می‌تواند تعیین‌کننده مهمی در دریافت درمان بین افراد سوء مصرف‌کننده مواد باشد و همچنین، رهنمودهایی برای بررسی درمان‌های مبتنی بر ایمان دارد.

واژگان کلیدی: مذهبی؛ اختلالات مربوط به مواد؛ درمان

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