Religious Orientation in Patients with Substance Use Disorders

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Abstract

As spirituality and religiosity is a neglected area of study and research in the treatment of addiction in our culture as it is in other cultures and as results of some of the previous studies had demonstrated that the patients view spirituality as essential to their recovery , so we wanted to study the importance of exploring this sensitive area in a sample of 132 of our Egyptian Moslem inpatients with substance use disorders as diagnosed according to the ICD 10 Research Diagnostic Criteria. We used the religious orientation scale for Moslems to test for both the internal as well as the external religious orientation. It was found that there is a highly significant correlation between high internal and external religious orientation and the polysubstance abuse, abuse of opiates, more relapses, more hospitalization, younger age at onset, as well as longer duration of the disorder. Also, the patient group showed a highly significant ($p< 0.001$) difference on comparison with the healthy control group on both internal religious orientation as well as external religious orientation, with the patient group showing the higher scores on the internal religious orientation and the lower scores on the external religious orientation. So, it can be concluded that spiritual and religious issues should be addressed in substance abuse patients since they may have a positive impact on patient behavior. Psychiatrists can make use of stress-reducing and adaptive potentials of religious beliefs in the management of such disorders and is worth inclusion when planning a multidimensional approach of treatment, More research is needed in this area especially correlating the use of religious approach in treatment and its impact on outcome. Also, more research is required studying the role of religious aspects in the etiology of other psychiatric disorders as well as in outcome when used among other lines of treatment. Also, this aspect should be included in medical education.

Introduction

Spirituality and religiosity is a neglected area of study and research in the treatment of addiction. This also applies to the other psychiatric diagnoses. It was found that only 3% of a quantitative review of the total output of four major psychiatric journals between 1978-1982 contained a quantified religious variable, and only three out of 3777 articles scanned were centrally and quantitatively concerned with traditional religious phenomena (Larson et al, 1986). This deficiency has attracted protest (Sims, 1994). According to a review conducted by the author, the British Journal of Psychiatry published no papers that had religious belief as a principal focus of psychometric concern between 1988-1992.

There are potential ethical problems, as in the assessment of psychosexual problems, the act of inquiry into religious belief may not be a morally neutral event- it can convey attitudes of approval or condemnation. Although patients may welcome their clinician's inquiry into their spiritual or religious state, giving spiritual guidance may be illegitimate act of trespass onto the territory of ordained minister. So, discussion of religious issues within the psychiatric assessment interview is often not only ignored but also avoided, possibly because it can be a

matter of unspeakable embarrassment because it is simultaneously intimate and relational. Psychiatric research into religious phenomena generally colludes with this unspoken policy of avoidance but may be impoverished as a result. This is particularly disappointing as the conceptual and psychometric apparatus for inquiry may be available and adaptable for the use and could turn a tradition of protest about the absence of research into clinically rewarding data (Crossley, 1995).

Berg (1993) noticed that in treating sickness in the United States, it is focused on what scientists can measure. It is the doctor's role to cure illness; not the priest's. The priest brings comfort to those who are ill and to their families. He is not expected to assist the doctor in providing a cure. But when it comes to alcoholism, we must remember that the combined experience of all the men and women of medicine in America from the time of Benjamin Rush to 1935, the year which Alcoholic Anonymous marks its beginning, could not develop an effective cure for alcoholism.

Results of some of the previous studies had demonstrated that the patients view spirituality as essential to their recovery and value spiritual programming in their treatment more than some concrete items(McDowell et al 1996). In alcoholism, we can find physiological causes which explain the progression of the addiction. The same holds true for smoking and other drug dependency. However, it is difficult for many to understand that something so non-physiological as spirituality can be used to cure a physical ailment. Although Eastern cultures have no difficulty with the concept, the idea goes against Western medical practices (Berg, 1993).

Moreover, even fewer research has been done on Moslems regarding their religious orientation and its impact on their illness. This of course applies to patients with substance use disorders, in whom this area is often neglected both in research as well as in management despite the fact that religiosity may be more strongly related to substance use disorders than to other psychiatric disorders. So, we thought of exploring this sensitive area in our Egyptian Moslem patients with substance use disorders. This is also important as there is a well known relationship between religious orientation and disease, health, and well being among the spiritual beliefs of Moslems.

Subjects and Method

1. Patients Group

The sample was formed of Egyptian 132 Moslem patients with substance use disorders as diagnosed according to the ICD-10 Research Diagnostic Criteria. They were selected from the inpatients in the Institute of Psychiatry, Ain Shams University according to quota method of sampling over the period of one year (from March 1997 to February 1998).

All patients were interviewed only after consenting to answer question related to their disorder and to their religious orientation.

Inclusion Criteria

Moslem patients with substance use disorders as diagnosed according to the ICD-10 Research Diagnostic Criteria , whatever is their age, educational level, socioeconomic status, substance of abuse, duration of their disorder, number of their relapses, underlying personality disorder (if present).

Exclusion Criteria

a) Patients with comorbid psychiatric disorder other than personality disorder.

b) Patients during their intoxication stage and their withdrawal symptoms.

2.Control Groups

The healthy control group was formed of

66 Moslem Individuals. They were selected from Medical and other universities students (specifically Faculty of Arts and of Social Work), employees, and workers in the Institute of Psychiatry, Ain Shams University, to match the patient group in age , sex, religion, educational level, and socioeconomic status.

Methods

The patient group was exposed to the following:

1. Full psychiatric examination according to the sheet of the Institute of Psychiatry, Ain Shams University.
2. Research Diagnostic Criteria of the ICD-10.
3. Religious Orientation Scale for Moslems to assess the relationship between substance use disorders and Islamic religious orientation.

It consists of two subscales:

a) The extrinsic religious orientation subscale.

b) The intrinsic religious orientation subscale.

Version "A" of the scale is for Moslems and is formed of 34 items. The scale has been standardized on Egyptians by El-Behairy and Demerdash(1988) with high inter-rater reliability and validity.'

A high score on the extrinsic subscale indicates a high extrinsic religious orientation i.e low religiosity, while a low score on the intrinsic subscale indicates a high intrinsic religious orientation i.e. high religiosity. The authors clarify this pattern by putting certain determinants of both extrinsic and intrinsic religious orientation.

Determinants of Extrinsic Religious Orientation

1. Religion is the prime source of psychological and social satisfaction.
2. Religion is a source of acceptance and social reward.
3. Religious rituals are practiced for the sole reason of social desirability.
4. Religious teachings are not followed in daily behavior.
5. Superstitious beliefs.
6. Resort to religion at times of stress.

Determinants of Intrinsic Religious Orientation

1. Doing good to satisfy God's wish.
2. Following religious teachings in daily behaviors.
3. Praying in the exact times of prayer.
4. Lifting the suffering of others.
5. Feeling anguish while reading the Koran.
6. Fear of God and praying this forewent.
7. Approaching God by following his leading and his book and the teachings of the Prophet.
8. Continuous self judgment and accountability.
9. Feeling tranquillity upon a continuous relatedness to God.

The control group was subjected to the same tools.

Statistical Analysis

This was done using the IBM computer with the Microstat Package -V2

Results

Our sample was formed of 132 patients with substance use disorder . table (1). They were all males with mean of age (27.9 + 5.6). While the mean age of the healthy control was (26.8 t 5.8). Regarding the educational grade of the patients, 9.5% reached preparatory school but did not graduate from it, 33%

reached secondary school but did not graduate from it, 33% are currently in college but did not finish it and are frequently failing due to indulgence in the life style of addiction, and only 24.5% finished their college. They were all living in urban areas. Regarding their marital status, 73% were single, 15% were married, and 12% were divorced. It is worth mentioning that only 12% were currently working and 58% of this group worked in private jobs owed to their close relatives (mostly to their parents).

Concerning the clinical characteristics of the studied group table (2), 92.9% were polysubstance abusers. Only 18% of the patients had one relapse, while 39% had 10 or more relapses. However, regarding the frequency of hospitalization of the patients, 33% were hospitalized for the first time, while 24% were hospitalized 10 or more times.

Regarding the age at onset of the substance use disorder, 27% had an onset below or at the age of 15, while only 3% had an onset above the age of 36. Also, the duration of the disorder differed among the studied group with 15% having a duration of 5 or less years and 48% had a duration more than 10 years.

Concerning the relation between religious orientation and the different clinical variables table (3), our results have shown that there was a highly significant correlation **($p < 0.001$)** between those who had high score on internal religious orientation and polysubstance abuse. The same highly significant correlation was found also on internal religious orientation , with both opiates (in the form of heroin injection as well as codeine in cough syrup), and benzodiazepines, more at higher scores of internal religious orientation. It is also worth mentioning that 'anticholinergic abuse was also correlated with higher scores of internal religious orientation, however ephedrine showed no difference between the high and low scores level. However, there was a significant correlation between the extremely low score on the internal religious orientation and a low number of relapses and an insignificant difference ($p > 0.05$) using ANOVA between the number of relapses in the different scores of internal religious orientation, while the number of hospitalizations was found to have a significantly high correlation ($p < 0.001$) with the internal religious score with those having higher score showing a lower number of hospitalization or have never been hospitalized before, and on using ANOVA only a significant difference was found on the internal religious scores. Regarding duration of the disorder, a highly significant ($p < 0.001$) was found with the internal religious score with those having higher score on internal religious score having longer duration of disorder. However, ANOVA has shown an insignificant difference on internal religious orientation. Regarding the age at onset of the disorder a highly significant ($p < 0.001$) correlation was found between younger age at onset and higher internal religious score. However, on using ANOVA only a significant difference was found on the internal religious scores.

On the other hand, the external religious orientation has shown the following correlation: a highly significant correlation **($p < 0.001$)** between those who had high score on external religious orientation and polysubstance abuse with a highly significant correlation ($p < 0.001$) between the different substances of abuse and the score of external religious orientation with opiate predominance (also both in the form of heroin injection as well as codeine in cough syrup) at a higher external religious orientation, anticholinergic abuse was also correlated with higher scores of external religious orientation , however ephedrine showed no difference between the high and low

scores level. There was a highly significant correlation ($p<0.001$) between the lower external religious orientation and the lower number of relapses, however an insignificant difference ($p> 0.05$) using ANOVA between the number of relapses in the different scores of external religious orientation. The number of hospitalizations was found to have a significantly high correlation ($p< 0.001$) with the external religious score with those having a higher score having lower number of hospitalization or have never been hospitalized, however on using ANOVA only a significant difference was found. Regarding duration of the disorder, a highly significant ($p< 0.001$) was found with the external religious score with those having higher score on external religious score having longer duration of disorder. Also, ANOVA has proven the same highly significant difference on external religious orientation. Regarding the age at onset of the disorder a highly significant ($p< 0.001$) correlation was found between younger age at onset and higher external religious score. However, on using ANOVA only a significant difference was found on the external religious scores.

It is worth mentioning that the patient group showed a highly significant ($p< 0.001$) difference on comparison with the healthy control group on both internal religious orientation as well as external religious orientation table (4), with the patient group showing the higher scores on the internal religious orientation and the lower scores on the external religious orientation.

Table (1)
Sociodemographic characteristics of the studied and the control groups.

Variables	Patient's Group	Control Group
- Mean age	27.9k5.6	26.8k5.8
- Sex	Males	Males
- Education		
Preparatory	9.5%	14%
Secondary	33%	41%
University	33%	29%
Graduated	24.5%	16%
-Marrital status		
Single	73%	41%
Married	15%	57%
divorsed	12%	2%
- Jobs		
Jobless	88%	3%
General work	5%	89%
Family work	7%	8%

Table (2)
The clinical characteristics of the studied group.

Variables	Control Group
- Age of onset	
=<15 years	27%
15-36years	70%
>36 years	3%
- Duration of illness	
=<5 years	15%
5-10 years	37%
>10 years	48%
- Hospitalization	
Once	33%
Two to ten times	43%
More than ten	24%
- Relapse rates	
Once	18%
Two to ten times	53%
More than ten	39%
- Type of substance abused	
Polysubstance	92.1%
One or two substances	7.9%
- Differential substance abused	
Opiates	87%
Cannabinoids	94%
Benzodiazepines	38%
Alcohol	22%
Others	31%

Table (3)
The significant of the high internal and external religious scores in relation to the clinical variables.
(@=insig.,*=sig.,**=highly sig.)

Variables	Intrinsic Religious orientation		Extrinsic Religious orientation	
- Pattern of abuse				
Polysubstance		High**		High**
One or two	Low@		Low@	
-Type of substances		High**		High**
Opiates		High**		High**
Benzodiazepines	Low@		Low@	
Cannabis	Low@			High@
Others				
- Age of onset		High**		High**
=<15 years		High*		High*
15-36years	Low@		Low@	
>36 years				
- Duration of Illness	Low@		Low@	
= 1<5 years		High*		High*
5-10 years		High**		High**
>10 years				
- Hospitalization		High@		High**
Once	Low@			High*
Two to ten times	Low**		Low@	
More than ten				
- Relapse rates	Low*		Low@	
Once		High*		High*
		High**		High**

Variables	Mean (±SD)	Mean (±SD) in control group	"T" Test	"P" Value
- Internal religious or. score	47.42 (+10.21)	23.05(+4.41)	23.43	<0.001
- External religious or. score	48.09(+8.04	56.38(+11.25)	5.52	<0.001

Discussion

As addiction is a multicultural problem, it is in need for multicultural solutions including religion. However, as religion is a multidimensional concept, so it is worth mentioning that we have assessed both the external as well as the internal religious orientation in order to approach ,as much as we can, the real religious status of our patients.

Similar to our results, it was found that religiosity in general is significantly and inversely related to alcohol and drug use. This coincides with previous studies by Clark and Midanik, 1982; Rachel et al., 1982; Gartner et al., 1991. Also, in a study of the risk factors for drug abuse in Pakistan, it was found that there was a lacking bonds with societal institutions or value systems as family, religion and career, which could mitigate against drug use (Gillis and Mubbashar, 1995).

Concerning our results, the deficient religious orientation was particularly noted in the area of internal orientation(in the form of high score on that aspect) and this may be one of the contributing factors in the development of substance use disorders. Of the main cornerstones of this internal religious orientation is doing good to satisfy God's wish as well as following religious teachings in daily behaviors, which if followed strictly will protect the person against substance use disorders. The high external religious orientation was noticed to be significantly highly correlated with aspects indicating severity of the substance use disorder. For this type of patients, high external religious orientation is the prime source of acceptance and social reward, while religious teachings are not followed in daily behavior.

Although our sample consisted entirely of male patients and this is one of the limitations of our study, yet other studies formed of both males and females found no relationship with female religion (Neve et al.,1996). Also, Nazar-Beutelspacher, 1994, found that non-religious practice was among the factors related to drug use in males in Mexico. Another limitation of our study is that our sample was formed entirely of inpatients and this means that it may have been biased toward the more severe cases i.e. polysubstance abusers with a very high rate of relapse.

Our results linked low religiosity and the superficial involvement in the religious rituals, to the early use, increased relapse rates and polysubstance abuse. This goes with O`Malley et al. (1985) who found that neither socioeconomic status nor personal income were very strongly associated with cocaine use in American adolescents and young adults; but a history of truancy, going out frequently in the evenings, and having relatively low religious involvement were. Also, Thomas and Hsiu (1993) found that significant predictors for alcohol and drug use included participation in religious services. More recently, Weill and Bourhis (1994) in their five-year prospective study found that among French male teenagers, boys who drank least in 1990 were docile, contented, religious, and already well aware of the dangers of alcohol in 1985.

It was suggested before that traditional religious belief may be most important in the decision to ever use a substance, but our results together with those of Kendler et al, 1997, showed that religious devotion may particularly influence the ability to quit or maintain low levels of use.

However, the measurement of religious practice or affiliation may be easy, but quantifying existential commitment is not. Furthermore, age and socioeconomic status are important confounding variables; other specific difficulties in getting access to belief include cultural barriers,

and defensive attitudes. The same problems was criticized in most of the work done on this aspect before(Crossley, 1995).

So, it can be concluded that spiritual and religious issues should be addressed in substance abuse patients since they may have a positive impact on patient behavior. Hater et al.(1984) found that the religious variables accounted for significant and unique variance only in the general well-being variable in opioid addicts. Also, we add our voice to McKee and Chappel, 1992 who had recommended that the medical model be expanded to a biopsychosocial-spiritual one especially on dealing with certain disorders as substance use disorders. Psychiatrists can make use of stress-reducing and adaptive potentials of religious beliefs in the management of such disorders.

Clearly, not all substance abusers can be reached, much less successfully treated, by way of religiously-oriented programs. This approach merits serious consideration, however, since for individuals with high degree of religious motivation it has produced positive results comparable to those other accepted forms of treatment. So, religious commitment and spiritually-oriented treatment programs can be significant factors that merit consideration and is worth inclusion when planning a multidimensional approach of treatment. Religious personnel can and should begin to work collaboratively with mental health care personnel involved in the management of substance use disorders to improve the level of care provided. At the very least, they need to communicate with each other.

More research is needed in this area especially correlating the use of religious **ap**proach in treatment and its impact on outcome. Also, more research is required studying the role of religious aspects in the etiology of other psychiatric disorders as well as in outcome when used among other lines of treatment.

Also, this aspect should be included in medical education as well as in the training of medical students. This is particularly as dealing with this sensitive area needs a special training. This will enhance the students' respect for individuality of their patients in their cultural context, increase their awareness of the patients' beliefs, values, and faith as resources for dealing with illness, suffering, and death. So, it is doubtless that psychiatry would benefit if the vocabulary and concepts of religion and spirituality were more familiar to trainee and practitioners.

On the other hand, we have to teach religious personnel and give them sufficient information on dealing with such patients. This will include orienting them to the relapsing nature of the disorder and that the majority of the relapsers are serious about changing their life style but can not develop alternative coping strategies to drug abuse (i.e. they need more support and help, rather than punishment and accusations of being manipulative, liar, criminal, and unforgivable. This has been stressed before by Berg (1993) who warned priests that they do not need preaching as by the time alcoholics reach out for help, they have already been defeated.

Last but not least, it is well apparent that attention to the psychoreligious dimensions of psychological healing would improve clinical practice in the area involving research, diagnostic assessment, iatrogenesis, treatment, and training. So, physician should make more use of stress-reducing and adaptive potential of religious beliefs in the management of such problems.

References

Berg SI (1993): Spiritual issues in re-

covery from alcoholism. Pastoral Life, 43(9): 32-37.

Clark WB and Midanik L (1982): Alcohol use and alcohol problem among US adults: results of the 1979 National Survey, in Alcohol Consumption and Related Problems. Edited by National Institute on Alcohol Abuse and Alcoholism. Washington, DC, US Government Printing Office, PP:3-52.

Crossley D. (1995): Religious experience within mental illness. Opening the door on research. Br. J. Psychiatry, 166: 284-286.

El Behairy AA and Demerdash A (1988): The Religious Orientation Scale: Arabic Version.

Gartner J, Larson DB, and Allen GD (1997): Religious commitment and mental health: a review of empirical literature. J. Psychol. And Theology, 19: 6-25.

Gillis JS and Mubbashar MH (1995): Risk factors for drug abuse in Pakistan: A replication. Psychological Reports, 76(1): 99-108.

Hater JJ, Singh BK, and Simpson DD (1984): Influence of family and religion on long-term outcomes among opioid addicts. Advances in Alcohol and Substance Abuse, 4(1): 29-40.

ICD-10 Classification of Mental and Behavioral Disorders(1993) : Diagnostic Criteria for Research.WHO, Geneva.

Kendler KS, Gardner CO, and Prescott CA (1997): Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. Am. J. Psychiatry, 154:322-329.

Larson DB, Pattison M, Blazer DG, et al. (1986): Systematic analysis of research on religious variables in four major psychiatric journals 1978-1982. Am. J. Psychiatry, 143:329-334.

McDowell D, Galanter M, Goldfarb L, and Lifshutz H (1996): Spirituality and the treatment of the dually diagnosed: an investigation of patient and staff attitudes. J Addict. Dis., 15(2): 55-68.

Mckee DD, Chappel JN (1992): L Spirituality and medical practice. J. Fam. Pract., 35(2): 201.

Nazar-Beutelspacher A, Tapia-Conyer R, Villa-Romero A, et al.(1994): Factors related to drug use by adolescents in urban areas of Mexico. Salud. Publica Mex.,36(6): 646-654.

Neve RJM, Drop MJ, Lemmens PH, and Swinkels H (1996): Gender differences in drinking behavior in the Netherlands: Convergence or stability? Addiction, 91(3): 357-373.

O`Malley PM, Johnston LD, and Bachman JG (1985): Cocaine use among American adolescents and young adults. NIDA Res. Monogr., 61: 50-75.

Rachal JV, Maisto SA, Guess LL, and Hubbard RL (1982): Alcohol use among youth, in Alcohol Consumption and Related Problems. Edited by National Institute on Alcohol Abuse and Alcoholism. Washington, DC, US Government Printing Office, PP:55-95.

Sims ACP (1994): ‘ Psyche'-spirit as well as mind? Br. J. Psychiatry, 165:441-446.

Thomas BS and Hsiu LT (1993): The role of selected risk factors in predicting adolescent drug use and its adverse consequences. Int. J. Addict 28(14): 1549-1563.

Weill J and Bourhis B (1994): Factors predictive of alcohol consumption in a representative sample of French male teenagers: a five-year prospective study. Drug Alcohol Depend., 35(1): 45-50.

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التوجه الدينى لدى المرضى المدمنين

ان مجال الروحانيات و الديانة مهمل من حيث البحوث و الدراسة فى علاج الادمان ، هذه الدراسة تهدف لكشف التوجه الديني لدى عينة من المرضى المصريين (١٣٢ مريض مسلم) سواء داخليين او خارجيين تم تشخيصهم حسب التصنيف الدولى العاشر للامراض.
و لقد وجد انه يوجد دلالة عالية بين التوجه الدينى الداخلى و الخارجى وسوء الاستخدام لأنواع عديدة من المواد المسببة للادمان.