Religious Behavior in Patients with Psychoactive Substance Use Disorders in Saudi Arabia

Sayed M.

Abstract

Religious and spirituality is a neglected area of study and research in the etiology and treatment of addictions. This study attempts to determine the religious. orientation among patients with substance use disorders, in Saudi Arabia.

A random sample of 51 cases was drawn from patients admitted in AL-Amal Specialized Hospital for addiction in EL Damam, Saudi Arabia. A structured questionnaire consisting of 30 items including socio-demographic and clinical characteristics of patients was completed for each patient. Religious Orientation Scale (ROS) was applied for each patient and to a matched control group.

Polysubstance use was the most common diagnosis (31.4%), followed by Opiates (27.5%), alcohol (19.6%), then volatile substance use (13 - 7%), amphetamine and cannabis were equally distributed (3.9 %). The scoring on the Total Intrinsic and ROS, were significantly lower in the patients than the control group, ($P<0.0001$), while scoring on the Extrinsic ROS was significantly higher in patients than the control group. A significant correlation was found between low religiosity and the repeated hospitalization.

Religious and spiritual aspects should be considered in the treatment and prevention of substance use disorders. Comprehensive addiction research should include not only biomedical, psychological and socio-cultural factors but spiritual aspects of the individual as well.

Introduction

Although religions have been far from silent on the use of psychoactive drugs, and spirituality has long been emphasized as an important factor in recovery from addiction, surprisingly little research has explored the relationships between these two phenomena (Miller, 1998).

Little is known about the relationships between psychoactive substance use and different aspects of religious background, belief, and behavior. Religion may prevent the onset or persistence of alcoholism by advocating doctrines that prohibit its use, by providing a supportive and structured environment within the religious community, by offering alternative cognitive and behavioral means of coping with painful emotions and feelings, or by a combination of these factors (Koenig etal., 1994).

Moreover, Studies involving both community and clinical samples have documented an inverse relationship between religious variables and use of psychoactive drugs including alcohol (Koenig, etal., 1992).

However, despite its potential protective and rehabilitative effects, religion may also foster denial and repression by allowing

only limited expression of sexual or aggressive drives (Koenig etal., 1994). Freud emphasized that religion might cause an unhealthy repression that could contribute to the development of neurosis. Neurotic individuals, in turn, may use psychoactive substance to numb the guilt aroused by religious teaching. Some studies have reported higher rates of alcoholism among members of religious denominations that completely prohibit alcohol use (Royce, 1995).

Miller, (1998) mentioned that the current situation indicate that spiritual and religious involvement may be an important protective factor against alcohol and drug abuse. Individuals currently suffering from these problems are found to have a low level of religious involvement and spiritual engagement appears to be correlated with recovery.

A recent Egyptian study by EL-Rasheed, el at (1992) colleagues on the religious orientation among patients with substance use disorders have found a significant correlation between the Internal and External religious orientation and polysubstance abuse, opiate abuse, more relapses, frequent hospitalization, younger age of onset as well as longer duration of the disorder.

While spirituality is a neglected area of study and research in the treatment of addiction, ***McDowell Et al (1996)*** had studied the role of spirituality in the treatment of the dually diagnosed. The patients view spirituality as essential to their recovery and value spiritual programming in their treatment more than some concrete items. On the other hand nursing staff underestimated both the patients level of spirituality and the importance placed on spiritual issues.

The present study examine the association between substance use disorders and the religious orientation in a sample of Saudi Patients. In an attempt to clarify the role of spirituality as a dimension in the etiology of substance use disorders and it's impact on the treatment and rehabilitation program.

Subjects and Methods

The study sample was randomly drawn from the inpatients department at AL Amal Hospital in EL Damam, Saudi Arabia. This hospital is specialized in the treatment and rehabilitation of male patients suffering from substance use disorders. A total of 51 of such patients were investigated after the resolution of the withdrawal state, patients with co-morbid psychiatric diagnosis were excluded from the study. All patients were invited to sign a written consent before being included in the study sample.

The study was conducted over a period of Six months, that started from August 1998 to January 1999.

The patient group was subjected to the following: -

1- Full history taking using a 30-items questionnaire specially designed for this work, including personal history, illness data and family history.
2- Research Diagnostic Criteria of the ICD-10.
3- Religious Orientation Scale (ROS) version A, it consists of two subscales: -

A- The extrinsic religious orientation subscale.
B- The intrinsic religious orientation subscale.

Version "A" of the ROS is designed for Moslems and is formed of 34 statements. The scale has been standardized on Egyptian by EL-Behairy and Demerdash

(1988) with high inter-rater reliability and validity.

The first 17 statements measure the extrinsic religious orientation while the rest of the scale (from 18 to 34), measure the intrinsic religious orientation.
Both the extrinsic, intrinsic and the total religious orientation scales has the following levels of scoring (very weak, weak, below average, average, high and very high).

A high score on either the extrinsic subscales or the total ROS indicate a high extrinsic religious orientation i.e. low religiosity, while a low score on the intrinsic subscales indicate a high intrinsic religious orientation i.e. high religiosity.
The authors clarify this ROS by putting certain determinates 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 teaching are not followed in daily behavior.
5- Superstitious beliefs.
6- Resorts to religion at times of stress.

Determinants of Intrinsic Religious Orintation: -

1- Doing good to satisfy God's wish.
2- Following religious teaching in daily behavior.
3- Praying in the exact times of prayer.
4- Lifting the suffering of other.
5- Feeling anguish while reading koran.
6- Fear of God and praying this fore went.
7- Approaching God by following his leading and his book and the teachings of the prophet.
8- Continuous self judgment and accountability.
9- Feeling tranquility upon a continuous relatedness to God.

A matched group of same age, sex and educational level were selected as a control group (N=44). This group was subjected to the ROS.

Statistical Analysis: -

Data was introduced to IBM-Personal computer and analysis was done using SPSS-Version 5. Data was described using the means and standard deviation for quantitative variables. Chi-Square and student-t-test were used for analysis of qualitative variables, and one-way-analysis of variance (ANOVA) was used to analyse the qualitative data.

Results

Soicodemographic data: -

Demographic characteristics of the study and control groups are presented in table (1).

Both groups were Saudi Moslems males. The mean age of the patients (33.1 ± 8.8) was slightly elder than in the control group (30.6 ± 6.8). About one quarter (25.5%) of patients were of primary school education, while the majority were at the level of preparatory school (43.1%). Around two fifth of patients (42.9%) had no out door occupation while the remainder had either manual job (14.6%), professional (20.8%) or clerk (20.8%). Half of the patients were single (50%), the remainder were either married (38%) or divorced (12%).

Clinical characteristics of the study sample: -

Figure (1) shows the frequency of various ICD-10 subcategories of Mental and Behavior Disorders due to Psychoactive Substance Use. Polysubstance use was the most common diagnosis (31.4%), followed by Opiates (27.5%), alcohol (19.6%), then Volatile substance (13.7%), Amphetamine and Cannabis were equally distributed (3.9% for each). While non-of the patients were using cocaine as well as non-of them were using hypnotic and sedative as a solitary substance.

There were no significant relation between the diagnosis and the patient's occupation education, residency, family structure, order of birth, family history of mental illness, type of treatment or any police involvement due to the addictive behavior (P>0.05).

On the other hand a significant relation was found between the patient's income and the type of substance used; Volatile substance use was significantly related to low income P<0.05. Moreover it was found that the source of referral to treatment significantly varies with the type of psychoactive substance use, self-referral was found among 60% of alcoholic patients, while 85.7% of patients using volatile substances were brought by their families and 46.2% of those using opiates were referred by the police for treatment, the differences were statistically highly significant (P<0.0001).

Also the duration of the illness differs significantly with the type of substance used; longer illness duration was found among patients who were using Volatile substance or palysubstances (P<0.05). While the mean number of hospital admission was (3.23±2.82). The mean age of smoking cigarettes was (15.1±2.57) and the mean number of cigarette consumption per day was (24.78±12.5), there was no significant difference between patients and control groups P > 0.05.

Religious Orientation Scale (ROS): -

Table (2) shows the mean values of the ROS and it's subtypes, the extrinsic ROS was significantly higher in-patients than the control group (53.5±9.3 and 44.6±6.5 respectively) (P<0.0001) i.e.: low religiosity in the patients groups. While the intrinsic ROS was slightly higher in the patient's than control group, the difference was statistically insignificant (40.1±8.7 and 38±12.4 respectively) P>0.05. On the other hand the total ROS was significantly higher in-patients than the control group (93.7±13.6 and 82.6±14.7 respectively), the difference was statistically highly significant (P<0.0001). i.e.: low religiosity in the patient's group.

The levels of the ROS and it's subscales are illustrated in tables 3,4,and 5. It was found that the majority of patients have been found in the levels of bellow average or weak on the intrinsic ROS (45.1% and 25.5% respectively), while two third of the patients have been found in the very high and above overage levels on the extrinsic Ros. Approximately 65% of patients have been found in the very weak levels on the total ROS. The differences in the scaring between patients and control groups were statistically significant (P<0.05).

The scoring on the Intrinsic, Extrinsic and total ROS was not significantly related to the patient's education, and occupants residency, martial status, income type of treatment, family structure, number of hospitalization and police involvement due to addictive behavior.

The relation between the type of psychoactive substance used and the scoring on the ROS and it's subtypes were clarified in this work. There was a significant relation between the type substance used and scoring on the Intrinsic ROS, 60% of Alcoholic, 57.1% of Volatile substance users and 43.8% of Polysubstance users had below average level on the Intrinsic ROS. While one third of patients using Opiates had a weak score on the intrinsic ROS. ($P<0.05$).

However the scoring on the Total ROS and the Extrinsic ROS did not differ significantly with the type of substance used. ($P>0.05$). Most of the extrinsic ROS scoring was in the levels of high and very high while the Total ROS was in the levels of weak and very weak regardless of the type of the psychoactive substance used by the patients.

In order to analyze the qualitative variable AVOVA was used, Regarding the cigarettes smoking no significant relation was found between the age of starting smoking and the current diagnosis, however by using ANVOVA the increased number of cigarettes smoking was significantly correlated with both Palysubstance and Amphetamine use ($P<0.05$). On the other hand no significant correlation was found between cigarette smoking and scoring on the ROS by using ($P>0.05$).

While there was no significant relation between the Total ROS the number of hospitalization ($P>0.05$), using ANOVA, it was found that those who had very weak, weak and below average scoring were frequently hospitalized during the course of their illnesses ($P<0.05$).

Moreover using ANOVA between the number of hospitalization and the Intrinsic ROS scoring, there was a significant correlation between the increased number of hospitalization and the below average and weak levels on the intrinsic ROS ($P<0.05$).

However there was no significant relation between hospitalization and scoring on the extrinsic ROS, using ANOVA between the number of hospitalization and the Extrinsic ROS, there was a significant correlation between the increased number of hospital admission during the cause of the illness and the high and very high on the Extrinsic ROS. ($P<0.05$).

Concerning the determinants of the Extrinsic ROS, significant different was found between higher among the patients and the control group: in the following religion is the prime source of psychological and social satisfaction ($P<0.001$) and superstitious beliefs ($P<0.0001$). Regarding the determinants of the intrinsic ROS, significant difference was found between the patient and the control groups: in the following doing good to satisfy God's wish ($P<0.0001$), and approaching God by following his leading, his book and the teachings of the prophet ($P<0.001$).

Results

Table (1) Socio-demographic characteristics of the studied and control groups

Variable	Patient's group N = 51	Control group N = 44
Mean age	33.1	30.6
Sex	Males	Males
Religion	Moslems	Moslems
Nationality	Saudi	Saudi
Education:		
Primary	25.5%	30%
Preparatory	43.1%	40%
Secondary	19.6%	20%
University	11.8%	10%
Marital status:		
Single	50%	50%
Married	38%	30%
Divorced	12%	20%
Occupation:		
Working	57.1%	52%
Not working	42.9%	48%

Fig (1) Types of Substance Use Disorders Among Studied Sample

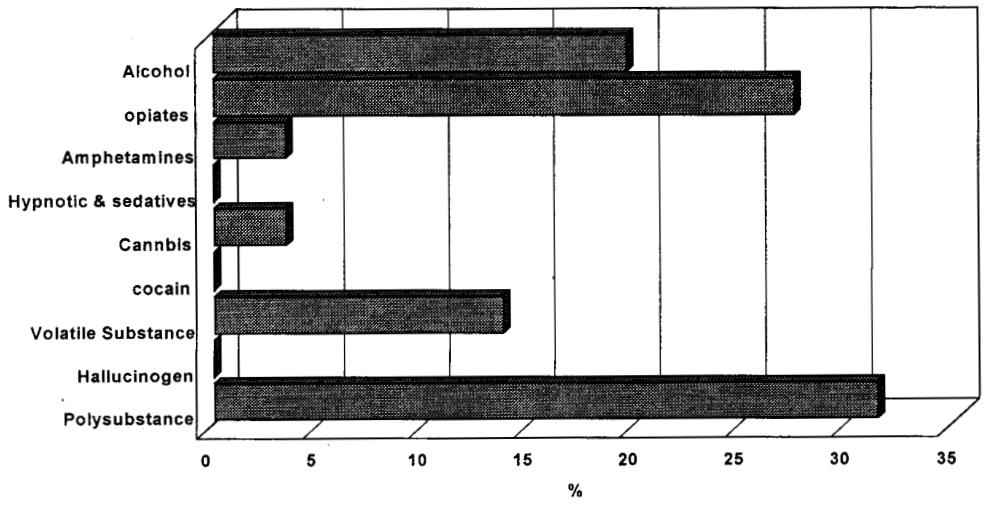

Table (2): Religious Orientation scale in the studied and control group:

Variable	Cases N=51	Control N=44	t-test	
			Df	P
Extrinsic ROS	53.5±9.3	44.6±6.5	89.1	0.000
Intrinsic ROS	40.1±8.7	38.0±12.4	75.6	>0.05
Total ROS	93.7±13.6	82.6±14.7	88.4	0.000

**Highly significant.*

Table (3): The level of Intrinsic ROS in studied and control groups: -

Levels	Cases		Control		Significant		
	No	%	No	%	X^2	Df	P
Very weak	5	9.8%	6	13.6%			
Weak	13	25.5%	12	27.3%			
Below average	23	45.1%	7	15.9%			
Average	6	11.8%	11	25%			
Above average	3	5.9%	5	11.4%			
High	0	0	3	6.8%			
Very high	1	2%	0	0	14.1	6	0.02*

**Statistically significant.*

Table (4): The levels of Extrinsic ROS in Studied and Control Group:

Levels	Cases		Control		Significant		
	No	%	No	%	X^2	Df	P
Very weak	0	0	1	2.3%			
Weak	1	2%	1	2.3%			
Below average	2	3.9%	10	22.7%			
Average	4	7.8%	5	11.4%			
Above average	16	31.4%	19	43.2%			
High	10	19.6	7	15.9%			
Very high	18	35.3%	1	2.3	22.0	6	0.001 *

**Statistically significant.*

Table (5): The levels of Total ROS in Studied and Control Group:

Levels	Cases		Control		Significant		
	No	%	No	%	X^2	Df	P
Very weak	24	47.1%	7	15.9%			
Weak	9	17.6	8	18.2%			
Below average	15	29.4%	10	22.7%			
Average	0	0	8	18.2%			
Above average	1	2%	10	22.7%			
High	2	3.9%	1	2.3%			
Very high	0	0	0	0	25	5	0.0001*

Highly significant.

Discussion

Religiosity and spirituality are neglected area of study and researches in the causation and treatment of addiction (McDowell, et al., 1996). Comprehensive addiction research should include not only biomedical, psychological and Socio-cultural factors but spiritual aspects of the individual as well.

The central finding of the present study is that religiosity in general is significantly and inversely related to alcohol and drug use. This is in agreement with the previous studies by EL-Rasheed etal., (1998); Miller, (1998); McDowell et al.,(1996); and Gartner et al., (1991).

Regarding the religious orientation subclass, this study had found that the intrinsic religious orientation was significantly higher in the patients than the control group, which indicates low level of internal religiosity. The main deficiencies were related to the following determinants doing goods to satisfy God's wish and Approaching God by following his leading, his book and teachings of the prophets. These may act as contributing factors in the development of intractable and incurable habits including substance use disorders. Meanwhile if this factors are strictly followed, this will protect the person against substance use disorders, these finding are supported by EL-Rasheed etal., (1998).

On the other hand, the extrinsic religious orientation was significantly higher in patients than the control group, which indicates high external religiosity. For these patients religion is the prime source of psychological and social satisfaction and they had superstitious beliefs, however they did not either follow religious teachings in daily behavior nor resort to religious at times of stress. The above mentioned factors are acting together making the person at high risk to substance use disorders.

An interesting finding was that the type of substance use disorder was significantly related to the scoring on the intrinsic religious orientation scale. For example patients with alcohol or opiates use disorders were found to have low internal religiosity ($P<0.01$). However, the extrinsic and total religious orientation did not differ with the type of substance use. It is not just a coincidence that the internal religiosity

not the external one could affect the selection of the drug addiction. As in Saudi Culture, one of Moslem community, alcohol is prohibited not only by Islam but also by the whole society. So the habit of alcohol drinking among Saudi population usually carried on a secretive basis, So the person with low internal religiosity is at a higher risk to develop alcohol use. Moreover these patients tend to seek treatment by themselves on a secrete way without being discovered by their family.

However, the demoralization caused by prolonged alcohol and opiates abuse could explain the low internal religiosity found in such patients.

Another interesting finding was that the low total religiosity, the low internal religiosity and the high external religiosity all were positively correlated with the need for frequent hospitalization during the course of the illness. So religion seems not only protect the person against substance use disorder but also it reduces the relapses of the illness. Our finding was in agreement with the results of EL-Rasheed etal., (1998), Miller, (1998), McDowell etal., (1996) and O'Malley etal., (1985).

However this study failed to find any significant association between the level of religious orientation and the following: patient's age, education, occupation, residency, martial status, income, family structure, type of treatment and police involvement due to the addictive behavior.

Vaillant (1993) mentioned that 'religion is the opiates of the masses; masks an enormously important therapeutic principle. Religion may actually provide a relief that drug and alcohol abuse only promises. Alcoholics and victims of other seemingly incurable habits feel defeated bad and helpless. Moreover, they suffer from impaired morale. If they are to recover, powerful new sources of self-esteem and hope must be discovered.

Religion is considered one of such source. Religion provides fresh imputes for both hope and enhanced self-care. Second, religion provides protection and security from bad and unwanted habits. Third, religion provides forgiveness of sins and relief from guilt.

So it can be concluded that spiritual and religious issues should be addressed in substance abuse patients since they may have positive impact on patient recovery. ***Hater etal., (1984)***. Found that the religious variables accounted for significant and unique variance only in the general well-being variable in opioid addicts.

Moreover McKee and Chappel (1992) recommended that medical model be expanded to a biopsychosocial spiritual one especially on dealing with certain disorder especially substance use disorders.

In addition, more attention should be given by staff to spirituality in the treatment of substance use disorder. Religiously oriented program must be tailored according to the patient's own beliefs in order to help the patient to get ride of that habits. Moreover collaborative work should be done between mental health personnel and religious personnel in order to improve the level of service provided. These religious personnel dealing with drug users should be invited to attend educational program regarding the drug addiction and to give them enough information on dealing with such patients. A proper religiously oriented program should provide the patient with support and help rather than induction of guilt and sin.

Another important implication of this study is to improve the religious orientation of the population at risk for substance use disorders in an attempt to reduce it's occurrence.

Last but not least further studies are recommended on a larger sample size and to include females suffering from such a problem. Also further studies comparing different cultures are also needed for proper replication of the results.

References

Koenig H., George L., Meador K., Blazer Th., and Ford S., (1994): Religious practices and Alcoholism in a southern Adult population. HCP Mar.

ParFrey PS., (1976): The effects of religious factors on intoxicant use. Scandinavian Journal of Social Medicine 3:135 – 140.

Koenig H., Gohen HJ. Blazer TH., etal; (1992): Religious coping and depression in elderly hospitalized medically ill men American Journal of Psychiatry 149 ; 1693 – 1700.

Vaillant C-E: The Natural history of alcoholism: Causes, patterns and paths to recovery. Cambridge Mass, Harvard University Press.

Miller WR, 1998: Researching the spiritual dimensions of alcohol and other drug problems. Addiction, 937 (979 – 990).

McDowell D, Galanter M, Gold Farb L., 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).

El Rasheed AH., Omar ANM and Nagy N, (1998): Religious orintation in patients with substance use disorders. Current psychiatry, Vol. 5 No2 (133 – 143).

Gar tner J, Larson DB and Atten GD: Religious commitment and mental health: a review of emperical literature. J. Psychol And Theology, 19 : 6 – 25.

O, Malley PM, Johnston LD, And Bachman JG (1985): Cocaine use among American Adolescents and Young adults. NIDA Res. Monogr ., 61 : 50 – 75.

McKee DD, and Chappel JN (1992): spirituality and medical practice J. Fam Pract., 35 (2) : 201.

Hater JJ, Sing BK, and Simpson DD (1984): Influence on family and religion on long term outcomes among opioid addicts. Advances in alcohol and substance abuse, 4(1): 29 – 40.

El BehaIRY aa AND Demerdash (1988): Religious orintation scale: Arabic Version.

Authors:

Maha S.
Lecturer of psychiatry
Faculty of Medicine
Ain shams University

Address of Correspondence

Maha S.
Lecturer of psychiatry
Faculty of Medicine
Ain shams University

السلوك الدين لدى المرضى المدمنين السعوديين

إن الروحانيات والديانة من الأوجه المهمة فى مجال دراسة ظاهرة الإدمان من حيث مسـببباتها وطرق علاجها . والهدف من هذه الدراسة بحث العلاقة ما بين تعاطى المواد المخدرة ومدى الوعـــي الديني عند المرضى. وقد تمت هذه الدراسة على عينة عشوائية من المرضى فى إحدى المستشـــفيات المتخصصة في علاج الإدمان في المملكة العربية السعودية. وقد تمت دراسة الجوانـــب الاجتماعيـة والإكلينيكية لهؤلاء المرضى بالإضافة إلى تقييم الوعي الديني باستخدام مقيـــاس الوعـــي الدينـــي – الصورة (أ) . وقد تم اختيار عينة ضابطة متجانسة من حيث الجنس ، العمر ودرجة التعلم . وأظهرت نتائج هذا البحث أن الوعي الديني الكلى الجوهري أقل في عينة المرضى عنه في العينة الضابطة أمـا الوعي الديني الظاهري فوجد أنه أعلى في العينة المرضية عن الضابطة .

ومن هنا يتضح أن الوعي الديني أقل في المرضى عنه في الأصحاء . ويتضح أيضا أهمية الوعي الديني في علاج والوقاية من سوء استخدام العقاقير.

THE OKASHA LECTURE

CURRENT PSYCHIATRY

1999

Psychiatry in Al Andalus
The Arab Influence

PRESENTED
BY

PROF. Juan Jose Lopez-Ibor, Jr.

President -Elect World Psychiatric Association
Prof. of Psychiatry and Chairman
San Carlos Hospital Department of Psychiatry
Complutense University of Madrid- Spain

Semiramis Intercontinental

1st JULY 1999

By invitation