The study of the effects of religiosity on adolescent alcohol and drug use and alcohol-related problems

Rickey Reanell Wallace
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ABSTRACT

SOCIAL WORK

WALLACE, RICKY REANEL B.S. UNIVERSITY OF ARKANSAS, 1988
M.S. TROY UNIVERSITY, 1997
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THE STUDY OF THE EFFECTS OF RELIGIOSITY ON ADOLESCENT

ALCOHOL AND DRUG USE AND ALCOHOL-RELATED PROBLEMS

Advisor: Dr. Robert Waymer

Dissertation dated May 2007

The purpose of this study is to examine the effect of religiosity as a central feature on juvenile delinquents, ages 12-17, who are chronically involved with drugs and alcohol. An estimated 400,000 adolescents sought treatment for substance abuse, which does not include those who failed to come to the attention of parents, school officials, treatment providers, or researchers (Adger, 1991). It is hypothesized that religiosity will have minimal statistical significance in the lives of substance abuse adolescents.

Secondly, a positive relationship between several dimensions of parental and family religiosity is also predictive of adolescent substance use. Thirdly, a positive relationship exist between religiosity and violation of social norms and laws. Its findings suggest that despite drug abusing adolescents delusional ways of thinking about the world, they continue to embrace a sense of hope that something other than themselves [God, Allah, Buddha] can help them re-establish an intrinsic sense of equilibrium in their lives. Relationships with religious oriented friends as role models is found to have had a
protective impact on juvenile adolescents who are involved with substance use in this study. This study further highlights the need for more empirical-based treatment strategies in working with this target population that incorporates religiosity as an intervention strategy.

Key Terms:  
Religiosity- supernatural power or spirit [God, Buddha, or Allah] who is the center of the universe and controls all natural and living organisms.  

Spirituality- innate feeling of connectiveness to something greater than oneself that invokes a sense of serenity and peace of mind.
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DEFINITION OF TERMS

1. Abstinence - Non-use of a specific substance. In recovery, non-use of any addictive psychoactive substance.

2. Abuse - Harmful use of a specific psychoactive substance. The term also applies to one category of psychoactive substance-related disorders.

3. Addiction - A primary, chronic, neurobiologic disease, with genetic, psychosocial and environment factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

4. Admission - That point in an individual’s relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive the services of the treatment program.

5. Adolescent - As used in the American Society of Addiction Medicine Patient Placement Criteria-2R, an individual aged 13 through 18. The term also frequently applies to young adults aged 18 to 21, who may be in need of adolescent-type services rather than adult type services.

6. Alcoholics Anonymous - A fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others recover from alcoholism. The only requirement for membership is a desire to stop drinking.

7. Alcoholism - A general but not diagnostic term, usually used to describe alcohol dependence, but sometimes used more broadly to describe a variety of problems related to the use of beverage alcohol.

8. Assessment - Those procedures by which a program evaluates an individual’s strengths weaknesses, problems and needs, and determines priorities so that a treatment plan can be developed.

9. Adjustment disorders - Category of disorders in which individual has difficulty adjusting to a common stressor.

10. Aftercare - Follow-up therapy after release from a hospital.

11. Aggression - Behavior aimed at hurting or destroying someone or something.

12. At-risk - Condition of being considered vulnerable to the development of certain abnormal behaviors.
DEFINITION OF TERMS (continued)

13. Attention deficit disorder - Maladaptive behavior in children characterized by impulsivity, excessive motor activity, and an inability to focus attention for appropriate periods of time.

14. Autonomy - Self-reliance; the sense of being an individual in one's own right.

15. Abstinence - The act of refraining from the use of alcohol and any other drug. It also refers to stopping addictive behaviors, such as overeating and gambling.


17. Addiction - A progressive disease process characterized by loss of control over use, obsession with use, continued use despite adverse consequences, denial that there are problems, and a powerful tendency to relapse.

18. Adulterant - A pharmacologically in-active substance used to dilute a drug.

19. Adulteration - The dilution of a drug in order to increase its volume; used by street dealers to increase profits.

20. Aftercare - The services that are provided recovering addicts after they leave a residential treatment program.

21. Agonist - A drug that initiates an effect when it imitates a neurotransmitter rather than blocking it.

22. Ala-NON - A 12-step organization to help the relatives and friends of alcoholics.

23. Alcohol - An organic chemical created naturally by the fermentation of sugar, starch or other carbohydrate. It can also be synthesized from ethylene or acetylene.


25. Alcohol-induced disorders - A diagnostic category in DSM –IV under alcohol-related disorders that describes a group of psychiatric symptoms caused by alcohol intoxication or alcohol withdrawal, including alcohol-induced withdrawal, amnesia, psychotic disorder, mood disorders.

26. Anti-depressants - A series of drugs that are used to treat depression, mostly by boosting the levels of serotonin in the brain, e.g., tricyclic antidepressant, Prozac, and Zoloft.
27. Antisocial personality disorder - A mental disorder in which the person disregards the rights and feelings of others, feels no remorse, needs instant gratification, cannot learn from mistakes, cannot form personal relationships and is often involved in risk taking, drug abuse, pathological lying, and criminality.

28. Anxiety - a state of intense fear and apprehension. Symptoms include higher pulse, respiration, and sweating. Long-term anxiety can increase one's susceptibility to drugs use since some drugs.

29. BAC - (blood alcohol concentration) the concentration of alcohol in the blood; used legally to identify drunk drivers.

30. Beer - an alcoholic beverage that is brewed by fermenting malted grains and hops, an aromatic herb.

31. Benzodiazepines - a group of minor tranquilizers, such as Klonopin and Xanax that calm anxiety, relax muscles, and induce sleep.

32. Big Book - The main book of Alcoholics Anonymous containing the philosophy of AA and autobiographical stories of recovering alcoholics, used extensively in AA meetings.


34. Binge drinking - drinking large amounts of alcohol at one sitting; artificially defined as five drinks or more for men and four or more for women in one drinking session at least once every two weeks but being abstinent in between these times.

35. Bipolar affective disorder - a mental illness characterized by mood swings.

36. Blackout - loss of awareness and recall without unconsciousness due to intoxication by alcohol or other drugs.

37. Borderline personality disorder- characterized by sharp shifts in mood, impulsivity (often self-destructive, anger, alienation, and unstable self-image; borderline personality disorders are often drawn to drug use.

38. Central Nervous System - the brain and spinal cord.

39. Chemical dependency - physical and/or psychological dependence on one or more psychoactive drugs.
DEFINITION OF TERMS (continued)

40. Chronic – slang for marijuana, potent marijuana, crack smoked with a marijuana cigarette.

41. Cirrhosis – a serious progressive liver disease that scars the liver; often caused by heavy chronic alcohol abuse.

42. Co-dependency – a pattern of painful dependence on another person’s compulsive behaviors and on approval from others in an attempt to find safety, self-worth, and identity. Codependents judge their self-worth by relying on other’s opinions of them, so they try too hard to please, have low self-esteem, are very impulsive, and are into denial.

43. Cognition – accurate appraisal of one's surroundings; often disrupted during drug use, detoxification, and initial abstinence.

44. Cold Turkey – detoxification from a drug, such as heroin, without the use of lower doses or other drugs to ease the withdrawal symptoms.

45. Compulsion – an uncontrolled need to perform certain acts, often repetitively, in order to forget painful thoughts or unacceptable ideas.

46. Continuum of Care – An integrated network of treatment services and modalities, designed so that an individual’s changing needs will be met as that individual moves through the treatment and recovery process.

47. Controlled Drug – psychoactive substances that are strictly regulated according to the Controlled Substances Act of 1970, cocaine, heroin, amphetamines, marijuana, there are five levels of controlled substances.

48. Countertransference – when a therapist or counselor lets personal feelings influence how he or she treats a client.

49. Crack – slang for cocaine that is made smokable by transforming cocaine hydrochloride to freebase cocaine using baking soda, heat, and water.

50. Crash – the comedown from a high (usually a stimulant high) in which energy is depleted by the drug and by staying awake for days. Depression and anhedonia are common.

51. Craving – the powerful desire to use a psychoactive drug or engage in a compulsive behavior. It is manifested in physiological changes, such as raised heart rate, sweating, anxiety, drop in body temperature, pupil dilation, and stomach muscle movements.
DEFINITION OF TERMS (continued)

52. Cross-dependence – occurs when an individual becomes addicted or tissue-dependent on one drug, resulting in bio-chemical and cellular changes that support an addiction to other drugs.

53. Cross-tolerance – the development of tolerance to other drugs by the continued exposure to a drug that affects body mechanisms to tolerate other drugs, tolerance to heroin translates to tolerance to morphine, alcohol, and barbiturates.

54. Dehydration – a deficiency of water in the body that can be aggravated by some drugs, particularly when exercising or dancing.

55. Delirium Tremens – severe withdrawal symptoms from high-dose, chronic alcohol use; symptoms can include visual and auditory hallucinations, trembling and convulsions, sometimes results in death.

56. Delta-9 tetrahydrocannabinol – the main active ingredient in marijuana; also known as THC.

57. Delusion – a mistaken idea that is not swayed by reason, often involving the senses.

58. Denial – the inability or the unwillingness to perceive one's addiction to a drug; a defense mechanism manifested by drug abusers and addicts.

59. Dependence – physiological adaptation to a psychoactive drug to the point where abstinence triggers withdrawal symptoms and re-administration of the drug relieves those symptoms, psychological need for a psychoactive drug to induce desired effects or avoid negative emotions or feelings, reliance on a substance.

60. Depressant – a psychoactive drug, such as alcohol, a sedative-hypnotic, or an opiate, that decreases the actions in the brain resulting in depressed respiration, heart rate, muscle strength, and other functions; also called a “downer.”

61. Depression – a psychological mood disorder characterized by symptoms such as depressed by symptoms such as depressed mood, feelings of hopelessness, sleep disturbances, and even suicidal feelings.

62. Detoxification – a drug therapy technique for eliminating a drug from the body. It can take a few hours to two weeks or more depending on length of use and the type of drug. It is the first step in most treatment protocols for addiction.
DEFINITION OF TERMS (continued)

63. Disease Concept – this model maintains that addiction is a chronic, progressive, relapsing, incurable and potentially fatal condition that is mostly a consequence of genetic irregularities in brain chemicals. The addiction is set into motion by drug use in a susceptible host in an environment that is conducive to drug misuse. Loss of control and compulsive use quickly follow.

64. Dis-inhibition – the loss of control over behavior, making the person more likely to perform formerly unthinkable or difficult actions, drinking alcohol makes them more likely to overcome shyness and talk to others.

65. Dopamine – a major neurotransmitter often affected by psychoactive drugs; involved in euphoria and voluntary muscle movement and emotional states of mind.

66. Drug Testing – examining the blood, breath, urine, or hair of people to determine if they are using drugs.

67. Drug Therapy – the use of drugs to detoxify a drug abuser, to reduce craving, or to substitute a less damaging drug for a damaging one, any medical treatment that involves the use of medication.

68. Dry drunk – an alcoholic who has quit drinking but is not in recovery. They crave alcohol constantly and generally have alcoholic personality traits such as insensitivity to others, rigid outlook, dissatisfaction, and lack of insight or self-examination but they have learned to resist the impulse rather than change their lifestyle.

69. DSM –IV (Diagnostic and Statistical Manual of Mental Diseases) a publication of the American Psychiatric Association that classifies mental illnesses.

70. DUI – (driving under the influence) drunk driving or driving under the influence of another psychoactive drug.

71. Effective dose – the dose of a drug that causes a desired effect 50% of the time. Twenty-five percent of the people tested require a higher dosage for the desired effect and 25% require a lower dosage.

72. Eight-ball - 1/8 of an ounce of any drug, usually heroin, cocaine, or methamphetamine.
DEFINITION OF TERMS (continued)

73. Environment – any external influence on a person, including relationships, school, work, living location, nutrition, availability of drugs, advertising, and kinds of friends. One of the three main factors most influential in forming a susceptibility to becoming an addict. The other two are heredity and the use of the drugs or the acting out of a compulsive behavior.

74. Ethanol (ethyl alcohol) the main psychoactive ingredient in beer, wine, and distilled liquors; usually made from fermented grains, fruits, or carbohydrate based vegetables, such as potatoes and rice.

75. Etiology – the study of the causes of a disease including addiction.

76. Excretion – the elimination of water and waste products, including drugs and their metabolites, due to metabolism through urination, sweating, exhalation, defecation, and lactation.

77. Experimentation – the first stage of drug use where the person is curious but uses the drug only sporadically and there are no negative consequences.

78. Facilitator – a professional intervention specialist or a knowledgeable chemical dependence treatment professional who arranges and participates in an intervention to break through an addict's denial and get him or her into treatment.

79. FAS – (fetal alcohol syndrome) birth defects caused by excessive use of alcohol while pregnant. Signs of FAS include, retarded growth, facial deformities, and delayed mental development.

80. Fat-Soluble – capable of being absorbed by fat. Most psychoactive drugs are absorbed by the brain because the brain has a high fat content.

81. Fight, Flight, Fright Center – an area of the old brain and the peripheral nervous system that alerts us and helps us react to danger by increasing alertness, releasing adrenaline, and raising heart rate and respiration. It is initially triggered by emotional memories and instinctual drives in the amygdala and hippocampus.

82. Flashback – a remembrance of the intense effects of a drug, such as LSD or PCP, that is triggered by a memory, by encountering environmental cues, or by a residual amount of the drug being released usually from fat cells.

83. Genetic Predisposition – a genetic susceptibility to use drugs addictively that comes into play when that person starts using psychoactive drugs.
84. Group Therapy – the use of several clients in a group to help each other break the isolation of addiction, increase knowledge, and practice recovery skills.

85. Habit – a term for addiction.

86. Habituation – a level of drug use just before abuse where the substance (or behavior) is used on a regular habitual, basis but does not yet have regular serious consequences. There is some loss of control.

87. Half Life – the time it takes for half of a drug that has entered the bloodstream to be inactivated through metabolism and excretion.

88. Hangover – alcohol withdrawal symptoms that occur 8-12 hours after stopping drinking. They include headache, dizziness, nausea, thirst, and dry mouth. The causes are the direct effects of alcohol and its additives.

89. Hard Drugs – used in the past to refer to strong schedule I drugs, such as heroin, cocaine, and amphetamines.

90. Hash Oil – an extract of marijuana that is added to food or to marijuana cigarettes. Its THC content can be as high as 20% to 80%.

91. Hashish – the potent sticky resin of the marijuana plant that is often pressed into cakes and sold or smuggled. The THC content is anywhere from 8% to 40%.

92. Heredity – the transmission of physical and even mental characteristics through genes, chromosomes and DHA.

93. Heroin – a powerful opiate analgesic, derived from morphine.

94. High-risk behavior – dangerous behavior, such as unprotected sex, violence, and risk taking, that can lead to injury or infection. It is often caused when drugs lower inhibitions or impair reasoning.

95. Homeostasis – the balance of functions and chemicals in the body as well as the process by which that balance is maintained; the process responsible for the development of tissue dependence, tolerance, and subsequent withdrawal from psychoactive drugs.

96. Impairment – physical and mental dysfunction due to psychoactive drugs or other addictive behaviors.

97. Ingestion – taking food, liquid, drugs, or medications into the stomach by mouth.
DEFINITION OF TERMS (continued)

98. Inhalant – any substance that is vaporized, misted, or gaseous that is inhaled and absorbed through the capillaries in the alveoli of the lungs.

99. Inhibition – controlling and restraining instinctual, unconscious, or conscious drives especially if they conflict with society’s rules.

100. Injection – a method of rapid drug delivery that puts the substance directly in the bloodstream, in a muscle, or under the skin.

101. Inpatient Treatment – a 7-28 day program in a hospital or other residential facility that focuses on detoxification, therapy, and education.

102. Intervention – a planned attempt to break through addicts’ or abusers’ denial and get them into treatment. Interventions most often occur when legal, workplace, health, relationship, or financial problems have become intolerable.

103. Intoxication – functional impairment; loss of physical and mental processes due to substance use. It can be acute due to high-dose use or chronic due to continuous lower-dose use. In both cases it is most often caused by the drug’s effect on the central nervous system.

104. Intramuscular Injection – injecting a drug into a muscle. It takes three to five minutes for the drug to reach the brain and have an effect.

105. Intravenous Injection – injecting a drug directly into a vein. It takes 15-30 seconds for the drug to reach the brain.

106. Joint – slang for a marijuana cigarette.

107. Juice – street name for methadone, PCP, or steroids.

108. Ketamine – used as a recreational club drug, it is an anesthetic that produces catatonia and deep analgesia; side effects include excess saliva, dysphoria, and hallucinations. Its chemistry and effects are very similar to PCP.

109. Klonopin – clonazepam; a popular benzodiazepine sedative. People in methadone maintenance use it to increase the high from methadone.

110. Krystal – street name for PCP; not to be confused with the street terms “crystal” or “crystal meth” that denote methamphetamine.

111. Latency – delay between the time a person uses a drug and the time it appears in urine, blood, saliva, or other fluid.
112. Lethal Dose – the amount of a drug that will kill the user. It can vary radically depending on purity, sensitivity of the user, tolerance.

113. Line – a thin line of cocaine hydrochloride, about two inches long, that is snorted.

114. Lithium – the main drug used to treat bipolar affective disorder.

115. Liver – the largest gland in the body (2-4 pounds) metabolizes protein and carbohydrates and most psychoactive drugs that pass through the blood, especially alcohol.

116. Loss of Control – the point in drug use where the user becomes unable to limit or stop use.


118. Major depression – a mental illness characterized by a depressed mood and sleep disturbances without a life situation causing it.

119. Malt liquor – a beer-like beverage with a slightly higher alcohol content than normal lager beer.

120. Marijuana – the common name for Cannabis plants that have high levels of psychoactive ingredients, especially THC.

121. MDMA – (methylenedioxyymethamphetamine) commonly known as “X” or “ecstasy,” a stimulant/hallucinogen first synthesized in the early 1900s and popularized in the 80s.

122. Medical Intervention – the use of medications to treat a substance-related or mental disorder. This is usually done in combination with group/individual therapy or other treatment techniques.

123. Medical Model – 1. Using medications to treat addiction because addiction is caused by irregularities of brain cells and chemistry. 2. In mental health, the concept that mental illnesses are caused by a disease process and by changes in brain chemistry.

124. Metabolism – the body’s mechanism for processing, using, inactivating, and eventually eliminating foreign substances, such as food or drugs, from the body.
125. Methamphetamine hydrochloride – also called “meth,” “crystal meth,” and “crystal;” an intense psychoactive stimulant based on the amphetamine molecule; used for injecting, ingesting, and snorting.

126. Misuse – An unusual or illegal use of a prescription, usually for drug diversion purposes. Any nonmedical use of a drug or substance.

127. Narcotic – this term from the Greek narkotikos, meaning “benumbing”; originally used to describe any derivative of opium but came to refer to any drug that induced sleep or stupor.

128. Narcotics Anonymous – a 12 step program developed along the lines of Alcoholics Anonymous but focusing on those addicted to drugs.

129. Native Americans – refers to indigenous people of North and South America who predated the colonizing European settlers of the fifteenth through nineteenth century.

130. Natural High – a feeling of elation and satisfaction that is induced without the use of psychoactive drugs.

131. Negative Reinforcement – a hypothesis about learning that says we learn an action when the response lets us avoid a negative stimulus or removes the negative circumstance. The threat of severe withdrawal from heroin reinforces the continued use of the drug.

132. Neonatal – referring to the period immediately after birth and through the Neurotransmitters – chemicals that transmit messages between nerve cells. The activity of these chemicals are strongly affected by psychoactive drugs.

133. Nickel Bag – five dollars worth of a drug, such as heroin; inflation has made it hard to find.

134. Nicotine – the active stimulant alkaloid of the tobacco plant, it mainly affects the natural neurotransmitter acetylcholine.

135. Norepinephrine – a neurotransmitter that affects energy release, appetite, motivation, attention span, heart rate, blood pressure, dilation of bronchi, assertiveness, alertness, and confidence.

136. Obsessive-compulsive disorder – an anxiety disorder characterized by disturbing obsessive thoughts that can only be resolved by acting out some compulsive behavior, such as hand washing.
DEFINITION OF TERMS (continued)

137. Old brain – brain stem, cerebellum, and the mesocortex; these areas regulate physiologic functions and help the person experience basic emotions and cravings.

138. Organic mental disorders – mental illnesses caused by physical changes in the brain due to injury, diseases, or drugs and chemicals.

139. Outpatient treatment – programs in which the client lives at home but receives therapy and support from a facility, therapist, or therapy group.

140. Over-the-counter drugs – drugs and medications that can be obtained without a prescription and are legally sold in supermarkets and drugstores.

141. Overdose – the accidental or deliberate use of more of a drug than the body can handle; causes severe medical consequences, including coma and death.

142. Paranoia – irrational suspicions that someone or something is out to harm you; often induced by psychoactive drugs.

143. Paranoid psychosis – irrational fears that someone or something is out to get you; the condition can be mimicked by drug use, particularly strong stimulant use.

144. Paraphernalia – drug-using equipment such as syringes, glass pipes, and water pipe.

145. PCP – a psychedelic drug first used as an anesthetic for people then for animals, but the side effects were too outlandish. It distort sensory messages, deadened pain, and stifle inhibitions. It can cause catatonia, coma, or convulsions.

146. Peripheral nervous system – one of the two major divisions of the human nervous system. The other part of the system is the central nervous system.

147. Personality disorders – abnormal and rigid behavior patterns that begin in childhood, often last a lifetime, and are often self-defeating.

148. Pharmacodynamic tolerance – a defense mechanism of the brain that causes neurons to become less sensitive to the effects of psychoactive drugs.

149. Polydrug abuse – the use of several drugs either in succession or at one time that causes significant physical, mental, or social distress.

150. Potency – the pharmacological activity of a given amount of drug.
DEFINITION OF TERMS (continued)

151. Predisposition – a susceptibility to overreact to the use of a drug; heredity and environment along with drug use, can activate this tendency to abusive and addictive use of psychoactive drugs.

152. Prescription drugs – any medication that needs a doctor’s permission to use.

153. Prevention – a group of social, medical, psychological, economic, or legal measures used to lessen potential for or the actual impact of drug abuse and addiction.

154. Problem drinking – a pattern of drinking, similar to abuse, in which the drinker is experiencing serious life problems due to drinking but has not yet earned a definitive diagnosis of alcoholism.

155. Psychoactive drug – any substance that directly alters the normal functioning of the central nervous system when it is injected, smoked, snorted, or absorbed into the blood.

156. Psychological dependence – drug-caused altered state of consciousness that reinforces dependence on the drug. This is different than tissue or physical dependence.

157. Psychosis – a psychiatric disorder that grossly distorts a person’s thinking and behavior making it difficult to recognize reality and cope with life.

158. Psychotherapy – a technique of treatment for emotional, behavioral, personality, and psychiatric disorders based principally on verbal communication and interventions with a patient as opposed to physical and chemical intervention.

159. Psychotic – of or relating to psychosis or the behavior associated with psychosis.

160. Psychotropic drugs – drugs used to treat mental illnesses.

161. Random testing – a method of drug testing with unannounced or short notifications; used by many sports organizations.

162. Recovery – the final step in drug treatment, following abstention, initial abstinence, and long-term abstinence in which clients have changed their style of living and have overcome their major physical and mental dependence on psychoactive drugs or addictive behaviors and are committed to abstinence.
DEFINITION OF TERMS (continued)

163. Recreational drug use – a level of drug use after experimentation where people seek out the drug to experience certain effects but there is no established pattern of use and it has a relatively small impact on their lives; use is sporadic, infrequent, and unplanned.

164. Rehabilitation – restoring an abuser or addict to an optimum state of physical and psychological health through therapy, social support, and medical care.

165. Reinforcement – a learning process whereby a person receives a reward for a certain action. That reward, in turn, increases the likelihood that the person will repeat that action.

166. Relapse – reoccurrence of drug use and addictive behavior after a period of abstinence or recovery.

167. Resiliency – the ability of an individual to resist drug use and abuse. The resistance qualities are formed by hereditary and environmental influences at home, in school, and in the community.

168. Sedative – a drug that eases anxiety and relaxes the body and mind; also called “tranquilizers” and “muscle relaxants.”

169. Serotonin – a neurotransmitter involved in mood stability, especially depression, anxiety, sleep control, self-esteem, aggression and sexual activity.

170. Setting – the location where a drug is taken; ambiance is important in determining the overall effect of a psychoactive drug, such as LSD, on a user.

171. Snorting – inhaling a drug through the nose to let the capillaries in the mucosal membranes absorb the drug; it takes 5-10 minutes for a drug to reach the brain when it is snorted.

172. Sobriety – a term for abstinence from drugs or alcohol (being sober) the concept is used mostly in Alcoholic Anonymous and other 12-step groups.

173. Social Drinking – a level of drinking between experimentation and habituation; drinking is sporadic, infrequent, and non patterned.

174. Speed – Street name for any amphetamine or methamphetamine.

175. Speedball – a drug combination of an upper and downer, usually heroin and cocaine or heroin and methamphetamine, that is injected, snorted, eaten, or smoked in combination with each other.
DEFINITION OF TERMS (continued)

176. Spirituality – an individual’s personal relationship with his or her higher power; awareness or acceptance that one is part of a greater purpose or existence than just their own worldly existence; a crucial part of 12-step programs.

177. Stimulant – any substance, including cocaine, amphetamines, diet pills, coffee. They stimulate the nervous system by increasing the electrical and chemical activity of the brain.

178. Street drugs – illegal psychoactive drugs, such as cocaine, heroin, and marijuana.

179. Stress – the body’s reaction to illness and environmental forces. It produces psychological strain and physiological changes, including the release of cortisol, rapid respiration and heart rate, constricted blood vessels, and release of hormones.

180. Tachycardia – rapid beating of the heart caused by cardiovascular disease or drugs, especially stimulants.

181. Therapeutic community – any long-term residential inpatient program that provides full rehabilitative and social services.

182. Therapy – the treatment of addiction or other problem through a variety of methods, including counseling and group therapy, that is conducted by a licensed or credentialed professional.

183. Tolerance – the increasing ability of the body to metabolize greater and greater amounts of a drug or other foreign substance to limit the impact on the body.

184. Tough Love – a treatment approach that requires an addict’s family to set strict limits on behavior to break through denial.

185. Toxicology – the study of toxic substances.

186. Tranquilizers – drugs that have anti-anxiety or antipsychotic properties but don’t induce sleep; also prescribed as muscle relaxants.

187. Treatment – the use of various techniques and therapists to change maladaptive patterns of behavior and restore the client to full health.

188. Triggers – any object or action that activates craving in a recovering drug user, the sight of white powder, money, a syringe, an old drug-using partner.
189. Twelve-step programs – self-help groups based on Alcoholics Anonymous and the 12 steps of recovery. Their purpose is to change addicts’ thinking and behavior.

190. Urinalysis – analysis of urine to test for drug use.

191. Valium – the most popular benzodiazepine of the 1960s.

192. Whiskey – a distilled alcoholic beverage made from a mash of fermented grains.

193. Whites - street name for Benzedrine (amphetamine) tablets, originally prescribed for weight control.

194. Wine – an alcohol beverage made from the fermented juice of grapes; can be made from other fruits and vegetables.

195. Withdrawal – the body’s attempt to rebalance itself after prolonged use of a psychoactive substance.

196. Zero Tolerance – a prevention philosophy that allows no tolerance or second chances for drug use; often used in schools.
CHAPTER I

INTRODUCTION

Early adolescence is one of the most sensitive periods in the life cycle. It is a transitional period during which young adolescents experience physical changes (Paikoff & Brooks-Gunn, 1990), new feelings and perspectives about their sense of self and relationships (Archer, 1982), and significant shifts in socially ascribed roles (Dunham, Kidwell, & Wilson, 1986). The "developmental organization" (Cicchetti & Toth, 1992) that occurs between late childhood and adolescence makes early adolescence a time of heightened vulnerability to emotional and behavior problems and substance use disorders. Moreover, problems during this critical period increase vulnerability to a range of negative outcomes throughout adolescence and into adulthood. Generally, the earlier youths begin to use drugs and experience related problems, the more serious the consequences and the more difficult it is to steer them on to a positive developmental course (Tarter, 1999).

It is estimated that 400,000 adolescents sought treatment for substance abuse, which does not include those who failed to come to the attention of parents, school officials, treatment providers, or researchers (Adger, 1991). The growing number of adolescents presenting for treatment to the nation's public treatment system pose many challenges. Rather than personally seeking treatment, many of these adolescents are
being mandated to attend treatment by the criminal justice system or their parents (Dennis, Dawud-Noursi, Muck, & McDermeit, 2003).

From 1915 to 1985, only a handful of evaluations of adolescent substance abuse treatment studies existed and many of these took place when adolescents were treated in adult programs or in segregated units with adult models. After the de facto criminalization of narcotics between 1915 and 1920, New York City treated 743 adolescents (under the age of nineteen) addicted to narcotics in segregated units at the Worth Street Clinic. By the 1920’s, however, this effort was declared a failure based on internal evaluations (Copeland, 1920; Graham-Mulhall, 1921; Hubbard, 1920).

It took the federal government until the 1930s to establish two federal narcotics “farms” (later called U.S. Public Health Hospitals) that were initially to be dedicated to the treatment of juvenile addiction. But by the time they opened, the average age of a person entering treatment was almost thirty-eight years (Lowry, 1956). From 1947 to adolescents (under age twenty-one) entering this facility rose from 22 to 440 (1900 percent) (Conferences, 1953). New York City also admitted another 250 adolescents per year in a residential treatment program at Riverside Hospital on the Old Welfare Island (Gamso & Mason, 1958). The lack of community resources to help young narcotic addicts in the 1950s triggered new initiatives within cities being hard hit by heroin addiction and these initiatives are the origins of the modern community-based treatment systems.

These included the creation in the 1950s and early 1960s of addiction wards in local hospitals such as the Detroit Receiving Hospital; Chicago’s Bridewell Hospital; and
Bellevue, Kings County, Manhattan General, and Metropolitan hospitals in New York City, as well as church-based efforts including such programs as St. Mark's Clinic in Chicago, the Addicts Rehabilitation Center in Manhattan, the Astoria Consultation Service in Queens, Exodus House in East Harlem, and other religiously affiliated programs such as Teen Challenge and the Samaritan Halfway House Society (White, 1998).

Despite the anti-marijuana campaigns of the 1920s and 1930s and the de facto criminalization of that drug with the Marihuana Tax Act of 1937, there is little evidence of large numbers of adolescents (or adults) seeking treatment for marijuana until the late 1960s when its use became more common (Anslinger & Cooper, 1937; Anslinger & Tompkins, 1953; Dennis & White, 1999; Rowell, 1929, 1937; Rowell & Rowell, 1939). The transition from adolescent admissions for narcotics to admissions for marijuana and alcohol did not start until the late 1960s and early 1970s. This also coincided with a series of national program evaluations of existing practice and attempts to apply adult treatment models to adolescents.

The Drug Abuse Reporting Program (DARP) (Sells & Simpson, 1979; Simpson, Savage, & Sells, 1978) was conducted in the early 1970s using a national stratified and purposive sample of existing community-based programs for narcotics use. The study included data on adolescents (under age twenty) at intake (n = 5,405) and a follow-up interview approximately three years later with 587 adolescents who had been treated in methadone maintenance (n = 119), therapeutic communities (n = 238), outpatient drug free (n = 158), and detoxification/other (n = 72). Prior to admission, 73 percent of the
adolescents used opioids (66 percent weekly or more often), however, the rate of any opioid use ranged from 93 percent of those being treated with methadone to 49 percent of those being treated in outpatient drug free. Even in this early study, marijuana had already emerged as the second most commonly used substance, with 62 percent reporting any use (46 percent weekly use) and ranging from 48 percent among those in methadone programs to 66 percent of the adolescents in outpatient drug free and therapeutic communities.

With a median length of stay of about two months, all levels of care substantially reduced opioid use, the rates of alcohol use went up slightly, and the amount of marijuana use remained the same or increased, particularly among those in methadone treatment.

The Treatment Outcome Prospective Study (TOPS) (Craddock, Bray, & Hubbard, 1985; Hubbard, 1985) was conducted in the late 1970s and early 1980s using a second national stratified and purposive sample of existing community-based treatment for any kind of drug use. The study included data on adolescents (under age twenty) at intake (n = 1,042) and twelve-month post discharge interviews with 256 adolescents who had been admitted to therapeutic communities (n = 106) or outpatient treatment (n = 150). By this time, 31 percent of the adolescents were being treated primarily for marijuana related problems, followed by admissions primarily related to amphetamines (7 percent), alcohol (5 percent), and only then opioids (4 percent). TOPS found 25 to 50 percent reductions in the rates of daily marijuana use, alcohol use and other drug use, and drug related problems after residential treatment (with a median length of stay of about three months). For adolescent outpatient treatment (with a median length of stay of two months),
however, the results were mixed with 25 percent or less reductions and several subgroups
9 eighteen to nineteen-year-olds in treatment for less than three months; twelve to
seventeen-year-olds in treatment for more than three months) actually increasing their
rates of substance use or other problems.

The Services Research Outcome Study (OAS, 1995) was conducted in the late
1980s to early 1990s using a national probability sample of existing community-based
treatment for any kind of substance use. The data include record abstraction and five-year
post-discharge follow-ups (that recaptured intake histories) with a total of 156
adolescents (under age eighteen) receiving treatment.

Although the data from this study are limited to the percent using five or more
times in the five years before and after treatment (with no detailed breakdown for
adolescents), it does help to further document the continuing shift toward a pattern of
using marijuana (68 percent), alcohol (80 percent), and the smaller roles of cocaine (20
percent) and opioids (2 percent) among adolescent admissions.

The median length of stay was two to three months, with 48 percent of the
adolescents going back into treatment one or more times in the five years after the index
episode (ranging from 65 percent of those who received less than a week of treatment to
40 percent of those who received less than a week of treatment to 40 percent of those who
received six small).

It caused considerable concern among policy makers because it found that from
the five years before to the five years after treatment, the prevalence of using (5+ times in
the past year) substances increased for marijuana (68 to 70 percent), alcohol (80 to 92 percent), cocaine (20 to 29 percent, and heroin (2 to 7 percent).

The National Treatment Improvement Evaluation Study (NTIES) (CSAT, 1999, 2000; Gerstein & Johnson, 1999) was conducted in the early 1990s using a national stratified and purposive sample of community-based treatment programs that had received demonstration grants to enhance treatment. The data include interviews with 236 adolescents (age thirteen to seventeen) at intake and twelve-month post-discharge who received any kind of treatment (no modality breakdowns are available). Again, most adolescents were being treated for marijuana (46 percent) or alcohol (10 percent), with heroin, crack, and cocaine together making up only 14 percent more.

With a median length of stay of about two months, NTIES found that residential treatment was associated with reductions in using (5+ times in the past year) marijuana (97 to 72 percent), cocaine (52 to 30 percent), and in alcohol intoxication (52 to 45 percent). Adolescent outpatient treatment, however, was associated with a slight reduction in marijuana use (77 to 69 percent), no change in cocaine use (13 to 13 percent), and a slight increase in alcohol intoxication (32 to 37 percent).

The Drug Abuse Treatment Outcome Studies of Adolescents (DATOS-A) (Grella, 1999, 2000; Hser, 1999, 2001; Powers, 1999; Rounds-Bryant, 1998) was conducted in the mid and late 1990s using a third national stratified and purposive sample of existing community-based treatment for any kind of substance use. The study included data on adolescents (age eleven to nineteen) at intake (n = 3,382) and twelve-month post-discharge interviews with 1,785 adolescents that had been admitted to long-term
residential (n = 727), short-term residential (n = 613), and/or outpatient treatment (n = 445). By the early 1990s, over 90 percent of the adolescents were using marijuana at intake (58 percent meeting dependence criteria) and 84 percent were using alcohol (27 percent dependent). In contrast, only 15 percent had cocaine dependence and 3 percent opioid dependence. For the year before to the year after treatment, the rates of marijuana (91 to 68 percent) and heavy alcohol use (34 to 20 percent) across modalities went down, while the rates of cocaine use went up slightly (17 to 19 percent).

Substantively, it is important to realize that most of the treatment programs in these evaluations were using adult treatment models with only minimum modifications. Early therapeutic communities such as Odyssey House and Phoenix House started admitting adolescents in the late 1960s and were quickly followed in the 1970s by Crossroads, Gateway Foundation, Inc., Synanon, and Safri House; almost immediately these programs began modifications in order to involve more professionals and families (Kajdan & Senay, 1976).

Early evaluations of adolescent treatment practice in the community were also methodologically limited by small samples spread over many different programs and undefined approaches, low treatment duration (generally about two months), and marginal follow-up rates (50 to 70 percent).

Complicating matters further, none of these studies were based on the kind of manualized approach that is required for easy dissemination to the field and that is increasingly the sine qua non for good substance abuse treatment (Carrol, 1997; Crits-Cristoph & Siqueland, 1996; Institute of Medicine, 1990; Lamb, Greenlick, & McCarty,
1998; Miller, 1995; Onken, Blaine, & Battjes, 1997; Ozechowski & Liddle, 2000; Stanton & Shadish, 1997; Weinberg, 1998).

Several other attempts have been made to develop and evaluate additional models of substance abuse treatment more appropriate for adolescents (Alford, Koehler, & Leonard, 1991; Azrin, 1994).

Statement of the Problem

The latest evidence from the National Household Survey on Drug Abuse (NHSDA) shows that the percentage of young people using drugs is increasing—from 9.7 percent in 2000 to 10.8 percent in 2001. There was also a significant increase in the estimated number of persons age 12 or older needing treatment for a drug problem (Epstein, 2002).

Clearly, the need for effective substance abuse treatment strategies for adolescents is great. Until recently, few of the promising adolescent treatment models tested through clinical trials research (Azrin, et al., 1994; Liddle & Dakof, 1995) had been evaluated in actual practice settings. While there are increasing attempts to transport interventions developed through efficacy research into applied settings (Dennis, et al., 2002; Liddle, et al., 2002), there still have been few rigorous evaluations of existing treatment models that have evolved in communities around the country. Thus, it is impossible to know how well these interventions work and how they might compare with interventions that have been developed through clinical trial research. There is also some question as to whether or not interventions developed from efficacy research will work with the same
effectiveness with the heterogeneous group of adolescents commonly enrolled in community-based treatment programs and can be carried out by staff currently employed in these programs.

The treatment field also currently lacks information on religiosity as a salient treatment multiplier and its significance relative to gender differences, rural and rural-remote adolescents, minority adolescents, adolescents with co-morbid conditions, and developmentally specific effects. Any one or a combination of these issues can interact with religion to either inhibit or enhance effectiveness (Dennis, et al., 2002; Liddle, et al., 2002).

Purpose of the Study

The purpose of this study is to examine the multidimensional impact of religiosity as a central feature for sustaining sobriety among juvenile delinquents, ages 12-17, who are chronically involved with drugs and alcohol, and are admitted into either Outpatient, Intensive Outpatient or Residential treatment, based on the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994) and ASAM level of care Patient Placement Criteria for the Treatment of Substance Related Disorders (PPC-2R; ASAM, 2001). Some of the dimensions this study seeks to examine are: (1) religiosity as a protective factor toward long-term sobriety for adolescents after discharge from ASAM levels I, II, and III (Outpatient, Intensive Outpatient or Residential Treatment) programs; (2) to determine the significance of a religiosity on teenager’s motivation to change; (3) to analyze the effects of religiosity on
remission of substance use for adolescents and improved family communication upon successfully completing treatment; and (4) to examine whether the influence of familial religiosity foster pro-social behaviors in other domains of the adolescent’s life i.e. school, home, and community.

Research Questions

Researchers and practitioners have provided ample evidence that alcohol and other drug abuse is interrelated with a host of other social problems and health compromising behaviors, gaining a greater understanding of these interactions among social problems such as poverty, violence, family dysfunction, school failure, delinquency and adolescent pregnancy, is best understood and ameliorated with the incorporation of faith-based initiatives, for change in maladaptive behavioral patterns or change in life is ultimately a spiritual matter (Perkins, 1993, p. 80).

Hypotheses

The role of religiosity in adolescent recovery as a potential determinant of positive life consequences and sobriety commands the examination of the following fundamental research questions:

1. Are there significant mean differences between religiosity and the amelioration of problematic behaviors in other life domains?
2. Are there significant mean differences between familial religiosity and improved parent-child communications?
3. Are there significant mean differences between adolescent’s belief in God and use of religiosity in daily living?
Significance of the Study

Literature on faith-based treatment is limited, largely descriptive and centers on the work of urban churches. While descriptive research is important and often provides valuable insights into a new field of inquiry, it fails to offer theoretical basis upon which to build knowledge or provide a conceptual “blueprint” for sound direct practice (Wallace, Mryers, & Holley, 1998). To begin to address the gaps in knowledge with regard to religiosity as a protective factor and helping adolescents live drug-free lifestyles, the historical underpinning of churches and other religious affiliations much examine the role and application of spiritual principles toward advancing the theoretical framework implicit in working with chemically dependent teenagers, and present a broad conceptual paradigm that faith-based practitioners can use to guide future efforts.

As a result of the Charitable Choice provision (i.e., section 104) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the Welfare Reform Act) and President Bush’s Faith-Based Initiative, policy makers, academics, and mainly clergy have focused considerable attention on the role of faith-based organizations in the delivery of social services (Chaves, 1999).

Recent studies suggests that many (between 60 percent and 90 percent) of American churches support at least one social service program, but only receive less than 3 percent of federal funds (Chaves, 1999). Religiosity has had an influence in the African-American community for decades, for the church is viewed a scarce place and the venue to meet the needs of the poor, substance abuser, illiterate, unemployed and to provide legal assistance to its community. Theoretical frameworks that do not account
for spirituality or religiosity are often insufficient to ameliorate the changing conditions that creates the need for external assistance. Moreover, persistent racial discrimination that denied African-Americans access to the religious, social, business, governmental, educational and recreational resources of the larger society, gave rise to the church as the central entity to meet these needs (Lincoln & Mamiya, 1990).

Many efforts to address the conditions of adolescent substance use, particularly for African-American teenagers, have relied on deficit-oriented social services models that denied them power and viewed increases in services as the solution to their problems (Wallace, Mryers, & Holley, 1998).

The thrust of this study is to offer an analysis of the aforementioned contextual factors that often works in tandem with religion to bring about a higher level of socio-emotional functioning.

Summary of the Introduction

The study has thus far delineated the evolution of the temperance movement and society's reaction to the need to provide a viable service for its members afflicted by chemical dependency. While many of the practices and interventions employed during the infancy stage of the profession's development were designed for adult patients, still today insufficient attention and research efforts are given to the overwhelming needs of adolescent substance abusers.

National studies have shown that drug use has declined or leveled off, while alcohol use has remained stable at high rates. However, the level of substance use and
abuse is still truly alarming, whether by historical standards or in comparison to other countries. This study of substance use among adolescents and young adults is important because of its ecological impact on human capital. Research has firmly linked adolescent substance use with low-esteem, poor psychological functioning, low academic achievement, a lack of vocational interest, dissonance between parent-child and little to low participation in religious related activities.

The most urgent question for researchers and practitioners is to ask how can religiosity be integrated into the treatment regiment of substance abusing teenagers without violating their civil rights, and what long-term impact such practice will have on recidivism, conformity to social norms, and improved functioning? The proceeding chapter is a survey of existing literature in an attempt to answer this question and to raise awareness about the pervasive need for ongoing research efforts to develop more holistic, innovative strategies to help adolescents recover.
CHAPTER II
REVIEW OF THE LITERATURE

The aim of this review of the literature to is to demonstrate the strengths and weaknesses of religiosity as a protective factor on multiple domains in an adolescent’s life. This chapter surveys existing literature that sets the stage for the continual need for scholarly research in the area of religiosity and its effect on adolescent development and problem-solving ability. An historical review of religiosity in the life’s of adolescent is briefly covered, religiosity and adolescent use, strengths, weaknesses and Jessor’s Value on Religion Scale is explained.

Historical Gaps in Adolescent Religiosity Literature

Several decades of social scientific studies have shown that religion is often a factor in the lives of American adolescents, influencing their attitudes and behaviors in ways that are commonly viewed as positive and constructive. Across a number of areas of concern, (Smith, 2003) various measures of religiosity are typically associated with a variety of healthy, desirable outcomes.

A large majority of studies that have included religion measures (especially church attendance and importance of religious faith) have found them to be inversely related to juvenile drug, alcohol, and tobacco use, and to delinquency (Wallace,
Williams, 1997; Evans, et al., 1995; Pawlak & Defronzo, 1993; Cochran & Akers, 1989; NCASA, 2001). Multiple studies also confirm that religiosity is inversely related to thoughts of suicide, attempted suicide, and actual suicide among American teenagers (Donahue, 1995). Religiosity also appears to act as a protective influence against suicide among youth most at-risk for it. Furthermore, religion is associated with lower levels of depression and hopelessness, which suggests it has an additional indirect effect on risk of suicide (Wright, Frost, & Wisecarver, 1993).

One renowned scholar of adolescence and his associates have found church attendance to be a key factor in promoting adolescent health-enhancing behaviors, such as diet, exercise, sleep, dental hygiene, and seatbelt use (Jessor, Turbin, & Costa, 1998). Another important adolescence scholar has shown that religious youth are less likely to engage in health-compromising behaviors and are more likely to take care of themselves, even after controlling for other relevant factors (Wallace & Forman, 1998).

Moreover, several reliable studies show that youth and their families who regularly attend church display greater overall satisfaction with their lives, more involvement with their families, and better skills in solving health-related problems than those whose parents attend church less often (Varon & Riley, 1999).

Strengths of Adolescent Religiosity Literature

Studies of adolescents have shown several examples of factors that reduce the impact of adverse experiences, that is, buffering effects (Wills, Biechman, & McNamara, 1996). For example, measures of family support and of problem-solving skills have been
shown to reduce the effect of life stress on outcomes such as adjustment and academic achievement (Dubow & Tisak, 1989; Wolchik, Ruehlman, Braver, & Sandler, 1989), and parental support has been shown to reduce the impact of negative life events on adolescent substance use (Wills, Vaccaro, & McNamara, 1992). There is some evidence for religiosity as a protective factor, indicated by studies showing that measures of religiosity are inversely correlated with indices of adolescent substance use (Wallace & Williams, 1997), and considerable evidence indicating that life stress is a risk factor for adolescent alcohol and other drug use (e.g., Chassin, Pillow, Curran, Molina, & Barrera, 1993; Wills, 1990).

Given the existence of buffering processes it is thus plausible to predict that religiosity has a buffering effect for adolescent stressors, reducing the impact of life events on alcohol and other substance use (Wallace & Williams, 1997). A number of studies show that religion is demonstrably associated with more effective “coping” with problems by youth, among teens both physically ill and well (Shortz & Worthington, 1994; Balk, 1991). Studies furthermore show inverse associations between religiosity and youth having had sex, the number of sexual partners, recency of sexual intercourse, and teenage pregnancy (Thornton & Camburn, 1989; Lammers, et al., 2000; Murry, 1994; Whitehead, Wilcox, & Rostosky, 2001).

In the area of family relations, not only has parental religiosity been linked with higher levels of parental involvement in and overall health of family interactions, there is also fairly consistent evidence that higher levels of church attendance and religiosity are typically associated with more pro-family attitudes and religious family values, while
declining religious commitment is found to be correlated with attitudes skeptical of family life (Brody, Stoneman, & Flor, 1996).

A few studies suggest that youth religiosity is linked to greater satisfaction with family life across a variety of family contexts, including nuclear families, step-families, and single-parent families. When it comes to education, generally, church attendance and positive perceptions of religion are related to positive school attitudes and behaviors. Robust, though mild, positive influences of church attendance are consistently visible on academic achievement, from childhood through late adolescence and into college (Muller & Ellison, 2001; Regnerus, 2000). Church attendance also appears to act as a protective influence against dropping out of school for at-risk youth (Scharf, 1998).

Evidence about religion and youth political and civic involvement is fairly thin. However, existing evidence does suggest that religious participation may be associated with greater political and civic involvement, especially during young adulthood (Smith, 1999; Serow & Dreyeden, 1990). Adolescents are generally less politically engaged than young adults. However, in most studies on the topic, religion appears to be linked with commitment to and involvement in community (Youniss, McLellan, & Yates, 1999).

Weaknesses in Adolescent Religiosity Literature

There is limited scholarly research about the religious lives of American adolescents. Most of the literature in the sociology of religion in the United States centers around adults, ages 18 and older. Few researchers of American adolescents in other disciplines pay minimal attention to youth's religious lives. As a result, our social
scientific knowledge of the religious affiliations, practices, beliefs, experiences, and attitudes of American youth is improved (Smith, Denton, Faris, & Regnerus, 2002).

Religiosity and Adolescent Substance Use

Studies of adolescent substance use have used various definitions of religiosity (Wallace & Williams, 1997). Categorical indices of religious affiliation (vs. none) have shown inconsistent results (e.g., Amey, Albrecht, & Miller, 1996), but consistent inverse relations with alcohol and other substance use have been found for measures that tap frequency of attendance at religious services (Adlaf & Smart, 1985; Amey, et al., 1996; Hadaway, Elifson, & Peterson, 1984). Effects for religiosity have been found in later adolescence as well as among younger persons (Foshee & Hollinger, 1996). Studies that index the perceived importance of religion have consistently shown inverse relations with substance use. Jessor and colleagues (Jessor, Chase, & Donovan, 1980; Jessor & Jessor, 1977) have found that a scale on the perceived importance of religion was inversely related to measures of problem drinking in regional and national samples of high school students. Inverse relations of similar measures to frequency of tobacco, alcohol, and marijuana use have also been found in other samples (Bahr, et al., 1998; Barnes, Farrell, & Banerjee, 1994; Resnick, et al., 1997).

Jessor's Value on Religion Scale

Religiosity was indexed in this study with the Jessor's Value on Religion Scale (Jessor & Jessor, 1977). A lead-in instruction stated, "Here are some questions on what you think about things. Read each one, and circle a number to show what you think."
Responses were made on scales that ranged from 1 to 4, with response points “not at all important,” “a little important,” “pretty important,” and “very important.” Internal consistency reliability (Cronbach’s alpha) was .78-.81 assessments. The items were “To believe in God,” “To be able to turn to prayer when you’re facing a personal problem,” and “To rely on your religious beliefs as a guide for day-to-day living.”

Negative life events. A 20-item inventory based on previous measures of adolescent stressors (Newcomb & Harlow, 1986; Wills, et al., 1992) was administered with a dichotomous (no-yes) response scale to describe events that occurred during the previous year. A subscale of 11 family events, those that could have occurred to a family member and did not directly involve the respondent (e.g. “Father/mother was unemployed”) had alphas of .58-.62. A 9-item scale of adolescent events, those that could occur directly to the respondent (e.g., “I had a serious illness”) had alphas of .54-.61.

Adolescent alcohol and other substance use. Substance use by the participant was measured with items that asked about the typical frequency of his or her alcohol, tobacco, and marijuana use. Three items were introduced to participants with the stem: “How often do you smoke cigarettes/drink alcohol/smoke marijuana?” Responses were made on scales that ranged from 0 to 5, with scale points “never used,” “tried once-twice,” “used four-five times,” “usually use a few times a month,” “usually use a few times a week,” and “usually use every day.” An item on heavy drinking asked the participant whether in the past month he or she had had three or more drinks on one occasion; response points were “no,” “happened once,” “happened twice,” and “happened more
than twice." The indices of cigarette, alcohol, and marijuana use were intercorrelated, consistent with prior methodological research (e.g., Needle, Su, & Lavee, 1989). Alpha for a 4-item composite score was .60-.80 over assessments.

Conceptual and Theoretical Framework

Most therapeutic settings are based on blended therapeutic approaches. They draw upon four theories of behavioral and emotional change (Rogerian, behavioral, cognitive, and reality therapy) and includes 12-step concepts and approaches. Rogerian concepts include unconditional positive regard, acceptance, building rapport, and empowering the adolescent (Rogers, 1951, 1959). Behavioral approaches include focusing on skills building/learning, behavior modification techniques, and habit control (Chiauzzi, 1991; Hester & Miller, 1989; Kazdin, 2000). Cognitive theory emphasizes evaluating perceptions and thoughts, and changing thinking patterns by reframing and cognitive restructuring (Ellis, et al., 1988; Walen, et al., 1992; Yankura & Dryden, 1990).

Reality therapy focuses on choices and their consequences, emphasizing that experiencing the consequences of their actions will help teach adolescents about responsibilities, and that their life problems are directly related to the choices they make (Glasser, 1976, 1992). There is also a strong emphasis on the early detection of substance use, the identification of Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorder (Adams & Wallace, 1994; Risberg, et al., 1995), and family involvement (Risberg & Funk, 2000). Motivational interviewing has more recently been employed as a technique (Miller & Rollnick, 1991) for working with chemically dependent
adolescents. These principles and the need to consider development issues associated with adolescence shape and guide all treatment interventions for adolescents and their families; however, religiosity is a construct that warrant further study to determine if its inclusion in treatment programs could enhance recovery or drastically reduce recidivism (Pullen, Modrcin-Taibott, West, & Wuenchen, 1999).

Proposed Study

An analysis will be conducted to determine the existence of significant mean differences between religiosity, family relationships, and other adaptive responses to environmental factors for adolescents age 12 to 17, who are screened and admitted into an ASAM level I, II, and III substance abuse treatment facility.

Summary of Proposed Study

A sufficient amount of empirical evidence exist supporting religiosity as a protective intervention strategy in meeting the needs of chemically dependent adolescents across ethnicities; however, a preponderance of this evidence failed to adequately engage African-American adolescents as participants in these studies; to this end, while the results may hold probable generalizability, external validity issues exist, thus limiting direct-care practitioners’ therapeutic repertoire for promoting the well-being of minority outgroups. Finally, thorough analysis of possible significance between multiple variables will potentially shed much needed insight on the relationship of religiosity and its influence on adolescent healthy, drug-free development.
Statement of Null Hypotheses

This study seeks to generate a viable inquiry as to the impact of religiosity on cessating adolescent substance use and maladaptive behaviors associated with use, by designing research questions that are ecological in nature and multidimensional. The multiple levels of care based on ASAM Placement Criteria allows the researcher to analysis the results from a broader range of potential interactions between IV variable and its effect on the DVs.

Null Hypotheses

The null hypotheses research statements are:

1. There will be no statistical significance between religiosity and the amelioration of problematic behaviors in other life domains.

2. There will be no statistical significance between familial religiosity and improved parent-child communications.

3. There will be no statistical significance between adolescent belief in God and how much religiosity is used in their daily living.
CHAPTER III
METHODOLOGY

This chapter outlines the methods and procedures that were employed in facilitating this study. The subcategories are research design; description of the site; sample population; instrumentation; treatment data and limitations of the study.

Design of Study

A descriptive and explanatory research design is employed in this study. The study is designed to ascertain data to examine the effects of religiosity on 84 respondents in major domains of their lives, for example school, home, work, community, church and treatment environment. GAIN instrument used in this study is norm with population under study and reflects positive internal and external validity and reliability.

Description of Setting

The facility identified in the study began serving adolescents in 1998, as a satellite ministry, under the umbrella of a larger non-profit organization. The governing organization acquired the satellite facility as an existing program for teenage substance abuser. A new curriculum was designed for outpatient skills groups, and transportation was provided to and from treatment for adolescents. Prior to that year, the outpatient (OP) and intensive outpatient (IOP) programs primarily served adolescents who were receiving
aftercare services post residential treatment. The advent of American Society of Addiction Medicine (ASAM) patient placement criteria in 1996 also spurred the development of outpatient counseling as a treatment option in its own right.

The residential facility in this study include several components including: 1) a monthly management report that provided data on performance indicators related to screening and admission, agreement to participate in the follow-up study, discharge data, and follow-up data; 2) collection of data reflecting the amount and type of services provided to adolescents; 3) a quantitative study based on surveys with staff, parents, and adolescent participants; 4) an outcome study.

The treatment program is located in Marietta, Georgia, (north of Atlanta, Georgia), but serves counties throughout the State of Georgia; Cobb County, however, reflects the following demographics: It is the third largest metro county in Georgia, with a 2005 population of 58,748 it includes a mix of more that 20 metro counties of Atlanta (470,688). The metropolitan Atlanta is the home to 9 major universities, Georgia State University, Kennesaw State University, Clark Atlanta University, Spelman, Emory University, Morehouse College, Life University, Southern Polytechnical University and Agnes Scott College. According to the 2005 census, Marietta, Georgia of Cobb County population is approximately 29.5% African-American, 1.1% Asian, 16.9% Hispanic, and 48.6% Caucasian (not Hispanic). Of the residents age 25 and over, 82.2% have a high school degree (or its equivalent) and 44.1% have some post-high school education. The county is the third fastest growing in the state and has a healthy economic base as evidenced by an unemployment rate of 5.8% in 2005.
Accreditation and State Requirements

All levels of care, as well as medical and psychiatric services, are located at the facility. The facility includes outpatient group rooms and 24 residential beds: twelve for females, and twelve for males. It has an outdoors basketball court, and classrooms for the on-site school. The program is accredited by the Council on Accreditation (COA) and is required under state regulations to conduct a needs assessment, use diagnostic practices, use ASAM patient placement criteria to determine their level of care, and develop an individualized treatment plan. A diagnosis is assigned according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994) and a level of care is determined according to the Patient Placement Criteria for the Treatment of Substance Related Disorders (PPC-2R; ASAM, 2001). Its academic component is accredited by the Southern Association of Colleges and Schools, as well as the Georgia Accreditation Commission (GAC).

Sampling Procedures

A convenient sample of eighty-four (84) respondents consented to participate in this study as part of their treatment. Generally, outpatient participants are either court-ordered for services or encouraged through external vehicles such as program advertisements, parents, linkages with agencies and schools, and case management outreach. Free assessments are provided for all youth who are referred to the center. The program is advertised through radio announcements and special events. Agency staff members have developed linkage agreements with other community agencies including
hospitals, social service agencies, juvenile court services, schools, and treatment facilities. Staff also network with professionals from other agencies by participating on interagency committees like the MAAC Committee, a group which discusses and makes plans to address the needs of dually diagnoses youth and their families.

Case managers play an important role in recruitment. They regularly visit every month or two with referral sources to reinforce the center’s commitment to working closely with referral sources. The visits help keep minor problems from becoming significant through frequent contact and discussion. Case managers also maintain regular contact with the adolescents who are referred for an evaluation.

Adolescents will frequently avoid scheduling the evaluation even though they are court-ordered to do so. Case managers enlist both family members and probation to apply pressure on the adolescent to follow through with the evaluation. If a treatment recommendation is made, case managers follow up with prospective adolescents to facilitate scheduling an admission appointment.

The ministry’s largest referral source is the criminal justice system. Informational meetings with probation officers, parole officers, and judges are focused on making the referral process as easy as possible. Since clinical experience suggests that relapse frequently occurs when an adolescent is released from jail, both family and probation are contacted and reminded that their son/daughter will be evaluated at the earliest convenience after the adolescent is released.

Outside of the schools, most of the referrals to the program are by telephone. During referral telephone calls, enough information is gathered to determine whether
substance abuse may be a problem and if further exploration is warranted. If adolescents are in crisis, they are provided immediate assistance. Otherwise the adolescent and their parent or guardian are scheduled for an assessment within ten business days. On-site at schools, student assistance specialists will typically complete a GAIN-Quick (GAIN-Q), which will determine whether a more in-depth assessment is needed. At the court services office or the detention center, either a GAIN-Q or the full GAIN-I is completed depending on the information provided. For example, most adolescents at court services are given a urine test prior to seeing the case manager for an evaluation. If the urine test results are positive, they will usually be administered the GAIN-I. If they are negative, then they will be given a GAIN-Q.

Once an adolescent is determined to need a comprehensive assessment, one will be provided at no cost to the adolescent or the family. It includes a biopsychosocial assessment based on the GAIN-I (Dennis, et al., 1996), a medical assessment (full physicals where indicated), interviews with collaterals, and a urine test if indicated. The GAIN-I is completed via an interview by a case manager or a substance abuse counselor. This instrument includes over 1500 questions and 100 scales (Dennis, Dawud-Noursi, Muck, & McDermeit, 2003) and takes an average of 90 minutes. Urine tests are conducted in the event that an adolescent denies any substance use.

When adequate information is available at the staffing to make a treatment recommendation, the case manager then meets with the adolescent and a guardian. The rationale for the treatment recommendation is explained. The case manager answers any questions and explains the admission process. If the adolescent is willing to follow
through with the treatment recommendation, an admission date and time is scheduled for the adolescent and guardian. Some families request time to think about the recommendation prior to scheduling an admission. In this circumstance, the case manager lets the family know that if they do not hear from them in several days, they will contact them to see if they are going to follow through with the recommendation.

Both the adolescent and guardian are expected to attend the admission appointment. The receptionist has the adolescent complete an adolescent demographic form, then the adolescent and guardian meet with a financial counselor to discuss methods of payment. Although the ministry does not receive state funding, services are not denied to anyone based on their inability to pay. If a call to an insurance company is required, the intake therapist gives the counselor information to facilitate the call.

The counselor then meets with the adolescent and guardian. While there is admission paperwork to complete, the admission process is considered a family session and emphasis is placed on building rapport. Both the adolescent and guardian are asked about problem areas and to help develop treatment goals. The counselor explains the different interventions that are required parts of the OP/IOP program including skills and counseling groups, individual and family therapy, AA/NA or Cocaine Anonymous (CA), and the Family Night program. Behavioral expectations of adolescents are also discussed and the adolescent signs a behavioral contract. The counselor determines who will be the primary collaterals that will be contacted throughout the adolescent’s treatment experience (e.g., family members, probation or parole, school, family doctor, family psychiatrist, etc.). Counselors place the responsibility for change with the adolescent and
guardian, while working to cultivate a sense of collaboration. They emphasize that
treatment can provide education, skills training, and support, but that its effectiveness is
dependent upon the adolescent’s level of honesty, openness, and willingness.

A review of screening and admission statistics for an eleven-month period (in
2003-2004) revealed that approximately one-fourth of the adolescents screened by
telephone for OP or IOP services were admitted within four weeks of their assessment. Of
the 190 adolescents who were screened by telephone, 86% completed the assessment
process. Of these, 66% were recommended for outpatient treatment. Fifty-one percent of
the adolescents recommended for one of the outpatient modalities were admitted within
28 days of their assessment. The remainder either did not set up an admission
appointment or failed to attend repeated appointments.

During this period, most referrals were made by a juvenile detention center (23%)
or family members (22%). Other referral sources included probation and parole (17%),
schools (12%), self (3%), other substance abuse treatment providers (3%), judges (3%),
the state’s child welfare agency (2%), and other sources (6%). Additionally, 6% of the
admissions were adolescents who “stepped-down” into outpatient from residential
treatment.

Human Subjects and Consent

The target population for this study were 84 adolescent substance users ages 12 to
17 years old, both males and females, who were found appropriate for treatment based on
ASAM criteria (PPC-2R; ASAM, 2001) for Level I (Outpatient) Level II (Intensive
Outpatient) and (Residential) treatment. The assessment was made with the GAIN-I, which was used both as a clinical assessment tool and the evaluation measure. Based on the GAIN-I assessment and a conference between the assessor and a supervisor, an adolescent was recommended for placement in a certain level of care. If this recommendation was for Level I, II, or III residential treatment and the adolescent accepted the treatment recommendation, he or she was approached about study participation. The adolescents had to be able to understand and be willing to sign the informed consent, and have a significant other, typically a parent, who understood and was willing to sign a collateral consent form.

Ultimately, 84 adolescents were recruited for participation in the outcome study over 21 months and were interviewed at 3, 6, 9, and 12 months post-intake. The cohort of adolescents receiving the standard admission procedures over a 12 month period that included same day assessments, same day recommendations, use of pre-set admission appointments, and admission tracking procedures. The admission procedures were implemented in at least 95% of the cases. More total adolescents were admitted to treatment under the streamlined admission procedure.

Table 1 provide data regarding the demographic and clinical characteristics of the program based on 84 adolescents who agreed to participate in the study. The majority of the adolescents were white male (84%), (14%) white females, and (2%) mix of Asian and Hispanic-American; (79%) attended school in the past 90 days (92%), and lived with a single parent (52%). Over half were either 15 or 16 years old, and most (76%) began experimenting with alcohol or drugs before age 15. Seventy-one percent reported using or
needing treatment for marijuana, 26% for alcohol, 5% for hallucinogens, and 8% for other drugs. In the 90 days prior to their assessments, they reported an average of 26 days using alcohol, marijuana, or other drugs, 9 days when they were drunk or high for most of the day, and 11 days in jail or another place where they could not use drugs.

Seventy percent reported that this was their first substance abuse treatment episode, while 27% reported having one or two prior treatment episodes. They reported being arrested, charged with a crime, and booked an average of 2.5 times. Seventy-two percent reported that this was their first substance abuse treatment episode, while 27% reported having one or two prior treatment episodes. Seventy-two percent reported current involvement with the criminal justice system.

Description of Instrument

The Global Appraisal of Individual Needs (GAIN) and the Jessor’s Value on Religion Scale were used as the primary data collection instruments, with an ability to write-in additional questions pertinent to the interviewer. The GAIN was developed through a 10 year collaboration of clinicians, researchers, and policy makers from over a dozen agencies and localities. The GAIN-I is a progressive and integrated series of measures and computer applications designed to support a) initial screenings, brief interventions and referrals, b) standardized biopsychosocial clinical assessments for diagnosis, placement and treatment planning, c) monitoring of changes in clinical status, service utilization, and costs to society, and d) subgroup and program level needs

It has been used with both adolescents and adults and in outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic communities, and correctional programs. It was adopted by over four dozen major agencies/systems of care in as many communities ranging from large urban areas to moderate size or small urban and rural areas/reservations.

The GAIN has eight core sections background, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. Each section contains questions on the recency of problems, breadth of symptoms, and recent prevalence in days or times, as well as lifetime service utilization, recency of utilization, and frequency of recent utilization. The items are combined into over 100 scales and subscales that can be used for DSM-IV based diagnosis, ASAM based level of care placement, JCAHO based treatment planning, and Drug Outcome Monitoring System. The GAIN also includes items designed to support most state/federal reporting requirements, for comparison to community samples from the National Household Survey on Drug Abuse (NHSDA), and for estimating changes in the cost to society based on the work of Dr. Michael French and his colleagues (Dennis, 2002).

It can be administered by computer, with paper and pencil, and (for higher functioning and literate clients) self-administered. The computer applications are written in Assessment Building System (ABS) so that HIPPA security concerns are addressed,
scalable to multiple types/levels of platforms, able to export the data to an ASC II file, and can be used to generate individual or group level reports on demand.

The psychometrics of the GAIN and the scale norms have been established for both adults and adolescents overall and by level of care within age. It includes over 100 indices. Key indices and their alphas for adolescents and adults where applicable are:

- Substance Problem Index (.88, .83), Substance Frequency Index (.87, .76), Current (past week) Withdrawal Index (.94, .94), Health Distress Index (.71, .73), Health Problem Index (.56, .71), Cognitive Impairment Index (formative), General Mental Distress Index (.95, .92), Traumatic Stress Index (.92, .96), Behavior Complexity Index (.94, .96), Emotional Problem Index (.80, .78), Treatment Resistance Index (formative), Treatment Motivation Index (formative), Self Efficacy Index (.76, .71), Problem Orientation Index (formative), Environmental Risk Index (.79, .76), Recovery Environmental Risk Index (formative), General Conflict Tactic (violence) Scale (.87, .91), Traumatic Victimization Index (.87, .88), Interpersonal Sources of Stress Index (formative), Other Sources of Stress Index (formative), General Social Support Index (.81, .80), Illegal Activities Index (.73, .84), Employment Inactivity Index (.79, .90), and Training (school) Activity Index (.87, .91). Most of these scales have 2 to 4 subscales and are currently undergoing completion an article demonstrating that the psychopathology scales consistently fall into 4 main statistical dimensions across age and level of care: Substance problem severity (.90), external behavior problems (.91), and crime/violence (.90). Scales have been added to provide better measures of reasons for and readiness to quit using alcohol and other drugs, personal strengths, and spirituality.
Data Collection Procedures

All 84 respondents were administered GAIN-I version, and the Jessor’s Value on Religiosity Scale without respect to what level of care they were assigned too. The computer based version of the GAIN instrument was administered to each participant, for consistency and literacy issues with some respondents. The conference room was used for each participant and all hygiene factors were managed according to the individual participant due to the open assessment and admission policy of the organization.

Each participant was welcomed to the facility and their rights with regard to confidentiality, informed consent and HIPPA laws were explained, as well as their right to withdraw from the study at any time without reprisal. The need for breaks and approximate length of time for the interview was also explained. All questions of the GAIN-I were read to each participant and clarity was given for any questions not quite understood without re-designing the meaning of the original question. Once participants completed the GAIN-I interview, and the Jessor’s Value on Religiosity Scale, narratives profile are generated and edited for clarity and discrepancies in responses, these scores are then computed, generating a frequency distribution scale and other cross references scales, respondents are then assigned to a particular level of care (OP, IOP, Residential) based the severity of their substance use and other dimensions of their profile.
Statistical Analysis

The analysis of the data employed descriptive statistics as measurements of central tendency, frequency distribution, and cross tabulation. Additionally, the test statistics for the study were phi and chi square.

Each variable was analyzed using frequency distribution in order to summarize the basic measurements. A frequency distribution of independent variables was used to develop background information profiles and to ascertain treatment data concerning each respondent.

Cross tabulations were employed to delineate the statistical relationship between independent variables and the dependent variables. Cross tabulations were conducted between religiosity and academic problems, fights, peer selection, family relationships, stealing, drug use and vandalism. Two test statistical measurements will be used. The first test is Phi (\( \Phi \)) which is a symmetric measure of association that is used to demonstrate the strength of relationship between two or more variables (Bromstead and Knoke, 1995). Chi Square is the second test statistic used to determine whether there is a significant statistical significance at the .05 level of probability among the variables in the study.

Limitations of the Study

There were potentially confounding variables such as involuntary placement of adolescents in treatment or convenient sampling, elopement, 30 days or less in the program, pre-mature termination, geographic location of respondents families, rural -vs-
urban dynamics and low literacy rates are limitations of this analysis. Additionally, respondents did not answer every question on the survey.

Summary of Methods

In this chapter, the researcher has presented the procedural design for collecting, evaluating and explaining the nature and scope of data for examination between means. Several subscales homogeneity variance-covariance will be discovered after the analysis is computed. Both the GAIN-I instrument and the Jessor’s Value on Religiosity Scale have the capabilities of rendering quantifiable data to assist the practitioner in making clinical decision based on the respondent’s self-reported needs.
CHAPTER IV

PRESENTATION OF FINDINGS

The purpose of this chapter is to present a descriptive and inferential analysis of the findings with regards to religiosity and its effect on sobriety, social behaviors and family relationships. The findings are delineated into two distinct sections: demographic data and research null hypotheses and questions.

Demographic Data

This section profiles the study's respondents and offers descriptive statistics used to analyze the data: gender, age, race, last grade attended, composition of household, parents marital status, and family income.

A convenient sample of eighty-four (84) respondents consented to participate in this study as part of their treatment. All 84 respondents were adolescent substance users ages 12 to 17 years old, both males and females, who were found appropriate for treatment based on ASAM criteria (PPC-2R; ASAM, 2001) for Level I (Outpatient) Level II (Intensive Outpatient) and (Residential) treatment. Characteristics of satellite ministry outpatient, intensive outpatient and residential adolescents at Intake (N=84)
Table 1

Demographic Profile of Study Respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>52</td>
<td>61</td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-14</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td>15-18</td>
<td>76</td>
<td>90.5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Caucasian</td>
<td>74</td>
<td>88.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Grades</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th grade</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>9th grade</td>
<td>23</td>
<td>27.4</td>
</tr>
<tr>
<td>10th grade</td>
<td>36</td>
<td>42.9</td>
</tr>
<tr>
<td>11th grade</td>
<td>23</td>
<td>27.4</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>44</td>
<td>52.4</td>
</tr>
<tr>
<td>5-9</td>
<td>40</td>
<td>47.6</td>
</tr>
<tr>
<td><strong>Parents Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>50</td>
<td>59.5</td>
</tr>
<tr>
<td>Separated</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Single</td>
<td>20</td>
<td>23.8</td>
</tr>
<tr>
<td>Deceased</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Family Annual Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$36,000-50,000</td>
<td>30</td>
<td>35.7</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>54</td>
<td>64.3</td>
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<tr>
<td>Variables</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Any Kind of Alcohol</td>
<td>21</td>
<td>27.4</td>
</tr>
<tr>
<td>Marijuana, hashish</td>
<td>23</td>
<td>30.3</td>
</tr>
<tr>
<td>Crack, free base cocaine, other cocaine</td>
<td>2</td>
<td>9.4</td>
</tr>
<tr>
<td>Amphetamine / methamphetamine</td>
<td>10</td>
<td>18.3</td>
</tr>
<tr>
<td>Inhalants</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>“Acid” or other hallucinogens</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some other drugs</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Calculated from adolescent self-report of need for treatment unless adolescent reports no need for treatment, then calculated from counselor determination.

Research Questions and Hypotheses

There are three null hypotheses and three research questions. An analysis of significance and efficacy of statements are provided in this section.
Research Question 1: Are there significant mean differences between religiosity and the amelioration of problematic behaviors in other life domains?

Hypothesis 1: There will be no statistical significance between religiosity and the amelioration of problematic behaviors in other life domains.

Table 2

I find strength and comfort in spirituality

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Occasionally</td>
<td>16</td>
<td>19.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>49</td>
<td>58.3</td>
</tr>
<tr>
<td>A number of times</td>
<td>17</td>
<td>20.2</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.96

Standard Deviation .702

As shown in Table 2, fifty-eight percent (58%) of adolescent substance abusing respondents indicated that they sometimes find strength and comfort through spirituality. Respondents also indicated sometimes (20%) find strength and comfort in spirituality. While (19%) of the respondents stated that they occasionally find strength and comfort in
spirituality. Finally, respondents scoring (2.4%) indicated that they never find strength and comfort through spirituality.

Table 3

I experience a connection to all of life

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Occasionally</td>
<td>18</td>
<td>21.4</td>
</tr>
<tr>
<td>Sometimes</td>
<td>59</td>
<td>70.2</td>
</tr>
<tr>
<td>A number of times</td>
<td>4</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.76 Standard Deviation .594

As shown in Table 3, adolescent substance abusing respondents indicated that they sometimes (70%) experience a connection to all of life. Respondents also indicated they occasionally (21%) experience a connection to all of life. While (4.8%) of the respondents stated that they on a number of times experience a connection to all of life. Finally, respondents scoring (3.6%) indicated that they never experience a connection to all of life.
Table 4

I feel [God’s] love for me directly.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>20</td>
<td>23.8</td>
</tr>
<tr>
<td>Sometimes</td>
<td>54</td>
<td>64.3</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.74  Standard Deviation .661

As shown in Table 4, adolescent substance abusing respondents indicated that they sometimes (64.3%) feel God’s love for them directly. Respondents also indicated occasionally (23.8%) feel God’s love for them directly. While (7.1%) of the respondents stated that they felt on a number of times God’s love for them directly. Finally, respondents scoring (4.8%) indicated that they never feel God’s love for them directly.
Table 5

I feel [God's] love for me through others.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>26</td>
<td>31.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>48</td>
<td>57.1</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.67 Standard Deviation .683

As shown in Table 5, adolescent substance abusing respondents indicated that they sometimes (57.1%) feel God’s love for them through others. Respondents also indicated that they occasionally (31.0%) feel God’s love for them through others. While (7.1%) of the respondents stated that they felt a number of times that God’s love for them through others. Finally, respondents scoring (4.8%) indicated that they never feel God’s love for them through others.
Table 6

I find comfort in religion and spirituality.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Occasionally</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>47</td>
<td>56.0</td>
</tr>
<tr>
<td>A number of times</td>
<td>10</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.76  Standard Deviation .705

As shown in Table 6, adolescent substance abusing respondents indicated that they sometimes (56.0%) find comfort in religion and spirituality. Respondents also indicated that they occasionally (28.6%) find comfort in religion and spirituality. While (11.9%) of the respondents stated that on a number of times found comfort in religion and spirituality. Finally, respondents scoring (3.6%) indicated that they never find comfort in religion and spirituality.
Table 7

I turn to my religion and spirituality for help.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Occasionally</td>
<td>20</td>
<td>23.8</td>
</tr>
<tr>
<td>Sometimes</td>
<td>54</td>
<td>64.3</td>
</tr>
<tr>
<td>A number of times</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Total:</td>
<td>100</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.70           Standard Deviation .673

As shown in Table 7, adolescent substance abusing respondents indicated that they sometimes (64.3%) turn to their religion and spirituality for help. Respondents also indicated that they occasionally (23.8%) turn to their religion and spirituality for help. While (6.0%) of the respondents stated that they turn to their religion and spirituality for help on a number of times. Finally, respondents scoring (6.0%) indicated that they never turn to their religion and spirituality for help.
As shown in Table 8, adolescent substance abusing respondents indicated that they sometimes (52.4%) feel inner peace and harmony. Respondents also indicated that they occasionally (34.5%) feel inner peace and harmony. While (7.1%) of the respondents stated that they feel inner peace and harmony on a number of times. Finally, respondents scoring (6.0%) indicated that they never feel inner peace and harmony.
As shown in Table 9, adolescent substance abusing respondents indicated that they sometimes (56.0%) feel spiritually touched by the beauty of creation. Respondents also indicated that they occasionally (29.8%) felt spiritually touched by the beauty of creation. While (9.5%) of the respondents stated that they felt a number of times spiritually touched by the beauty of creation. Finally, respondents scoring (4.8%) indicated that they never feel spiritually touched by the beauty of creation.

Table 9

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>25</td>
<td>29.8</td>
</tr>
<tr>
<td>Sometimes</td>
<td>47</td>
<td>56.0</td>
</tr>
<tr>
<td>A number of times</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>100</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Mean 2.70  
Standard Deviation .708
Table 10

I feel thankful for my blessings.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Occasionally</td>
<td>21</td>
<td>25.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>44</td>
<td>52.4</td>
</tr>
<tr>
<td>A number of times</td>
<td>16</td>
<td>19.0</td>
</tr>
<tr>
<td>Total: 100</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Mean 2.87  
Standard Deviation .757

As shown in Table 10, adolescent substance abusing respondents indicated that they sometimes (52.4%) feel thankful for their blessings. Respondents also indicated that they occasionally (25%) felt thankful for their blessings. While (19%) of the respondents stated that they felt a number of times thankful for their blessings. Finally, respondents scoring (3.6%) indicated that they never felt thankful for their blessings.
Table 11

I feel a selfless caring for others.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Occasionally</td>
<td>28</td>
<td>33.3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>51</td>
<td>60.7</td>
</tr>
<tr>
<td>A number of times</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.65  
Standard Deviation .591

As shown in Table 11, adolescent substance abusing respondents indicated that they sometimes (60.7%) felt a selfless caring for others. Respondents also indicated that they (33.3%) felt a selfless caring for others. While (3.6%) of the respondents stated that they felt a selfless caring for others on a number of times. Finally, respondents scoring (2.4%) indicated that they never felt a selfless caring for others.
Table 12

When I have done something to hurt someone, I ask them to forgive me.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Occasionally</td>
<td>28</td>
<td>33.3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>50</td>
<td>59.5</td>
</tr>
<tr>
<td>A number of times</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.67          Standard Deviation .608

As shown in Table 12, adolescent substance abusing respondents indicated that they sometimes (59.5%) felt when they had done something to hurt someone, they ask the person to forgive them. Respondents also indicated that they occasionally (33.3%) felt when they had done something to hurt someone, they ask the person to forgive them. While (4.8%) of the respondents stated that they felt on a number of times when they had done something to hurt someone, they ask the person to forgive them. Finally, respondents scoring (2.4%) indicated that they never asked the other person to forgive them after they had hurt them.
Table 13

When I have done something to hurt someone, I ask [God] to forgive me.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>Occasionally</td>
<td>14</td>
<td>16.7</td>
</tr>
<tr>
<td>Sometimes</td>
<td>60</td>
<td>71.4</td>
</tr>
<tr>
<td>A number of times</td>
<td>5</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.77  Standard Deviation .647

As shown in Table 13, both male and female adolescent substance abusing respondents indicated that they sometimes (71.4%) ask God to forgive them when they had done something to hurt someone. Respondents also indicated that they occasionally (16.7%) ask God to forgive them when they had done something to hurt someone. While (6.0%) of the respondents stated that on a number times they ask God to forgive them when they had done something to hurt someone. Finally, respondents scoring (6.0%) indicated that they never ask God to forgive them when they had done something to hurt someone.
Table 14

When someone has hurt me, I try to forgive them.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Occasionally</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>48</td>
<td>57.1</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total: 100</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

Mean 2.64     Standard Deviation .722

As shown in Table 14, adolescent substance abusing respondents indicated that they sometimes (57.1%) try to forgive others when they hurt them. Respondents also indicated that they occasionally (28.6%) try to forgive others when they hurt them. While (7.1%) of the respondents stated that on a number of times when someone has hurt them, they try to forgive them. Finally, respondents scoring (7.1%) indicated that they never forgive others when they have been hurt by them.
Table 15

When someone has hurt me, I try to get even with them in some way.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td>Occasionally</td>
<td>17</td>
<td>20.2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>52</td>
<td>61.9</td>
</tr>
<tr>
<td>A number of times</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.69 Standard Deviation .760

As shown in Table 15, adolescent substance abusing respondents indicated that they sometimes (61.9%) try to get even with others in some way when they hurt them. Respondents also indicated sometimes (20.2%) try to get even with others in some way when they hurt them. While (8.3%) of the respondents stated that on a number of times they try to get even with others in some way when they hurt them. Finally, respondents scoring (9.5%) indicated that they never try to get even with others when they hurt them.
Table 16

When someone has hurt me, I hold resentment against them and keep it inside.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Occasionally</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>48</td>
<td>57.1</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total: 100</strong></td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.64  
Standard Deviation .722

As shown in Table 16, both female and male adolescent substance abusing respondents indicated that they sometimes (57.1%) hold resentment against others and keep it inside when someone hurt them. Respondents also indicated that they occasionally (28.6%) hold resentment against others and keep it inside when someone hurt them. While (7.1%) of the respondents stated that on a number of times they held resentment against others and kept it inside when someone hurt them. Finally, respondents scoring (7.1%) indicated that they never hold resentment against others when someone hurt them.
Table 17

I know that [God], Allah, Buddha] forgives me.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Occasionally</td>
<td>13</td>
<td>15.5</td>
</tr>
<tr>
<td>Sometimes</td>
<td>57</td>
<td>67.9</td>
</tr>
<tr>
<td>A number of times</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.76  Standard Deviation .722

As shown in Table 17, adolescent substance abusing respondents indicated that they sometimes (67.9%) know that God, Allah, Buddha forgives them. Respondents also indicated that they occasionally (15.5%) know that God, Allah, Buddha forgives them. While (8.3%) of the respondents stated that on a number of times they knew that God, Allah, Buddha forgave them. Finally, respondents scoring (8.3%) indicated that they never knew if God, Allah, Buddha forgave them.
Table 18

I find it hard to forgive myself for some of the things I have done wrong.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>19</td>
<td>22.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>56</td>
<td>66.7</td>
</tr>
<tr>
<td>A number of times</td>
<td>5</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.74  Standard Deviation .642

As shown in Table 18, both male and female adolescent substance abusing respondents indicated that they sometimes (66.7%) find it hard to forgive themselves for some of the things they have done wrong. Respondents also indicated that they occasionally (22.6%) find it hard to forgive themselves for some of the things they have done wrong. While (6.0%) of the respondents stated that on a number of times they found it hard to forgive themselves for some of the things they have done wrong. Finally, respondents scoring (4.8%) indicated that they never find it hard to forgive themselves for some of the things they have done wrong.
Table 19

I often feel that no matter what I do now, I will never make up for some mistakes I have made in the past.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>25</td>
<td>29.8</td>
</tr>
<tr>
<td>Sometimes</td>
<td>49</td>
<td>58.3</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.68  Standard Deviation .679

As shown in Table 19, of the 84 adolescent substance abusing male and females respondents (58.3%) indicated that they sometimes feel that no matter what they do now, they will never make up for some mistakes they have made in the past. Respondents also indicated that they have occasionally (29.8%) felt that no matter what they do now, they will never make up for some mistakes they have made in the past. While (7.1%) of the respondents stated that they on a number of times felt that no matter what they do now, they will never make up for some mistakes they have made in the past. Finally, respondents scoring (4.8%) indicated that they never felt that no matter what they do now, they will never make up for some mistakes they have made in the past.
Research Question 2: Are there significant mean differences between familial religiosity and improved parent-child communications?

Hypothesis 2: There will be no statistical significance between familial religiosity and improved parent-child communications.

Table 20

I know that my family loves me despite my wrongs.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Occasionally</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>50</td>
<td>59.5</td>
</tr>
<tr>
<td>A number of times</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Total:</strong> 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.76  Standard Deviation 0.652

As shown in Table 20, of the 84 adolescent substance abusing respondents indicated that they sometimes (59.5%) know that their families love them despite their wrongs. Respondents also indicated that they occasionally (28.6%) know that their families love them despite their wrongs. While (9.5%) of the respondents stated that on a
number of times they knew that their families loved them despite their wrongs. Finally, respondents scoring (2.4%) indicated that they never knew their families love them despite their wrongs.

Table 21
My family believes in a higher being [God].

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>17</td>
<td>20.2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>57</td>
<td>67.9</td>
</tr>
<tr>
<td>A number of times</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Total: 100</strong></td>
<td></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Mean 2.77 Standard Deviation .647

As shown in Table 21, adolescent substance abusing respondents indicated that they sometimes (67.9%) their families believe in a higher being [God]. Respondents also indicated that occasionally (20.2%) their families believe in a higher being [God]. While (7.1%) of the respondents stated that on a number of times they felt their families
believed in a higher being [God]. Finally, respondents scoring (4.8%) indicated that their families never believed in a higher being [God].

Table 22

I call on [God] when my family has conflicts with each other.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td>Occasionally</td>
<td>29</td>
<td>34.5</td>
</tr>
<tr>
<td>Sometimes</td>
<td>40</td>
<td>47.6</td>
</tr>
<tr>
<td>A number of times</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Total: 100</strong></td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.55  Standard Deviation .782

As shown in Table 22, of the 84 male and female adolescent substance abusing respondents (47.6%) indicated that they sometimes call on [God] when their families have conflicts with one another. Respondents also indicated that they occasionally (34.5%) call on [God] when their families have conflicts with one another. While (8.3%) of the respondents stated that on a number of times they have called on [God] when their
families had conflicts with one another. Finally, respondents scoring (9.5%) indicated that they never call on [God] when their families have conflicts with one another.

Table 23

Do you belong to a church, temple, mosque, or other religion organization?

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>63</td>
<td>75.0</td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>23.8</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 1.26 Standard Deviation .469

According to Table 23, (75%) of the respondents indicated that they belongs to a church, temple, mosque, or other religion organization. While (23.8%) of the adolescent substance abusing respondents stated that they do not belong to a church, temple, mosque, or other religion organization.
Research Question 3: Are there significant mean differences between adolescent's belief in God and use of religiosity in daily living?

Hypothesis 3: There will be no statistical significance between adolescent belief in God and how much religiosity is used in their daily living.

Table 24

To be able to turn to prayer when you’re facing a personal problem.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>11</td>
<td>13.1</td>
</tr>
<tr>
<td>A little important</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>55</td>
<td>65.5</td>
</tr>
<tr>
<td>Pretty</td>
<td>16</td>
<td>19.0</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>100</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Mean 2.90  Standard Deviation .859

As shown in Table 24 both adolescent female and male substance abusing respondents indicated that they (65.5%) felt it was somewhat important to be able to turn to prayer when you're facing a personal problem. Respondents (19.0%) also indicated that they felt it was pretty important to be able to turn to prayer when you’re facing a
personal problem. While (13.1%) of the respondents stated that it was not at all important to be able to turn to prayer when you’re facing a personal problem. Finally, respondents scoring (2.4%) indicated that it was a little important to be able to turn to prayer when you’re facing a personal problem.

Table 25
To be able to rely on religious teachings when you have a problem.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>A little important</td>
<td>12</td>
<td>14.3</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>53</td>
<td>63.1</td>
</tr>
<tr>
<td>Pretty</td>
<td>12</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 2.83  Standard Deviation .774

As shown in Table 25, adolescent substance abusing respondents (63.1%) indicated that it was somewhat important to be able to rely on religious teachings when they have a problem. Respondents (14.3%) also indicated it was pretty important to be able to rely on religious teachings when you have a problem. While the same percentage
(14.3%) of the respondents stated that it was of little importance to be able to rely on religious teachings when they have a problem. Finally, respondents scoring (8.3%) indicated that it was not at all important to be able to rely on religious teachings when they have a problem.

Table 26

To rely on your religious beliefs as a guide for day-to-day living.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>A little important</td>
<td>12</td>
<td>14.3</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>57</td>
<td>67.9</td>
</tr>
<tr>
<td>Pretty</td>
<td>9</td>
<td>10.7</td>
</tr>
<tr>
<td><strong>Total: 100</strong></td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.82  Standard Deviation .714

As shown in Table 26, of the 84 adolescent substance abusing respondents (67.9%) indicated that it was somewhat important to rely on your religious beliefs as a guide for day-to-day living. Respondents (10.7%) also indicated it was pretty important to rely on your religious beliefs as a guide for day-to-day living. While (14.3%) of the
respondents stated that it was of little importance to rely on your religious beliefs as a guide for day-to-day living. Finally, respondents scoring (7.1%) indicated that it was not at all important to rely on your religious beliefs as a guide for day-to-day living.

Table 27
To believe in God.

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>A little important</td>
<td>10</td>
<td>11.9</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>54</td>
<td>64.3</td>
</tr>
<tr>
<td>Pretty</td>
<td>13</td>
<td>15.5</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.87 Standard Deviation .773

As shown in Table 27, of both male and female adolescent substance abusing respondents, (64.3%) indicated that it was somewhat important to believe in God. Respondents (15.5%) also indicated that it was pretty important to believe in God. While (11.9%) of the respondents stated that it was of little importance to believe in God.
Finally, (8.3%) of the respondents indicated that it was not at all important to believe in God.

Table 28

How important would you say that religion and religious beliefs are to you?

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>A little important</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>34</td>
<td>40.5</td>
</tr>
<tr>
<td>Pretty</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Very important</td>
<td>13</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Total: 100 100.0

Mean 3.36  Standard Deviation 1.094

As shown in Table 28, of 84 adolescent substance abusing respondents (40.5%) indicated that religion and religious beliefs were somewhat important to them. Over twenty-eight percent (28.6%) indicated that religion and religious beliefs were pretty important to them. While (15.5%) of the respondents stated that religion and religious beliefs were very important to them. Respondents scoring (8.3%) indicated that religion
and religious beliefs were not at all important to them. Finally, seven point-one percent (7.1%) of the respondents indicated that religion and religious beliefs were of little importance to them.

Table 29

During the past year, how often did you attend religious services at a church, temple, or mosque?

<table>
<thead>
<tr>
<th>Items</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>13</td>
<td>15.5</td>
</tr>
<tr>
<td>A few times a year</td>
<td>30</td>
<td>35.7</td>
</tr>
<tr>
<td>5-10 times a year</td>
<td>24</td>
<td>28.6</td>
</tr>
<tr>
<td>Once a month</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td>2-3 times a month</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Every week</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Total: 100</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.67  Standard Deviation 1.235

Table 29 indicates that of the 84 adolescent male and female substance abusing respondents, (35.7%) related that they attended religious services at a church, temple, or mosque a few times a year. Respondents (28.6%) stated that they attended religious
services at a church, temple or mosque 5-10 times a year. While (15.5%) responded that they never attended a church, temple, or mosque during the past year. Moreover, (9.5%) of the 84 respondents indicated that they attended a church, temple, or mosque once a month during the past year. (8.3%) stated that they attended a church, temple, or mosque 2-3 times a month during the past year, and finally (2.4%) of the respondents stated that they attended a church, temple, or mosque every week during the past year.
CHAPTER V
CONCLUSION

Americans developed three kinds of social policies in the early and middle 19th century, one of which was a popular policy consisting of “moral treatment” for Americans who had (or might fall into) sinful lifestyles, including crime, alcoholism, mental illness, or neglect of religion (Jansson, 2001). The American Temperance Society during this era contended that immorality was the primary cause of alcoholism and that prohibition would eradicate the problem (Jansson, 2001).

Since this period, we have come to understand that many factors, including culture, the presence of role models in families, genetic predisposition, poverty, psychological and physical factors, advertising, and peer pressure all influence the development of alcoholism.

Factors that contribute to adolescent drug abuse can be traced to earlier difficulties (Conger & Ge, 1999), early behavior problems (Patterson, Bank, & Stoolmiller, 1990), and peer rejection and negative peer affiliation (Loeber, 1989).

The findings from this study points out the importance of morality as a salient pathway to change for drug abusing adolescents who struggle to combat these environmental pressures, and to achieve a more healthy identity. Sixty-four percent of the respondents reported that it was somewhat important to believe in God, and sixty-seven
percent believe that it is important to include religion in their day-to-day living among their peers.

Often, respondents in this study presented to the center with multiple impairments in the primary domains of their lives (family, school, friends, religion), displaying disruptive behaviors such as oppositional defiance, aggression, promiscuity, threats toward authority figures and a disintegration of self.

Oyserman and Markus (1990, p. 114) hypothesize that “adolescent who are not successful in constructing and maintaining positive selves in the conventional domains of the family, friends, or school are likely to seek alternative ways to define the self.” Most of the adolescents reported conflictual or non-existing relationships with their parents. Given the increased susceptibility to problem behaviors during the early adolescent transition, this is a critical period for intervention efforts (Cicchetti & Richters, 1993). Furthermore, the difficulty of treating severe drug abuse in late adolescence and adulthood has motivated researchers and clinicians in the drug abuse field to identify effective “early interventions” that may halt the progression of deviance before negative behavioral patterns become highly resistant to change (Hogue & Liddle, 1999).

Fifty-eight percent of adolescents in this study can be characterized as spiritually ambivalent due, in part, to their vacillating scores with regards to comfort levels with spirituality and ability to garner strength from religion. Factors that perhaps contributes to this uncertainty, in some cases, can be attributed to a history of appealing to Christ for help during periods of excruciating pain, and repeated episodes of abuse (physical, emotional, sexual) and to no avail. They often think in very concrete versus abstract
terms; they might say they do not have a drug “problem” but then readily acknowledge
having three or more symptoms of dependence. This is an indication of their inability to
recognize the link between “concrete” symptoms and the abstract label of a problem.

This study sufficiently points out that over fifty percent of the respondents believe
a “Christian” pathway or environment enables them to think in the “abstract” which
translates to living a more responsible lifestyle, and engaging less high risk behaviors.
These results rejects the null hypothesis contending that no significance would be found
between adolescent’s belief in God and the use of religiosity in daily living. Adolescents
that are introduced to abstract Christian principles that relates to recovery, interact with
staff members who espouse Christian lifestyles, encouraged to read their bible and
Christian affirmations, attend church and weekly Christian youth meetings, as well as
participate in daily corporate prayer, are likely to live a goal-oriented positive lifestyle.
It is safe to postulate that “Christian” related activities have the potential to stimulate a
renewed interest in how Christ can help substance abusing adolescents deal with their
daily struggles and open the door for these same adolescents to reclaim a relationship
with Christ at some point in their lives.

Over half of the adolescent respondents indicated that family religiosity is
significant with respect to improved parent-child relationships; thus, rejecting the null
hypothesis pertaining to a parallel relationship between religiosity and how families get
alone.

Risk and protective factors provide targets and guidelines for early intervention
(Liddle, 2000). Protective factors within the family can help to insulate early adolescents
from risk factors for drug abuse, including strong identification with parents (Brook, Kesseler, & Cohen, 1999), a responsive and involved parent-adolescent relationship (Eccles, 1999), and parental limit setting and effective communication (Fletcher & Jefferies, 1999). These factors influence the formation of a positive identity for the adolescent. Identity development is one of the major tasks of adolescence. It occurs through a combination of role modeling, identification processes, and validation from others (Adams, 1985).

Accordingly, relationships with both parents and peers are critical in the process of identity formation. Close, responsive family relationships engender youth with a healthy sense of identity and self-efficacy (Jackson, Dunham, & Kidwell, 1990), whereas families characterized by a lack of warmth, involvement, and structure tend to promote apathy, lack of direction, and low self-efficacy (Adams, Dyk, & Bennion, 1987).

In addition, peer group membership and interactions with peers strongly impact the young adolescent’s development of self-worth and identity. Young adolescents tend to select peers who are at their own level of identity development (Akers, Jones, & Coyl, 1998). For instance, a young adolescent who is confused about his or her sense of self and in a state of “identity diffusion” is likely to gravitate to others who are exploring similar identity issues. Furthermore, young adolescents tend to internalize the sense of identity that they construct together with peers (Pugh & Hart, 1999).

Drug use is most common and pervasive in young adolescents who are characterized as identity diffuse and have problems with identity development (Jones, 1992, 1994). Young adolescents’ relationships with their parents necessarily undergo a
process of change and transformation (Steinberg, 1991). While this transformation does not meet the predictions of chaos and rebellion that traditional psychodynamic theorists envisioned (Blos, 1962), it does involve a reformulation of parent and adolescent roles within the family (Steinberg, 1991).

Developments in cognitive skills, emotional experiences, and social roles change the ways young adolescents relate to parents, and parents of young adolescents experience life transitions of their own that impact the nature of the parent-adolescent relationship (Silverberg, 1996). Drug abuse among adolescents exacerbate this critical period of transition into adulthood.

Research demonstrates that an early adolescent’s well-being is closely connected to parental acceptance, involvement, and support (Lieberman, Doyle, & Markeiwicz, 1999). Minor increases in parent-adolescent conflict, which generally surround trivial matters, tend to decline during middle and late adolescence after peaking during and after puberty (Laursen, Coy, & Collins, 1998). Serious conflict and turmoil in families of young adolescents is indicative of more severe family problems (Steinberg, 1991) and tends to be a function of earlier difficulties within the family (Conger & Ge, 1999).

RECOMMENDATIONS

The aim of this study was to determine the significance of religiosity in the lives of substance abusing adolescent males and females in multiple life domains, to include its impact on family relationships. Clearly, religiosity influences the decision-making
processes of all respondents in this study. As a result of these findings, further research is recommended in the following areas:

1. Empirical studies that clearly define adolescent’s cognitive schema with regards to religiosity versus spirituality.

2. While descriptive research is important and often provides valuable insights into a field of inquiry, it fails to provide the theoretical foundation upon which to build knowledge or to provide a conceptual map for advancing the field of religiosity and adolescent substance abuse treatment as a salient pathway to prolonged recovery.

3. The inverse relationship found between religiosity and adolescent substance use warrant research designs that seeks to study religiosity as a viable intervention strategy and a protective factor for substance abusing teens re-entering their communities, schools, or church organizations.

4. This study serves as a call-to-action for African-American researchers, clergy and social workers to collaborate with HBCUs in developing a theoretical treatment model that addresses the specific needs of African-American adolescents to buffer the effects of contextual factors (political, economic, social, and the dereliction of educational institutions) to prevent the pathological aggressive behavioral patterns often waged against each other, in the absence of persistent drug use among African-American teenagers, as the literature clearly points out.
APPENDICES
APPENDIX A

Request for Research Approval

Date: August 10, 2005

To: Mrs. Linda Wells, Administrator Community-Based Ministries
    Georgia Baptist Children's Homes and Family Ministries, Inc.

From: Mr. Ricky R. Wallace, Program Director
      Nelson L. Price Treatment Center

Re: Approval to Conduct On-site Research with Existing Clients

Per our conversation regarding permission to survey current and past medical records to
extract research data toward satisfying Clark Atlanta University Whitney M. Young Jr.,
School of Social Work dissertation requirements, I am formally requesting that
permission is granted to conduct this research on-site with parental consent.

I will submit letters to consumers and parents regarding the review of their records for
research purposes and to inform them about the nature of the research study.

I would like to thank you for your assistant with this career endeavor.

Sincerely.

cc: Robert Waymer, Ph.D., Committee Chair
    Richard Lyle, Ph.D., Committee Member
    Kwaku Danso, Ph.D., Committee Member
APPENDIX B

Survey Questionnaire

Jessor’s Value on Religion Scale

Section I: Demographic Information
Place a mark (X) next to the appropriate item. Choose only one answer for each question.

1. My gender is? 1) _____ Male 2) _____ Female

2. My age group is? 1) _____ 11-12 2) _____ 13-14
   3) _____ 15-18

   2) _____ Caucasian 3) _____ Hispanic 4) _____ Asian 5) _____ Other

4. What is the last grade you attended? 1) _____ 7th grade 2) _____ 8th grade
   3) _____ 9th grade 4) _____ 10th grade 5) _____ 11th grade 6) _____ 12th grade

5. How many people live in your household? 1) _____ 1-4 2) _____ 5-9

6. What is your parent’s marital status? 1) _____ Married 2) _____ Separated
   3) _____ Divorced 4) _____ Single 5) _____ Deceased

7. What is your family’s income? 1) _____ 0-10,000 2) _____ 10,000-25,000
   3) _____ 25,000-35,000 4) _____ 35,000-50,000 5) _____ 50,000+

Section II: Nonreligious spirituality Items

Please read each one of the question and circle from (1 to 4) to show if you have felt this way.

1 = Never
2 = Occasionally
3 = Sometimes
4 = A number of times
8. I find strength and comfort in spirituality.  
9. I experience a connection to all of life.  
10. I feel [God’s] love for me directly.  
11. I feel [God’s] love for me through others.  
12. I find comfort in religion and spirituality.  
13. I turn to my religion and spirituality for help.  
15. I am spiritually touched by the beauty of creation.  
16. I feel thankful for my blessings.  
17. I feel a selfless caring for others.  
18. When I have done something to hurt someone, I ask them to forgive me.  
19. When I have done something to hurt someone, I ask [God] to forgive me.  
20. When someone has hurt me, I try to forgive them.  
21. When someone has hurt me, I try to get even with them in some way.  
22. When someone has hurt me, I hold resentment against them and keep it inside.  
23. I know that [God], Allah, Buddha] forgives me.  
24. I find it hard to forgive myself for some of the things I have done wrong.
APPENDIX B

(continued)

25. I often feel that no matter what I do now, I will never make up for some mistakes I have made in the past.  
    1 2 3 4

26. I know that my family loves me despite my wrongs.  
    1 2 3 4

27. My family believes in a higher being [God].  
    1 2 3 4

28. I call on [God] when my family has conflicts with each other.  
    1 2 3 4

29. Do you belong to a church, temple, mosque, or other religion organization?  
    Yes  
    No  
    (1)  
    (2)

Section III: Religious Importance

Please read each one of the question and circle from (1 to 5) to show if you have felt this way.

1 = Not at all important  
2 = A little important  
3 = Somewhat important  
4 = Pretty important  
5 = Very important

30. To be able to turn to prayer when you're facing a personal problem.  
    1 2 3 4

31. To be able to turn to rely on religious teachings when you have a problem.  
    1 2 3 4

32. To rely on your religious beliefs as a guide for day-to-day living.  
    1 2 3 4

33. To believe in God.  
    1 2 3 4

34. How important would you say that religion and religious beliefs are to you?  
    1 2 3 4 5
APPENDIX B

(continued)

35. During the past year, how often did you attend religious services at a church, temple, or mosque? (CHECK ONE)

1) _____ Never

2) _____ A few times a year

3) _____ 5-10 times a year

4) _____ Once a month

5) _____ 2-3 times a month

6) _____ Every week
APPENDIX C

SPSS Program Analysis

TITLE 'Effects of Religiosity on Adolescent Substance Abuse'.
SUBTITLE 'RICKY WALLACE PHD PROGRAM - CAU SCHOOL OF SOCIAL WORK'.
DATA LIST FIXED/
  ID  1-3
  GENDER  4
  AGEGRP  5
  ETHNIC  6
  EDUC  7
  HOUSE  8
  MARITAL  9
  INCOME  10
  COMFORT  11
  CONNECT  12
  LDIRECT  13
  LOTHER  14
  RELIG  15
  HELP  16
  PEACE  17
  BEAUTY  18
  BLESS  19
  CARING  20
  FORGIVE  21
  HURT  22
  SOMEONE  23
  HURTME  24
  RESENT  25
  ALLAH  26
  MYSELF  27
  MATTER  28
  WRONGS  29
  FAMILY  30
  CONFLICT  31
  CHURCH  32
  PROBLEM  33
  TEACH  34
  GUIDE  35
APPENDIX C

(continued)

BELGOD 36
WOULD 37
ATTEND 38.

VARIABLE LABELS
ID 'Case Number'
GENDER 'Q1 My Gender'
AGEGRP 'Q2 My age group'
ETHNIC 'Q3 The race that describes me best'
EDUC 'Q4 Highest grade attended'
HOUSE 'Q5 How many people live in your household'
MARITAL 'Q6 My parents marital status'
INCOME 'Q7 My family annual income'
COMFORT 'Q8 I find strength and comfort in spiritually'
CONNECT 'Q9 I experience a connection to all of life'
LDIRECT 'Q10 I feel GOD love for me directly'
LOOTHER 'Q11 I feel GOD love for me through others'
RELIG 'Q12 I find comfort in religion and spirituality'
HELP 'Q13 I turn to my religion and spirituality for help'
PEACE 'Q14 I feel inner peace and harmony'
BEAUTY 'Q15 I am spiritually touched by the beauty of creation'
BLESS 'Q16 I feel thankful for my blessings'
CARING 'Q17 I feel a selfless caring for others'
FORGIVE 'Q18 I ask them to forgive me when I have hurt someone'
HURT 'Q19 I ask GOD to forgive me when I have hurt someone'
SOMEONE 'Q20 When someone has hurt me I try to forgive them'
HURTME 'Q21 When someone has hurt me I try to get even with them'
RESENT 'Q22 When someone has hurt me I hold resentment against them'
ALLAH 'Q23 I know that - GOD Allah Buddha - forgives me'
MYSELF 'Q24 I find it hard to forgive myself for some of my wrongs'
MATTER 'Q25 I will never make up for some of my mistakes'
WRONGS 'Q26 I know that my family loves me despite my wrongs'
FAMILY 'Q27 My family believes in a higher being GOD'
APPENDIX C

(continued)

CONFLICT 'Q28 I call on GOD when my family has conflicts with each other'
CHURCH 'Q29 Do you belong to a church temple mosque or other religion organization'
PROBLEM 'Q30 To be able to turn to prayer when you are facing a personal problem'
TEACH 'Q31 To be able to rely on religious teachings when you have a problem'
GUIDE 'Q32 To rely on your religious beliefs as a guide for day to day living'
BELGOD 'Q33 To believe in GOD'
WOULD 'Q34 How important would you say that religion and religious beliefs are to you'
ATTEND 'Q35 During the past year how often did you attend religious services'.

VALUE LABELS
GENDER
1 'Male'
2 'Female'/'

AGEGRP
1 '11-12'
2 '13-14'
3 '15-18'/

ETHNIC
1 'African American'
2 'Caucasian'
3 'Hispanic'
4 'Asian'
5 'Other'/

EDUC
1 '7th grade'
2 '8th grade'
3 '9th grade'
4 '10th grade'
5 '11th grade'
6 '12th grade'/

HOUSE
1 '1-4'
2 '5-9'/

MARITAL
1 'Married'
2 'Separated'
<p>| <strong>INCOME</strong> | 1 'Under $10,000' | 2 '$10,000-25,000' | 3 '$26,000-35,000' | 4 '$36,000-50,000' | 5 'Over $50,000'/ |
| <strong>COMFORT</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>CONNECT</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>LDIRECT</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>LOTHER</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>RELIG</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>HELP</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| <strong>PEACE</strong> | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times'/ |
| BEAUTY       | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| BLESS       | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| CARING      | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| FORGIVE     | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| HURT        | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| SOMEONE     | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| HURTME      | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |
| RESENT      | 1 'Never'                                      |
|             | 2 'Occasionally'                               |
|             | 3 'Sometimes'                                  |
|             | 4 'A number of times'                          |</p>
<table>
<thead>
<tr>
<th>APPENDIX C</th>
</tr>
</thead>
<tbody>
<tr>
<td>(continued)</td>
</tr>
</tbody>
</table>

| ALLAH       | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| MYSELF      | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| MATTER      | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| WRONGS      | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| FAMILY      | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| CONFLICT    | 1 'Never' | 2 'Occasionally' | 3 'Sometimes' | 4 'A number of times' |
| CHURCH      | 1 'YES'   | 2 'NO'           |
| PROBLEM     | 1 'Not at all important' | 2 'A little important' | 3 'Somewhat important' | 4 'Pretty important' | 5 'Very important' |
APPENDIX C

(continued)

TEACH
1 'Not at all important'
2 'A little important'
3 'Somewhat important'
4 'Pretty important'
5 'Very important'/

GUIDE
1 'Not at all important'
2 'A little important'
3 'Somewhat important'
4 'Pretty important'
5 'Very important'/

BELGOD
1 'Not at all important'
2 'A little important'
3 'Somewhat important'
4 'Pretty important'
5 'Very important'/

WOULD
1 'Not at all important'
2 'A little important'
3 'Somewhat important'
4 'Pretty important'
5 'Very important'/

ATTEND
1 'Never'
2 'A few times a year'
3 '5-10 times a year'
4 'Once a month'
5 '2-3 times a month'
6 'Every week'/.

MISSING VALUES
GENDER AGEGRP ETHNIC EDUC HOUSE MARITAL INCOME COMFORT CONNECT LDIRECT LOTHER RELIG HELP PEACE BEAUTY BLESS CARING FORGIVE HURT SOMEONE HURTME RESENT ALLAH MYSELF MATTER WRONGS FAMILY CONFLICT CHURCH PROBLEM TEACH GUIDE BELGOD WOULD ATTEND (0).
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APPENDIX C

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END DATA.
APPENDIX C

(continued)

FREQUENCIES
/VARIABLES GENDER AGEGRP ETHNIC EDUC HOUSE MARITAL INCOME COMFORT CONNECT LDLIRECT LOTHER RELIG HELP PEACE BEAUTY BLESS CARING FORGIVE HURT SOMEONE HURTME RESENT ALLAH MYSELF MATTER WRONGS FAMILY CONFLICT CHURCH PROBLEM TEACH GUIDE BELGOD WOULD ATTEND
/STATISTICS =.
REFERENCES


Center for Substance Abuse and Mental Health Services Administration (SAMHSA). Catalog of Federal Domestic Assistance No. 93.230.


