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An investigation of social support, beliefs about substance abuse, and religiosity

Melissa LaCoste

To the Graduate Council:

I am submitting herewith a thesis written by Melissa LaCoste entitled "An investigation of social support, beliefs about substance abuse, and religiosity." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Communication.

John Haas, Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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and recommend its acceptance:

Accepted for the Council:

Vice Provost and Dean of Graduate Studies

AN INVESTIGATION OF SOCIAL SUPPORT, BELIEFS ABOUT SUBSTANCE ABUSE, AND RELIGIOSITY

A Thesis
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Melissa LaCoste
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ABSTRACT

The purpose of this study is to examine the relationships among social support, religiosity, and substance abuse. Recent research suggests that a connection exists between substance abuse and a variety of factors that include religiosity and social support. While existing research suggests a link between social support and both religiosity and substance abuse, no single study has explored the relationship among these three factors. Moreover, the research on substance abuse has centered on usage-related issues rather than on participant beliefs about substance abuse. The goal of this study is to extend previous research by expanding our understanding of the relationship among substance abuse, social support, and religiosity. The results of the study suggest that religious individuals define substance abuse along a number of different dimensions. Moreover, definitions of substance abuse do not impact on how church members view religiosity or social support. In addition, the results of the data analysis involving the demographic variables indicate a complex pattern of relationships between the demographic variables and religiosity and social support.

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Chapter 1

Introduction

Substance abuse is an ongoing problem in the United States. "Each year drug and alcohol related abuse kills more than 120,000 Americans" (Health and Human Services, 2000, p. 1). Moreover, smoking is responsible for one in every five deaths in the United States (American Cancer Society, 2002; Centers for Disease Control and Prevention, 2002). Taken together, the research on substance abuse suggests that alcohol, drug, and tobacco use significantly increases the risk for lung and other cancers, as well as cardiovascular, respiratory, and chronic diseases (Centers for Disease Control and Prevention, 2002).

Substance abuse not only results in destructive health conditions, but can also be fatal. Extreme cases of substance abuse can be deadly because substance abusers are especially prone to considering the option of suicide as well as becoming more susceptible to a range of diseases (Centers for Disease Control, 2002, Substance Abuse Mental Health Service Administration, 2002; World Health Organization, 2002). In addition to the increased suicide risk, many lethal diseases can be the result of substance abuse. For example, lung cancer, emphysema, sclerosis of the liver, and other diseases mainly affect substance abusers (Centers for Disease Control, 2002).

Despite its reported impact on society, developing a universal definition of substance abuse has been problematic. Definitions of substance abuse involve a range of substances and include both legal and illegal substances. For example, the University of Utah Health Services Center defines substance abuse as "the abuse of illegal substances or the abusive use of legal substances" (2001, p. 1). Others, such as the Substance Abuse

and Mental Health Service Association define substance abuse as a person's addiction to harmful drugs, alcohol, or tobacco products (2002). These definitions make clear the difficulties associated with precisely defining substance abuse.

In addition to conceptual difficulties, our understanding of substance abuse is largely limited to self-reports regarding the extent to which a person is a substance abuser (see Substance Abuse and Mental Health Service, 2002). Surprisingly, little is known about how people define and make judgments about substance abuse. Moreover, our understanding of the role of social factors such as religiosity or social support in defining and making judgments about substance abuse remains unclear. To date, the research designed to explore the social factors that may be associated with substance abuse such as religious involvement (e.g., Ellison & Levin, 1998; Gartner et al., 1991; Gorsuch & Butler, 1976; Hays et al., 1986; Mathews et al., 1998; Miller et al., 2000; Moore et. al, 1990; Mueller et al., 2001; Whooley et al., 2002) has centered on the relationship between usage and level of involvement. However, few, if any, studies have explored the relationship among social support, religiosity, and belief systems about substance abuse.

The notion that social factors may play a role in substance abuse is not new. For example, one avenue commonly used to help avoid the use of alcohol, drugs, and tobacco is social support. Moreover, social support is commonly associated with religious organizations. The supportive interactions that take place between individuals in religious organizations can help produce a lasting positive effect on a person's health (Alcoholics Anonymous, 2002; Anderson et al., 1996). Often social support can provide incentive for members of a religious organization to avoid unhealthy substances (Ellison & Levin, 1998; Mann, 2000; Mathews et al., 1998; Plante & Sherman, 2001). This could

account for the decreased rates of substance abuse among religious individuals (Plante & Sherman, 2001).

Physicians, treatment groups, and religious organizations have employed social support as a mechanism to attack substance abuse, and to help individuals end their addiction to alcohol, drugs, and tobacco products (Gordy, 1996). Rehabilitation and addiction programs often employ social support as a major part of their curriculum. For example, 40% of Americans admit to being a member of a small group that meets on a regular basis and provides caring and support for its members (Wuthnow, 1994, p. 47). Previous research has focused on the impact religiosity has on substance abuse, and tends to rest on assumptions about the nature of the relationship (Plante & Sherman, 2001). That is, researchers tend to presume that religious individuals have lower occurrences of substance abuse. Many scholars agree that social support within a religious organization serves to encourage members to avoid alcohol, drugs, and tobacco (Kendler et al., 1996; Miller, 1998; Plante & Sherman, 2001).

Levels of social support within any organization or group can be used to help predict occurrences in alcohol, drug, and tobacco usage. Previous research has found direct links between low levels of substance abuse and high degrees of religious involvement (Mathews, et al., 1998). Researchers who study social support assert that when people receive low levels of social support, substance abuse is more likely to occur (Alcoholics Anonymous, 2002; Plante & Sherman, 2001). However, the true mechanism or mechanisms that account for lower occurrences of substance abuse are still unknown.

The results of this initial research into substance abuse and social factors such as religiosity and social support suggest a number of promising avenues for future research.

Future research could profit by gaining a better understanding of the relationship that is reported to exist between low levels of social support and increased substance abuse (Plante & Sherman, 2001). Moreover, given the reported impact of social support on substance abuse, more research needs to be done on the relationship between social support and beliefs about substance abuse.

"The evidence, though sometimes conflicting and over–interpreted, is nevertheless convincing: rates of health and life span vary across religions and religious denominations, but on average, high levels of religious involvement are moderately associated with better health" (Hart, 1999, p. 102). In other words, everyday social groups often do not offer the same type of social support and encouragement that is found in religious organizations. Individuals who choose to be a part of an organized religious group are less likely to abuse alcohol, or use drugs and tobacco (Plante & Sherman, 2001). Interestingly, little, if any, research has been conducted that attempts to merge beliefs about substance abuse and social support with religiosity.

Taken together we know that people who are interested in health have an interest in social support. This is not new terrain; people have been investigating this topic for decades. What is not known is how social support, substance abuse, and religiosity are related. Programs across the globe have been established to provide social support to individuals battling any form of substance abuse. The purpose of this study is to investigate social support and beliefs about substance abuse in a religious organization. A discussion of the current literature follows.

Rationale

The rationale for this study is four fold. First, although an impressive body of literature exists regarding substance usage and religious involvement, there is still much to be learned about the beliefs that may account for lower occurrences of substance abuse for those involved with religion (Mathews et al., 1998; Plante and Sherman, 2001). To date, the majority of studies related to this topic focus on the incidence of substance abuse among individuals with high religious commitment, and make assumptions based on correlations between low incidences of substance abuse and better health. However, limited information has been established regarding the underlying reasons for the healthy avoidance of these substances. It has been suggested that future studies could expand on previous investigations involving the relationship between religiosity, social support, and substance abuse and help researchers to broaden these possible explanations (Mathews, et al., 1998; Plante and Sherman, 2001).

Second, although many researchers have made assumptions about the beliefs that help religious individuals to avoid alcohol, tobacco, and drugs, the relationship between participation in a religious organization and beliefs about substance abuse is still a mystery. Nevertheless, Plante and Sherman (2001) recommend that future research focus on trying to uncover the major reason or reasons that explain the relationship between religiosity and substance abuse. This objective may be best achieved by focusing on beliefs about substance abuse rather than usage data.

Third, thus far no single study has attempted to link social support, substance abuse, and religiosity. Many organizations, groups, and rehabilitation centers make social support one of their top priorities, however no studies attempt to investigate these

issues within a religious context (Alcoholics Anonymous, 2002). Social support has also been positively linked to health outcomes, however no studies have attempted to link social support, substance abuse, and religiosity.

Fourth, to date little if any information is known about how individuals vary in their perceptions of substance abuse, religiosity, and social support. Differences in perceptions of substance abuse, social support, and religiosity could be impacted by gender, age, and length of time within an organization. This study addresses the need to further investigate this issue, and help close this gap that exists in the literature.

Research Questions

As noted, religious involvement can improve one's chance of survival. However, researchers have yet to determine if participation in religious organizations provides the support people need to avoid alcohol, tobacco, and drugs or to impact on their belief systems about substance abuse. Although much research (Plante & Sherman, 2001; Strawbridge, 2001) has determined that individuals who participate in religious activities are more likely to change poor health behaviors and maintain good ones that have already been established, further investigation is suggested due to the limited amount of research regarding this topic (Strawbridge, 2001).

Based on the previous literature and present rationale, the following research questions will be guiding this research:

RQ 1: How do active members of religious organizations define substance abuse?

RQ 2: What, if any, relationship do organizational members see between supportive communication and religiosity?

RQ 3: What, if any, differences exist among members of religious organizations in religiosity and supportive communication on the basis of definitions of substance abuse?

RQ 4: What, if any, differences exist among members of religious organizations in religiosity and supportive communication on the basis of demographic variables?

Chapter 2

Literature Review

The purpose of this project is to investigate the relationship among religiosity, beliefs about substance abuse, and social support. The relationship between religion and health care issues, such as substance abuse has been investigated repeatedly over the past few decades. Researchers have been interested in the driving force behind the relationship between religion and lower occurrences of substance abuse. However, little is known about the perceptions religious individuals have concerning substance abuse. Taken together, the opportunities for social support that arise from participation in religious organizations may prove to be the true catalyst for lower substance abuse rates.

Religious involvement produces many health benefits that could be attributed to the attitudes, beliefs, and rituals practiced by religious individuals. Individuals who attend regular church services and activities may be more likely to improve their health by adopting healthy habits regarding substance abuse (Ellison & Levin, 1998). Attendance in church functions provides a wide range of health benefits. Often, those who participate are more likely to quit smoking and limit drug and alcohol intake (Cochran, Beeghley, & Bock, 1998; Ellison & Levin, 1998; Koenig et. al, 1994, 1998).

For many years the relationship between religion and health care was a mystery, however in the late 1980s many researchers became intrigued by the correlation emerging between religious individuals and improved health outcomes. Scholars in many areas of social and behavioral sciences have begun to recognize the relationship often formed by religious individuals and lower occurrences of substance abuse. An attempt to learn more about the effects religion has on substance abuse treatment has begun to become an area

of importance to many health care workers (Ellison & Levin, 1998). Although some health care officials and researchers concentrate primarily on the area of substance abuse treatment, individuals from an array of concentrations have studied and published information about this topic. For instance, health workers such as general practitioners, emergency room physicians, pediatricians, psychiatrists, obstetricians, geriatric care providers, social workers, counselors, child welfare officials, and physical therapists have all become interested in the connection between religion and substance abuse (Scheyett, 2000). Accounts reporting on the links between religion and substance abuse, although they are limited in number, can be found in many areas of study including: social work, communication, western medicine, and holistic medicine (Ellison & Levin, 1998).

Ordinary social groups often do not offer the same type of support and encouragement that is found in religious organizations. Individuals who choose to be a part of an organized religious group are more likely to have better health and are less likely to be associated with smoking, alcohol, or drugs (Ellison & Levin, 2001). Many studies have attempted to examine the relationship between religiosity and substance abuse, however no studies have attempted to combined religiosity, substance abuse, and social support (Ellison & Levin, 2001). This review will be organized around a discussion of religiosity, conceptions of substance abuse, and social support.

Religiosity

While the terms religiosity and spirituality are often used interchangeably (Mathews, et al., 1998), the focus of this paper is on organized religion. The definition of religious commitment is used in this study and is referred to as the participation in the practices or rituals that are associated with a particular religious organization (Craigie et

al. 1990; Levin & Schiller, 1987; Mathews et.al, 1998). Spirituality is often referred to as "personal views and behaviors that express a sense of relatedness to the transcendental dimension or to something greater than the self" (Reed 1987, p. 35).

As significant as spirituality is to the study of religiosity and health Mathews et al. (1998) provides a framework for the decision to exclude spirituality from this work. First, little, if any, consensus exists in the scientific community on the most appropriate definition of spirituality (Connelly, 1996). However, a greater consensus exists on the best way to define religious commitment. Second, instruments for measuring spirituality are only in the beginning stages of development. Third, empirical research on spirituality and health is limited, whereas literature focusing on religious commitment and health is more readily available.

Attempts to define religiosity have been made continually over the years. Scholars from a variety of disciplines have attempted to find an all-encompassing definition of religiosity. "Over the centuries, influential thinkers have offered their own definitions, with greater or lesser degrees of assurance, but virtually all of these definitions have been found wanting by the majority of scholars" (Connelly, 1996, p. 1). In many cases the definitions of religiosity are too narrow, leaving out significant information, while in other cases the definitions are too broad (Connelly, 1996; Mitchell, 1998; Robinson, 2000).

There are many different definitions of religiosity currently used in the literature. For instance Mitchell (2000) refers to religion as "an organized system of worship that gives a framework to the relationship we have with the universe and with a higher power" (p. 1). However, although many definitions of religion exist, "it involves what

people do in their lives: religion has been called 'enacted tradition' or 'embodied belief'" (Kirkland, 2000, p. 1).

> It originates in humanity's tendency to seek and to maximize the meaning and value of our life-experience by (re-) aligning that life-experience with a higher or deeper reality, with "an unseen order" that somehow transcends ordinary human existence. That alignment can serve to integrate diverse aspects of our lives (individually and collectively), and to imbue our lives with a sense of purpose and direction. The concern with establishing and maintaining a harmonious relationship with the higher/deeper reality while conducting our everyday life often generates religious values-guidelines for thought and action that often develop into powerful cultural forces (Kirkland, 2000, p. 1).

Religiosity and Health

Two avenues of healing, religion and medicine, have traditionally worked hand in hand to help cure the sick (Myers, 2001). "Religious and healing efforts were often conducted by the same person; the priest was also a healer. Hospitals were established in monasteries, then spread by missionaries" (Myers, 2001, p. 1). However, as medical science developed healing and religion began to deviate from one another (Myers, 2001; Sloan et al., 1999). "Rather than simply asking God to spare their children from smallpox, people began vaccinating them. Rather than seeking a spiritual healer when burning with bacterial fever, they turned to antibiotics" (Myers, 2001, p. 1).

In recent years religiosity has increasingly come to be viewed as central to health. A series of recent surveys, program changes, and empirical investigations support this contention. Mathews (1997) reports that four out of five Americans believe that

religiosity and spirituality are both related to health. A "Yankelovich survey concluded that 94% of HMO professionals and 99% of family physicians agree that personal prayer, meditation, or other spiritual and religious practices can enhance medical treatment" (Myers, 2001, p. 1). By1999 almost 50% of America's 126 medical schools were offering courses pertaining to the study of spirituality and health, up from three in 1994 (Myers, 2001; Sloan et al., 1999). Since 1995, Harvard Medical School has hosted numerous medical conferences on Spirituality and Healing, attracting more than 2000 health care professionals (Myers, 2001). In recent years Duke University has established a Center for the Study of Religion/Spirituality and Health. And" a recent poll of 1000 United States adults where 79% of the respondents believed that spiritual faith could help people recover from disease, and 63% believed that physicians should talk to patients about spirituality in relation to their health" (Sloan, et al., 2001, p. 1).

Just as polls and changes in medical programs support that contention that health and religiosity are associated, empirical research supports this claim. In the late 1980s many researchers became intrigued by the correlation emerging between religious individuals and improved health outcomes (Ellison & Levin, 1998). Scholars from a large variety of disciplines have begun to recognize the relationship often formed by religious individuals and medical outcomes (Ellison & Levin, 1998). Although some investigators focus their research mainly on the area of religiosity and health, individuals from many other well-known concentrations have studied and published information about this topic (Ellison & Levin, 1998; Plante & Sherman, 2001). For instance, "fields including sociology, psychology, health behavior, health education, psychiatry, gerontology, and social epidemiology" have been involved in researching religiosity,

spirituality, and health care (Ellison & Levin, 1998, p. 958). Accounts reporting on the links between religiosity and health, although they are limited in number, can be found in health journals such as "The American Journal of Public Health, The American Journal of Psychiatry, The Journal of the American Medical Association, The Journal of Gerontology, The Journal of Psychosomatic Medicine, and leading journals devoted to medical sociology and the sociology of religion" (Ellison & Levin, 1998, p. 958).

"Among the diseases that have been examined in this body of research are heart disease, hypertension and other circulatory ailments, stroke, cancer (various sites), and gastrointestinal disease, as well as overall self–rated health, physical disability, and self–reported symptomatology" (Ellison & Levin, 1998, p. 959). Much of the research published on this topic suggests that religious involvement is positively correlated with health. For instance, Plante and Sherman (2001) noted that high blood pressure (Larson et al., 1989; Levin & Vanderpool, 1989; Steffen et al., 2000), cancer (Andrykowski, Brady, & Hunt, 1993; Belec, 1992; Collins, Taylor, & Skokan, 1990; Curbow, Somerfield, Baker, Wingard, & Legro, 1993), heart disease (Comstock & Partridge, 1972), and compliance, functioning, and anxiety (Harris, et al., 1995) were examined in both religious and non-religious individuals. In each study it was concluded that frequent religious involvement was positively associated with the health of individuals.

Physicians have been telling the public for years that unhealthy behaviors such using alcohol, drugs, or tobacco are negatively associated with health. Often, medical recommendations are supported by religious beliefs; so religious individuals are more likely to follow their doctor's recommendations. A recent study involving a physician suggested that "patients who are active in their religions not only lived healthier and

happier lives than did his nonreligious patients but that religious patients sometimes experienced what he considered to be miracles in terms of their health" (DuPont, 2001, p. 1347). Also, a study conducted regarding heart diseases and religiosity concluded that "patients not participating in any social groups were four times more likely to die after heart surgery, and patients who were not religious were over three times more likely to die" (Benn, 2001, p. 141).

Improved physical health and lower rates of morbidity and mortality are among the top goals of all health care providers, lawmakers, and patients. Being involved in religion seems to explain why some people may live longer than others. Currently, "nearly 95% of Americans believe in God or in some universal spirit, 42% attend religious worship, 67% are members of a local religious body, and 60% feel that religion is very important in their lives" (McCullough, 2000, p. 2). Regular religious attendance, across all denominations, is related to longer life according to a 2000 study that examined 42 studies involving 125,826 people (McCullough, 2000). "Religion appears to soothe the body as well as the soul, as people who are highly religious tend to live longer than others, a review of more than forty scientific studies has found" (Mann, 2000, p. 1).

Over the past few decades much research has been done to investigate empirically the effects religiosity has on illness and disease. A few examples of these studies includes:

- Oxman and Reed, who suggests that weekly church attendees had lower mortality rates than those who did not regularly attend religious services (1998).

- Strawbridge, Cohen, Shema & Kaplan stated that religious attendance reduces mortality risk among church attendees, due to social ties, stable marriages, and improved healthy behaviors (1997).
- Hummer, Rogers, Nam, & Ellison found that individuals who did not attend religious services were at a greater risk for death from respiratory disease, infectious diseases, cancer, diabetes, and external causes (1999).
- Koening, George, & Peterson found that higher intrinsic religiosity was positively associated with longer remission periods from depression (1998).
- Comstock & Tonascia found that residents of Washington County, Maryland who were frequent church attendees were less likely to die than were infrequent church attendees (1977).
- Leibovici found that individuals who were suffering from bloodstream infections had a significantly lower mortality rate and a reduced stay in the hospital if they were prayed for (2001).

In addition, Larson et al. (1992, p. 557) found that "in almost every instance, religious people lived longer than nonreligious people," "even taking into account other risk factors such as weight, age, and smoking" (Gartner, et al., 1991, p. 16). Also, Zuckerman (1984) suggest that religious individuals have mortality levels much higher than those who are not religious. Correspondingly, these findings showed similar results even when taking into account other health factors such as age, marital status, education, income, race, gender, and health status as a whole. Also, Levin & Vanderpool from the

University of Texas concluded that infrequent church attendance should be considered a risk factor for morbidity and mortality (1987).

Definitions of Substance Abuse

Substance abuse research is often characterized by self-report studies that aim to examine the extent to which someone is a substance abuser. Currently, a gap in the literature exists between scientific research and perceptions of substance abuse. To date, perceptions of substance abuse have been studied in one of two ways, adolescent perceptions of substance abuse and health care provider perceptions of substance abuse.

Often studies explore how adolescents conceptualize substance abuse (Freidman, Schwartz, & Utada, 1989; Pilgrim, Abby, Hendrickson, & Lorenz, 1998; Rosenbaum, & Hanson, 1998; Nucci, Guerra, & Lee, 1991). For instance, Nucci, Guerra, & Lee attempted to gain a working knowledge of how low-drug-use adolescents compared to high-drug-use adolescents define substance abuse (1991). It was discovered that high-drug-use subjects were more likely to view drug use as a personal rather than a prudential issue compared to their low-drug-use counterparts. To those who used drugs more often drug use was a matter that could be handle only on a personal level. In addition, high-drug-use subjects were more likely to view themselves as the only authority and had a total disregard for parents or law officials. Other studies have yielded similar results stating that often adolescents view drug use as personal and they often do not view adults as authority figures (Freidman, Schwartz, & Utada, 1989).

A review of the literature suggests that there are two areas of focus in the perceptions of substance abuse among health care providers. One involves health care provider attitudes, views, and perceptions of substance abusers, while the other focuses

on the provider lack of awareness or understanding regarding substance abuse (Schwyett, 2000).

Many articles discuss and devote particular interest to health care providers views and attitudes toward substance abusers (Erdner, 1997; Harkness, & Contrell, 1997; Moyers, & Miller, 1993; Najavits, Griffin, Luborsky, & Frank, 1998; Ogborne, Braun, & Schmidt, 1998; Schaler, 1997; Taricone, & Janikowski, 1990; Walton, Blow, & Booth, 2000). Substance abusers in these studies tended to be viewed as selfish individuals who have no personal regard for themselves or those around them (Substance Abuse and Mental Health Service Administration, 1999). Given this widespread perception, the Substance Abuse and Mental Health Services Administration has urged health care officials to work together to change the attitudes and stigma associated with substance abuse (1999). This stigma makes treatment for substance abuse difficult due to negative provider attitudes toward substance abuse (Substance Abuse and Mental Health Service Administration, 1999).

Other studies direct attention toward doctors', nurses', and social workers' lack of understanding toward substance abuse issues (Change, Behr, Goetz, Hiley, & Bigby, 1997; Change, Astrachan, Boris, & Bryant, 1994; Davis, 1997; Hughes, Storr, Brandenburg, Baldwin, & Sheehan, 1999; Roche, Parle, Campbell, & Saunders, 1996; Stapleton, 1999; Zellman, Jacobsen, & Bell, 1997), and many even go as far as to suggest that educational systems should began to take responsibility for increasing the competence of their students in the arena of substance abuse treatment (Adger, Macdonald, & Wengner, 1999; Ford, Klag, Whelton, & Goldsmith, 1994; Graham, Parran, & Jaen, 1992; Hopkins, Zarro, & McCarter, 1994; Miller, & Sheppard, 1999;

Jarvis, & Schnoll, 1999; Rose, 1998; Substance Abuse and Mental Health Service Administration, 1999). Often health care providers who do not have specific training in the area of substance abuse lack the skills needed to address substance abuse appropriately.

Substance Abuse and Religiosity

Interestingly, religiosity has been found to play a significant role in substance abuse as well. Religious individuals are less likely to use alcohol and other drug related items (Mathews, et al., 1998). For example, Park et al. (2001) found that among high school students those who were religious were less likely to drink alcohol. Also, Moore et al. (1990) found that being unaffiliated with a religious organization in medical school accounted for an increased risk of alcoholism. "Individuals who claim to have a personal relationship with the Divine are only half as likely to become alcoholics or drug addicts, or for that matter even to try contraband drugs" (Mercola, 2002, p. 1). Studies have shown that "adults and teens who consider religion to be very important and who attend religious services weekly or more are far less likely to smoke, drink, or use illicit drugs" (National Center on Addiction and Substance Abuse, 2002, p. 2). "Also, participation in a community sharing the same faith or spirituality may provide a sense of acceptance and belonging, minimizing the need to turn to addictive substances and providing support in resisting them. In addition, individuals may be less likely to use substances because their personal connection with a higher power fills a need that makes substance use unnecessary or provides hope for the future and strength to resist the opportunity to use substances" (Center for Addiction and Substance Abuse, 2002, p. 13).

As stated earlier, individuals who have a high degree of religious commitment are less likely to use alcohol and other harmful substances, and if they do they are less likely to abuse these substances (Gartner et al., 1991; Gorsuch & Butler, 1976; Hays et al., 1986; Mathews et al., 1998; Moore et al., 1990). A handful of recent studies have investigated the relationship between substance abuse and religiosity. For instance, Gorsuch and Butler (1976) researched the literature pertaining to the social and psychological factors that may predispose individuals to abuse drugs. It was found that individuals with high religious commitment were less likely to have used drugs in the past and are less likely to use them in the future. Years later Gartner et al. (1991) replicated this study. These findings posed similar results, suggesting that in 11 out of 12 studies reviewed dealing with alcohol and other drug abuse; religious commitment was associated with reduced risk for substance abuse.

Research involving adolescence, religiosity, and substance abuse tends to support the contention that there is a connection between religiosity and substance abuse. For example, a study by Hays et al. (1986) identified religious association as a factor that could reduce the risk of substance abuse among adolescents. In this study a sample of 13-18 year olds was examined to determine the relationship between predictors of risk, (e.g., personality, environmental and behavioral factors) and alcohol and drug abuse. Conformity, commitment, and religiousness were factors most strongly associated with decreased use of alcohol, marijuana, and other illegal drugs. Larson and Wilson (1980) surveyed a group of alcoholics about their religious history. It was concluded that 89% of the alcoholics had lost interest in religion early in their teen years, whereas in a control group, 48% had an increased interest in religion and 32% remained unchanged.

Moreover, Emmons et al. (1998) found that among United States college students, those who were religious were less likely to smoke in their lifetime.

Taken together, the substance abuse literature has spotlighted usage and usage-related issues. Less is known, however, about how beliefs concerning substance abuse are related to religiosity or supportive communication.

Social Support

Social support can be defined as "the perception of belonging to a social network or group through mutual obligation or communication" (Kaplan, Sallis, & Patterson, 1993, p. 132-133). Social support within a family or any organization is vital to its functioning. Often researchers examine the amount of social support within a family or organization to determine how well they can make decisions, or get through difficult times together. Social support can be used to examine the connection between relationships and illness, decision making, education, closeness between siblings, as well as many other aspects of healthcare or organizational functioning.

The effects of social support in any medical situation can be positive. Decades ago physicians and other health professionals began to investigate the relationship between social support and cure rate, recovery rates, and prevention (Gordy, 1996). After the completion of many successful studies, "the view that social support has a direct correlation with medical success ceased to be seen as a radical position, an unsurprising result given that most practicing physicians have experienced its reality throughout their working lives" (Gordy, 1996, p. 1). Individuals who become ill or that are involved in some type of medical emergency or tragedy all benefit from social support. Memberships in communities or social networks can encourage the adoption of

healthy behaviors or reinforce already established good behaviors, and they can also make recovery much easier by sending aid to those in need (Benn, 2001; Ellison & Levin, 1998; Hummer et al., 1999; Plante & Sherman, 2001; Sorenson, 1995).

Social support can take place in a variety of settings. Although therapy groups, such as Alcoholics Anonymous, are common places at which people receive social support, it can be given and studied in an assortment of settings. Social support within healthcare settings has been studied a great deal over the pasts few years. Many studies have been conducted over the years to determine how social support relates to organizations (Hullett, 2000; Kelly, 1999). Often, employees receive many personal and emotional benefits from organizations where unconditional support can be received. On the other hand, people that experience a low level of social support are often faced with many individual difficulties throughout their life. For instance, a study that investigated caregivers' provision of supportive communication to nursing home residents concluded that often both the patient and the caregivers both benefited from social support (Hullett, 2000). The caregivers were less likely to burn out, while the patients who received social support healed more quickly, and complied with their treatment regimens on a more consistent basis (Hullett, 2000).

Social support has been shown to positively affect individuals with illness, likely due in part to communication between caregivers, family members, and patients. Another study was done to evaluate the role of social support among families caring for an individual with chronic fatigue syndrome (Kelly, 1999). In this study, there were 41 participants, 25 whom had a primary support giver. It was concluded that the individuals who had a support system had better results from treatment regimens, as well as

increased energy and self esteem because they constantly had the other individuals helping them to make all the necessary medical steps to recover.

Social Support and Religiosity

These aspects of social support can also be applied to religious individuals. Individuals involved in religious organizations have a large body of social ties that help aid them in times of need. Social support within a religious congregation, Sunday school class, or support group can be related to positive health outcomes. In a recent study examining small groups, nearly three-quarters of all group members said they received encouragement when they are feeling down, and 92 percent of participants say they received at least one type of social support from other group members (Wuthnow, 1994). "Religious communities are often conduits for various kinds of social support, tangible or instrumental aid, and socioemotional assistance" (Ellison & Levin, 1998, p. 706). Research suggests that social support positively correlates with health care and illness (Ellison & Levin, 1998). This could help to explain the positive association between religiosity and better health (Kelly, 1999). While the most common areas religious organizations target with social support involve poverty, family needs, and youth needs, a growing number of religious organizations are beginning to offer programs directly related to health outcomes (Ellison & Levin, 1998). For instance, programs involving management of hypertension, weight control, improving dietary practices, and dealing with HIV/AIDS are becoming more prevalent in society today (Caldwell et al., 1992; Chaves & Higgins, 1992; Ellison & Levin, 1998). In addition many individuals are entitled to counseling sessions with their clergy regarding family, personal, or spiritual issues (Ellison & Levin, 1998).

Like families or other groups, religious groups provide a place where their members can be exposed to ongoing social support and love (Easterbrook, 1999; Ellison & Levin, 1998; Sorenson, 1995). Religious individuals belonging to spiritual groups experience a great deal of benefits by being involved in these organizations. Most importantly, social support plays a significant role in the healing process. Individuals can experience support that encourages them to regain their health, change their health behaviors or patterns, or merely lend a helping hand in times of need (Easterbrook, 1999; Ellison & Levin; 1998; Levin & Schiller, 1987; Oxman & Freeman, 1995). All of these things promote positive health and wellness, which could account for the improved health status of religious individuals.

Not only do religious members get support through various groups and counseling, but the friendships that are made through religious involvement also play a role in social support. According to Ellison and Levin (1998), members of religious congregations often provide a type of informal support that can be given in the form of encouragement, transportation, meals, goods, or other services. Interestingly, some studies even indicate that the "experiences of volunteering and assisting others can benefit support providers as well as the recipients" (Ellison & Levin, 1998, p. 706). For instance, Taylor and Chatters investigated church members as a form of informal support in a 1988 study which found that working with others provided much satisfaction and social support. Also, a 1989 study by Maton examined the relationship between community settings that helped to reduce stress in religious individuals. These authors believe that being involved in a social support network can be a positive experience for all parties involved. Individuals who provide social support receive a great deal of

personal satisfaction, as a result of the opportunity to provide social support (Taylor & Chatters, 1988).

Also, many studies have examined the power prayer can have on religious individuals (Cohen et al., 2000; Leibovici, 2001; Sheler, 2001). Prayer is a form of social support "from the standpoint of modern scientific medicine, no treatment should be employed without evidence of its effectiveness and safety. Therefore, it is not surprising that some scientists are attempting to test the efficacy of prayer as a form of therapy" (Cohen, 2000, p. 40). Praying has been linked to improved health outcomes for decades; however, only in recent years have scholars begun to recognize the effects it has on medical outcomes. For instance, a study conducted at St. Luke's Hospital in Kansas City, Missouri found that patients hospitalized in the coronary care unit who were prayed for suffered 10 percent fewer complications than those who had no one assigned to pray for them (Harris, 1999). Prayer, in many cases is, now understood as "a kind of treatment modality, one more in the arsenal of weapons available to medicine to fight against disease" (Cohen et al., 2000, p. 40). A growing number of physicians have begun to encourage spirituality among their patients. Many doctors and nurses have suggested that "surgery and syringes aren't the only effective healing tools, some doctors and hospitals have begun adding a spiritual component to patient care—from new age meditation techniques to traditional prayer" (Sheler, 2001, p. 47).

Most importantly, healthy habits, such as not drinking or smoking or doing drugs can all lead to better health (Ellison and Levin, 1998; Myers, 2001; Plante and Sherman, 2001; Sloan, et al., 1999). Current research suggests that religious individuals often have better health (Ellison and Levin, 1998; Mathews et al., 1998; Plante and Sherman, 2001).

Social support within religious organizations and the health of religious individuals have been shown to have a positive association. Social support can encourage individuals to adopt healthy behaviors, such as not drinking, smoking, or using tobacco. Most often it is easier to establish behaviors when you are surrounded with other individuals who also engage in the same behaviors. Religious organizations are prime places for individuals to learn and establish healthy habits, in turn improving their health. Religious individuals can help encourage others to avoid unhealthy acts, while also serving as role models. It has been suggested that if individuals surround themselves with people who avoid unhealthy behaviors, they are less likely to engage in unhealthy acts (Ellison & Levin, 1998; Plante & Sherman, 2001). This can make it easier for individuals to adopt healthy habits, maintain already established healthy habits, and lead to overall healthier lifestyles.

Summary

The review of the literature suggests that much could be learned from investigating the link between beliefs about substance abuse, social support, and religiosity. Shifting the focus from usage-related investigations to beliefs about substance abuse would provide valuable new insights. The current literature reveals a connection between social support, religiosity, and substance abuse. However, the literature tends to focus on self-reports aimed at finding out the extent to which a person is a substance abuser. Therefore, this study attempts to learn more about the perceptions individuals have about substance abuse within their religious community.

Chapter 3

Methods

The purpose of this study was to examine the relationships among religiosity, beliefs about substance abuse, and social support. This study explored the interrelationships between the three variables in two large religious organizations. The project employed a survey research design to gather data from members of the organizations.

Organization & Participants

The organizations that agreed to participate in the study are Sevier Heights Baptist Church in Knoxville, Tennessee and First Christian Church of Knoxville in Knoxville, Tennessee. Sevier Heights Baptist Church is located in a suburban area of Knoxville, and has been in operation for more than 25 years. The church maintains an active membership of approximately 4000 predominately white members. The church offers a number of services to members, including an on-site counseling center. Worship services are offered on Wednesday nights as well as twice on Sunday mornings. In addition, Sunday school classes meet before the Sunday morning worship services. Each Sunday school class meets for one hour per week. Table 1 presents a summary of the demographic information for each organization.

A total of 79 people from this church agreed to participate in this study. Study participants included active church members ranging from age 18-76. Of the 79 surveys included in this study, 51.8% were females (n= 40) and 48.1% were males (n= 38).

First Christian Church of Knoxville is located in a suburban area of Knoxville, Tennessee, and has operated for more than 50 years. The church maintains an active

membership of approximately 100 predominately white members. The church offers a number of services and activities to members on a weekly basis. Worship services are offered on Wednesday nights and once on Sunday mornings. In addition, Sunday school classes meet each week before Sunday morning services, and a dinner is provided before each Wednesday night service. Each Sunday school class meets for one hour per week, and Wednesday night dinner lasts for approximately one hour. From this organization 33 surveys were collected. Study participants ranged in age from 23-73. Of the 33 surveys included in this study from First Christian Church, 45.4% were females (n= 14) and 54.5% were males (n= 18).

A grand total of 112 people participated in the project, ranging from 18 to 76 years of age (see Table 1). Of the 112 participants 48.1% were female (n= 54), 50.9% were male (n= 56), and 1.8% did not respond to the question (n= 2). As noted in Table 1, 47.7% were married (n= 52), 45.9% were single (n= 50), 4.6% were divorced (n= 5), .9% was widowed (n= 1) and 2.7% did not respond to the question (n= 3). Also, of the 112 participants, 4.5% participate in church activities more than once a day (n= 5), 1.8% participate in church activities once a day (n= 2), 64.5% participate in church activities more than once a week (n= 71), 26.4% participate in church activities more than once a month (n= 31), while 2.7% participate in church activities less than once a month (n= 3) and 1.8% did not respond to the question (n= 2).

Procedures

The study was implemented in a single phase in both organizations. At Sevier Heights Baptist Church the study was administered in cooperation with the church psychologist, Dr. David Abernathy.

Table 1
Demographic Information

Category		Overall	Church One	Church Two
Length of Church Membership				
	Mean	13.46	23.81	7.93
	Range	0-62	0-56	1-62
	Standard Deviation	15.301	15.888	11.802
Age				
	Mean	41.45	47.44	38.93
	Range	18-76	23-73	18-76
	Standard Deviation	16.422	13.956	16.808
Frequency of Church Attendance				
	Mean	3.21	3.22	3.21
*	Range	1-5	1-4	1-5
	Standard Deviation	.731	.751	.727
Sex				
	Female	54	14	40
	Male	56	18	38
Marital Status				
	Married	52	24	28
	Single	50	6	44
	Divorced	5	2	3
	Widowed	1	0	1

* 1. More than once a day
2. Once a day
3. More than once a week
4. Once a week
5. More than once a month
6. Less than once a month

Dr. Abernathy agreed to organize the procedures in conjunction with the Sunday school classes. The survey questionnaire was administered to each of the Sunday school classes as a part of the class.

Each Sunday school teacher was given a packet of surveys to distribute to class members. Each member was asked to complete the survey during the class and return it to the teacher. The teachers then placed the completed surveys in an envelope and delivered them to a designated box in the counseling center. The surveys were then collected by the researcher and returned to the University of Tennessee for analysis.

At First Christian Church of Knoxville, the study was conducted in cooperation with the church pastor Dr. Scott Rollins. Dr. Rollins agreed to organize the procedures in conjunction with the Sunday school classes and the Wednesday night dinner. The Sunday school classes were comprised of 10-15 individuals, and the Wednesday night dinner was made up of 35 individuals.

The survey questionnaire was administered to each of the Sunday school classes as part of the class. Each Sunday school teacher was given a packet of surveys to distribute to class members. Each member was asked to complete the survey during the class and return it to the teacher. The teachers then placed the completed surveys in an envelope and delivered them to a designated box in the church office. The surveys were then collected by the researcher and returned to the University of Tennessee for analysis.

Measures

Two separate measures were employed to collect data for the project. The Systems of Belief Inventory, developed by Holland et al. (1997) is designed to measure

both religiosity and social support. A second measure, a Substance Abuse Inventory, was developed for this project, and is designed to assess beliefs related to substance abuse.

Systems of Belief Inventory

The Systems of Belief Inventory is a 15-item questionnaire that includes two subscales (See Appendix A). The first subscale addresses religiosity, and the second investigates social support. In this project the alpha reliability score for religiosity was $\alpha = .8015$ and for social support $\alpha = .7273$. In addition, the mean score for the religiosity subscale was 3.72 and the standard deviation was .332. For the social support subscale the mean was 3.64 and the standard deviation was .376.

The Systems of Belief Inventory "is one of the few instruments to focus explicitly on social aspects of spiritual life, which represent an important contribution" (Plante & Sherman, 2001, p. 142). Initially a test re-test reliability score of $\underline{r} = .95$ has been reported for this instrument (Holland, et al., 1997). In addition, these authors report that the measure demonstrated strong convergent validity. That is, scores on the Systems of Belief Inventory for religious groups were significantly higher than those of lay groups. These differences held equally in retest scores, which showed consistently higher means in the religious groups than in the lay groups.

Substance Abuse Inventory

An extensive review of the literature involving substance abuse measures revealed that no measures focus on beliefs related to substance abuse. Rather, existing measures center on usage issues. Therefore, a measure was developed for this project. The goal was to craft a measure that was sensitive to beliefs within the religious community as well as to the beliefs of the individual. Thus, a two-part measure drawing on different

kinds of substances (e.g., tobacco and alcohol) was developed to explore beliefs within religious communities as well as individual beliefs. In addition, a third part was added to the measure that included a free response statement asking the participant to define substance abuse.

When administering the measure, participants were first asked to report on the degree to which they believe it is acceptable for others in the religious community to use alcohol, tobacco, and drugs (such as cocaine and marijuana). Second, participants were provided with a free response statement asking them to define substance abuse. Third, participants were asked to report on the extent to which they believe tobacco, alcohol, and drugs (such as cocaine and marijuana) involve substance abuse.

Unfortunately, participant misunderstandings led to difficulties with administering the first and third parts of the measure. Less than 30% of the study participants returned surveys with usable responses for the first and third parts of the measure. However, a total of 90 usable responses were returned for the second part or free response portion of this measure.

Analysis

Data analysis for the project includes descriptive statistics, correlations, t- tests, and difference testing procedures employing the General Linear Models procedure. The discussion of analysis will be organized around the research questions.

Research Question 1

Research question one explores how members of religious organizations define substance abuse. Data for this question were generated from the free response question

involving the definition of substance abuse. The data were content analyzed with a view toward identifying themes in the definitions.

The first step in analyzing this qualitative portion of the survey involved coding the responses to the open-ended question, "Please provide us with your definition of substance abuse." Study participants generated a total of 90 definitions. Initially, two coders independently reviewed the definitions and sorted them into categories by theme. Both coders identified a total of five categories of substance abuse definitions. The categories are reported in Table 2. Following this procedure, three coders independently coded the definitions based on the categories developed in the initial procedure. For the purpose of analysis, responses that ranged across categories were coded on the basis of the dominant category. The dominant categories were identified as those in which the participant devoted the largest portion of his or her response. Cohen's Kappa was employed to assess inter-coder reliability. A score of .93 ($p.<001$) resulted from the procedure. Discrepancies between coders were discussed until agreement was reached.

The category labeled "amount" is centered on responses that referred to excessive use of alcohol, drugs, or tobacco products. Next, the category referred to as "rules/legal or illegal" refers to substance abuse in terms of not following societal or legal codes. "Harmful" centered on the negative impact of drugs, alcohol, and tobacco products on oneself or others. "Necessity to live/control" involved answers that centered on control of a substance over an individual or its impact on daily activities. Last, a category called "religiosity" was created to include all responses that referred to the acceptance or rejection of substance abuse as guided by religious beliefs.

Table 2
Coding Scheme for Definitions of Substance Abuse

Category	Description
Amount	Centered on excessive use Example- Excessive use of legal or illegal drugs
Rules/legal or illegal	Centered on substance abuse in terms of not following societal or legal codes. Example- use of drugs beyond their intended medical purpose
Harmful	Center on negative impact of drug use on self or others Example- substance abuse is the use of a substance to the degree that is harmful to oneself or others
Necessary to live/control	Dependency on a daily basis. Center on control of substance over a individual or its impact on daily activities Example- something that one has in their life that can control their lives and can make their lives out of control
Religious	Acceptance or rejection of substance abuse conforming to religious beliefs. Example-To me substance abuse is someone who does not care about themselves or their body. To me they don't realize their body is the temple for our father up in heaven. Once you have God in your heart it is possible for God to do anything for you

Research Question2

Research question two explores the relationship between religiosity and supportive communication. For the purpose of analysis, correlations employing Pearson's Product Moment Correlational analysis were used to explore the relationship.

Research Question 3

Research question three asks if there are differences among members of religious organizations in religiosity and supportive communication on the basis of definitions of substance abuse. To investigate this relationship, the GLM univariate analysis procedure was employed.

Research Question 4

Research question four asks if there are differences among members of religious organizations in religiosity, and supportive communication on the basis of demographic variables. A series of difference testing procedures including t-test and the GLM procedure were employed to explore this relationship. For each subscale in the Substance Abuse Inventory, a t-test was done between the scale items and each demographic variable.

Chapter 4

Results

The purpose of this study was to examine the relationships among religiosity, beliefs about substance abuse, and social support. The results of the study suggest religious individuals define substance abuse along a number of different dimensions. In addition, the results suggest that definitions of substance abuse do not impact on how church members view religiosity or social support. The results of the data analysis involving the demographic variables indicate a complex pattern of relationships between the demographic variables and religiosity and social support. A discussion of the results will be organized around the research questions.

Research Question 1

Research question one explores how members of religious organizations define substance abuse. Participants defined substance abuse along a variety of different dimensions. A pattern of themes emerged from the coding that included: amount, rules/illegal legal usage, harmful, necessary to live/control, and religiosity. The category labeled "amount" is centered on responses that referred to excessive use of alcohol, drugs, or tobacco products. Next, the category referred to as "rules/ legal or illegal" refers to substance abuse in terms of not following societal or legal codes. "Harmful" centered on the negative impact of drugs, alcohol, and tobacco products on oneself or others. "Necessity to live/control" involved answers that centered on control of a substance over an individual or its impact on daily activities. Last, a category called "religiosity" was created to include all responses that referred to the acceptance or rejection of substance abuse as guided by religious beliefs. Organization members most

Table 3
Categorical Responses

Category	Total	Church One	Church Two
Amount	16	6	10
Rules	18	4	14
Harmful	17	7	10
Necessary to Live/Control	33	12	21
Religiosity	6	2	4
Total	90	31	59

frequently defined substance abuse in terms of "necessity to live/control" of a substance over an individual. This category accounted for approximately 37% of responses. Table 3 identifies the number of responses associated with each category.

Research Question 2

Research question two explores the relationship between supportive communication and religiosity (See Table 4). To explore the relationship between supportive communication and religiosity Pearson's product moment correlations were used. Results revealed that a moderate positive correlation exists between perceptions of social support and religious beliefs and practices ($\underline{r} = .57$; $p<.001$). Additional analyses were conducted for each church to more fully examine the relationship between social support and religious beliefs and practices. Again a moderate positive correlation

Table 4
Correlations between Supportive Communication and Religiosity

Overall	($\underline{r}$ = .57; p<.001)
Church One	($\underline{r}$ = .574; p<.001)
Church Two	($\underline{r}$ = .470; p<.001)

was reported for church one ($\underline{r}$ = .574; p<.001) as well as for church two ($\underline{r}$ = .470; p<.01).

Research Question 3

Research question three investigates differences among members of religious organizations in religiosity and supportive communication on the basis of definitions of substance abuse. Initial data analysis examined differences among members of religious organizations across both organizations. The results of the GLM procedure indicated that there was no statistical significance in religiosity (F(4,89) = 1.3; p<.272) or social support (F(4,89) = 1.2; p<.306) on the basis of definitions of substance abuse.

Research Question 4

Research question four explores whether differences exist between members of religious organizations in religiosity and supportive communication on the basis of demographic variables (See Table 5). The demographic variables involved in the analyses include: membership time in the organization, gender, age, marital status, and attendance. Difference testing procedures were employed to determine whether differences exist between participants for each of the demographic variables. Difference

Table 5

Differences Between Members in Religious Organizations in Religiosity and Supportive Communication on the Basis of Demographic Variables

	Religiosity	Supportive Communication
Gender	t = 2.7;p<.007	t = 1.69;p<.094
Attendance	F(4,107) = .396;p<.811	F(4,106) = 2.9;p<.025
Marital Status	F(4,107) = .694;p<.598	F(4,106) = .692; p<.599
Age	F(5,104) = 1.51; p<.084	F(5,104) = .1.27; p<.188
Length of Time In the Organization	F(5,89) = .667; p<.888	F(5,88) = .758; p<.769

testing procedures revealed a limited number of significant relationships among the study variables.

Gender

The first demographic variable concerned gender. Interestingly, gender exhibits an inconsistent pattern of relationships. Specifically, t-tests revealed significant differences in some situations, but not others. When examining differences for gender across organizations, significant differences were observed between men and women for religiosity (t = 2.7; p<.007). Specifically, average scores for females (mean = 3.82) were significantly higher than average scores for males (mean = 3.64). However, no significant differences were observed between men and women for social support (t = 1.69; p<.094).

Interestingly, in one church females reported significantly higher scores in the measure of religiosity ($t = 2.10$; $p<.04$) than their males counterparts. However, in the second church men and women did not differ significantly in scores on the religiosity measure. T-tests also used to examine the relationship between gender and social support. Overall the scores were not significant ($t = 1.69$; $p<.245$). That is, men and women did not differ significantly in the scores on the measure of social support.

Attendance

Attendance also exhibits an inconsistent pattern of relationships. Once again, difference-testing procedures (GLM) revealed significant differences in some situations but not others. For instance, when examining differences for attendance across organizations, significant differences were observed between attendance and social support ($F(4,106) = 2.9$; $p<.025$). That is, individuals that attend church more often report higher levels of social support. However, when examining differences across organizations for religiosity, no significant differences were observed ($F(4,107) = .396$; $p<.811$).

Marital Status

When examining differences in marital status across organizations, no significant differences were observed for social support ($F(4,106) = .692$; $p<.599$) or religiosity ($F(4,107) = .694$; $p<.598$).

Age

When examining differences for age across organizations, no significant differences were observed between age and religiosity ($F(5,104) = 1.51$; $p<.084$). Also,

when examining differences for age and social support no significant differences were observed ($F(5,104) = 1.27$; $p<.188$).

Length of Time in the Organization

Last, when examining differences in membership years across organizations, no significant differences were observed in both social support ($F(5,88) = .758$; $p<.796$) or in religiosity ($F(5,89) = .667$; $p<.888$).

Chapter 5

Discussion and Conclusion

The purpose of this project was to explore how individuals define substance abuse in religious organizations, and how definitions of substance abuse may be linked to religiosity and social support. The results suggest that members of religious organizations employ a variety of definitions of substance abuse. Moreover, how members conceptualize substance abuse appears to have little impact on how religiosity and social support are perceived. This chapter discusses what the present findings signify and is organized around the research questions.

Defining Substance Abuse

Research question one explored how religious individuals conceptualize substance abuse. As noted in previous research, substance abuse is a very difficult term to define (Substance Abuse and Mental Health Administration, 2002). For example, some definitions focus more on illegal or legal uses of substance abuse, while others tend to focus more on addiction. For years, researchers have been struggling with the dimensions of how to define substance abuse. In addition, religious individuals have employed a variety of definitions for substance abuse. In this study, five categories were established to help understand how religious individuals understand and interpret substance abuse. The definitions discovered in this study involved definitions referring to amount-related issues; how harmful alcohol, drugs, and tobacco are to your body; control issues that result from a substance abuse problem; rule-related subjects such as legal and illegal issues; and on beliefs and practices that are reinforced by religious organizations. A substantial portion (37%) of the study participants viewed substance

abuse as "necessity to live/control over an individual". An approximately equal number of participants defined substance abuse in terms of "amount", "rules", or "harmful". Interestingly, only a few participants (6.5%) defined substance abuse in religious terms. The low occurrence of religious definitions could be a result of participants feeling as if substance abuse would not be a problem if people were religious.

These definitions tend to involve negative attributions toward the substance abuser. That is, substance abuse is defined in terms of failure to conform to rules or maintain control over ones life or doing harm to oneself or others. In many respects this result is consistent with previous research. For example, previous research that examined perceptions of substance abuse focused on adolescents' perceptions of substance abuse and health care provider perceptions toward substance abuse. Studies that have examined adolescent perceptions of substance abuse concluded that adolescents define substance abuse as either a personal or a prudential issue (Nucci, Guerra, & Lee, 1991). In addition, similar studies examining health care provider perceptions toward substance abuse concluded that often health care officials define substance abuse in a negative light (Erdner, 1997; Harkness, & Contrell, 1997; Schaler, 1997). Unlike previous research, the definitions in this study suggest that individuals employ a wider range of dimensions when defining substance abuse rather than employing more global assessments of substance abuse.

This could have important implications for health care providers. Health care professionals from all realms of the discipline are constantly searching for new and improved ways to treat substance abuse. Often, understanding why someone is a substance abuser and formulating a successful treatment plan is difficult for physicians

and other health care workers. However, understanding that different individuals may have competing definitions of substance abuse may help in the quest to treat substance abusers.

Often, a universal treatment plan is established in each treatment facility, clinic, or hospital to treat all patients who are considered to be substance abusers. If recovery plans could be formulated and based on the individual's conceptualization of substance abuse, treatment may be more successful. Specifically, treatment programs should seek to persuade abusers to subscribe to medical notions of substance abuse rather than rely on lay definitions of substance abuse. Lay definitions may not make clear to the abuser that a problem exists and behavioral changes are required.

Social Support and Religiosity

Research question two explores the relationship between social support and religiosity. Social support within a religious organization often helps to explain the low levels of substance abuse (Ellison & Levin, 2000). Research has suggested that individuals who are involved in social groups that do not advocate high levels of smoking, drinking, or drug use are less likely to become substance abusers. Often, religious organizations are prime places to find this type of social support. Social support is consistently named in the previous literature as a mechanism that helps religious individuals avoid these substances. However, in previous studies there is no clear explanation for the low occurrence of substance abuse, and the debate on what the best way to measure this issue has not yet been solved (Ellison & Levin, 2000).

Increasingly, social support is perceived as an important aspect of substance abuse prevention and recovery. Previous studies have attempted to study social support within

a religious context in hopes of explaining the lower occurrences of substance abuse (Ellison & Levin, 2001). However, many researchers have only made assumptions regarding social support, and suggested that social support could be the underlying reason for lower occurrences of substance abuse issues. However, the findings in this study were consistent with those from previous research. Social support was found to have a moderate positive relationship with religiosity.

This finding not only supports the findings from previous research, but also has implications for religious organizations. Religious organizations could consider having substance abuse programs within the church. Since social support could be a determining factor in substance abuse avoidance, recovering individuals could receive this support through church related programs. This would not only encourage individuals to become involved in a supportive organization in hopes of avoiding alcohol, drugs, and tobacco but also could help in making recovery much easier and longer lasting.

Social Support, Religiosity, and Definitions of Substance Abuse

Research question three explored the relationship between social support, religiosity, and definitions of substance abuse. Interestingly, social support scores and religiosity scores do not differ on the basis of how a person conceptualizes substance abuse. Individuals' definitions of substance abuse are not contingent upon how religious they are, or how much they rely on their organization for social support.

Since definitions of substance abuse reported in this study tend to hinge on negative attributions about the abuser, it is not surprising that perceptions of social support would remain relatively constant regardless of the definition of substance abuse. Perceptions of social support may be more likely to change if definitions varied in terms

of positive and negative attributions toward the abuser. When supportiveness is an issue in drug abuse treatment program, it would not appear to matter how the participants define substance abuse.

Consistent with the results associated with social support, perceptions of religiosity do not appear to be impacted by definitions of substance abuse. While a small number of respondents (6.5%) defined substance abuse in religious terms, the majority of respondents attributed substance abuse to other factors. Thus, even in religious communities treatment programs will likely need to address other factors in addition to religion in developing substance abuse programs.

Demographic Variables, Religiosity, and Social Support

Research question four deals with demographic variables, religiosity, and social support. This question explored the relationship between demographic issues, religiosity and social support. The results suggest that some demographic variables make a difference in how social support or religiosity are viewed, however others do not. Specifically, gender and church attendance appear to be related to perceptions of social support and religiosity. However, age, length of church membership, marital status do not appear to be related to perceptions of social support and religiosity.

Interestingly, gender and attendance were the only two demographic variables that had any significance in relation to religiosity and social support. Females reported much higher responses in both the areas of religiosity and social support. This finding suggests that females derive more social support from religious organizations than do their male counterparts. This finding is supported by the current literature because females tend to be more relational in nature and it may have little or nothing to do with

the actual amount of social support. However, these results could have important implications for health care workers who are trying to put together a treatment program for substance abuse. For instance, any substance abuse program that hinges on social support needs to take into account that females derive more social support from religious organizations than do males.

While member attendance in the participating organizations does not appear to be related to perceptions of religiosity, perceptions of social support tended to be tied to attendance. That is, individuals who attend church more frequently perceive greater levels of social support than their counterparts who attend less frequently. These results could have important implications for substance abuse treatment programs. For example, substance abuse programs that hinge on religiosity should be less concerned with church attendance than with other factors. However, if recovery from substance abuse problems hinges on social support, then church attendance may well be a contributing factor to the success or failure of the program.

Implications and Future Directions

Much can be learned about the relationships that exist between religiosity, social support, and substance abuse. The issue of how religiosity and social support impact on perceptions of substance abuse is complex. While some physicians and health officials choose to implement substance abuse programs that are highly involved with social support it appears that religious organizations have the potential to bring about the level of social support necessary for program success. Moreover, this study suggests that it is the supportive component rather than the religious component that impacts substance abuse and substance abuse-related issues most. However, in this study it is unknown if

any of the participants were substance abusers. If no one in the sample was or ever has been a substance abuser, then all that is known is that they are religious and well supported in their religious community and have never chosen to abuse alcohol, tobacco, or drugs. Moreover, this choice may have nothing to do with their religion or social support.

The search to clearly understand perceptions of substance abuse is still on-going. To date, much of the previous research revolves around understanding the attitudes, views, and opinions health-care workers have towards substance abuse treatment and substance abusers, or explain adolescent views toward substance abuse. As discussed, individual definitions of substance abuse do not fall in a predictive pattern. Many categories have been established to help understand how religious individuals define substance abuse. Future research could use a similar method to compare these definitions from a religious organization to those generated from a secular one. In addition, programs such as Alcoholics Anonymous could be used to examine similar issues. For instance, the definitions of substance abuse given by those individuals who are substance abusers could be compared to those individuals who are not. Studies focusing on these areas could help to clear up the issues surrounding the definition of substance abuse.

Health-care officials may also be influenced by the results of this project and others that may follow. Agencies and treatment groups such as the Centers for Disease Control and Prevention, the National Institutes of Health, Alcoholics Anonymous, along with many others are constantly striving to create effective health-care campaigns and treatment programs to prevent substance abuse. By understanding individual definitions of substance abuse, more effective public service information could be created. Workers

could relate treatment materials and campaign information to their target populations by incorporating their definitions of substance abuse. This could help to create more effective treatment programs, but also help in deterring people from becoming involved in substance abuse.

Religious organizations could also use this information to improve their outreach programs. By understanding how individuals view substance abuse, churches and other religious organizations could better tailor their outreach programs to their target population's needs. This could result in increased participation in outreach programs, and decrease the percentage of relapse in the participants.

Limitations

These results, although significant, have many limitations. One limitation comes from the study's sample. Questions could be raised about the sample's diversity. This study was conducted using only individuals from predominantly white churches in Knoxville, Tennessee. Future research could include using the same study with a more diverse population. The generalizability of the study results would be enhanced if individuals from many different churches, denominations, or socio-economic groups were involved in the project. The sample mainly represented individuals who were Christian, white, and from the same church.

A second limitation derives from the measures chosen for the study. Since no measure existed that centered on perceptions of substance abuse, a substance abuse scale had to be developed for this project. A number of difficulties were associated with the development and use of the measure. First, there was no opportunity to pretest the measure so as to address potential concerns of respondents. Second, the participating

organizations required that the measures be administered in such a way as to make it difficult to respond to participant questions about the measure. Third, less than 30% of the respondents completed the first and third portions of the Substance Abuse Measure. Therefore, our understanding of how members of a religious community define substance abuse was restricted to the second part of the Substance Abuse Measure.

Summary

The results of this study suggest that members of religious communities define substance abuse along a variety of different dimensions. While a variety of dimensions are employed, each tends to center on negative attributions about the abuser. Moreover, perceptions of social support and religiosity do not appear to be related to how members of religious communities define substance abuse. Future research would benefit from focusing on beliefs about substance abuse in addition to the current emphasis placed on usage-related investigations. Beliefs about substance abuse could provide valuable new insights that could be applied in many areas of substance abuse treatment and outreach. One of the key contributions addressed through this study is the development of the Substance Abuse Inventory. Until now no attempt has been made to understand more about the perceptions individuals hold toward substance abuse. Future research could benefit from refining the measure and using it for further investigation. The current study suggests that the relationship between social support, religiosity, and perceptions of substance abuse may be more complex than originally conceived. Therefore, future studies should attempt to learn more about the perceptions of substance abuse within religious communities as well as throughout society.

REFERENCES

References

Adger, J.; Macdonald, D.I.; & Wenger, S. (1991). Core competencies for involvement of health care providers in the care of children and adolescents in families affected by substance abuse. *Pediatrics, 103*(5), 1083-1084.

Alcoholics Anonymous. (2002). Available: www.aa.org

American Cancer Society. (2002). Available: www.americancancersociety.org

Anderson, D. & Deshaies, J.J. (1996). Social Support, social networks and coronary artery disease rehabilitation: A review. *The Canadian Journal of Cardiology, 12*(8), 739-744.

Andrykowski, M.A.; Brady, M.J. & Hunt, J.W. (1993). Positive psychosocial adjustment in potential bone marrow transplant recipients: Cancer as a psychosocial transition. *Psycho-Oncology, 2,* 261-276.

Belec, R.H. (1992). Quality of life: Perceptions of long-term survivors of bone morrow transplantation. *Oncology Nursing Forum, 19,* 31-37.

Benn, C. (2001). Does faith contribute to healing? Scientific evidence for a correlation between spirituality and health. *International Review of Mission, 90*(356/357), 140-148.

Berry, J.W.; Worthington, E.L. (2001). Forgivingness, Relationship Quality, Stress While Imagining Relationship Events, and Physical and Mental Health. *Journal of Counseling Psychology, 48*(4), 447-455.

Caldwell, C.H.; Greene, A.D. & Billingsley, A. (1992). The black church as a family support system: Instrumental and expressive functions. *Journal of Sociology, 6*, 421-440.

Change, G.; Astrachan, B.M.; and Bryant, K.J. (1994). Emergency physicans' ratings of alcoholism treaters. *Journal of Substance Abuse Treatment, 11*(2), 131.

Change, G.; Behr, H.; Goetz, M.; Hiley, A.; & Bigby, J. (1997). Women and alcohol abuse in primary care: Identification and intervention. *American Journal on Addiction, 6*(3), 183-192

Charatan, F. (2001). Bush's initiative could help groups that promote faith healing. *British Medical Journal, 322*(7285), 512.

Chatters, L.M. (2000). Religion and Health: Public health research and practice. *Annual Review of Public Health*, 21, 335-367.

Chatters, L.M.; Taylor, R.J.; & Lincoln, K.D. (1999). African American religious participation: A multi-sample comparison. *Journal for the Scientific Study of Religion*, 38(1), 132-145.

Chaves, M. & Higgins, L.H. (1992). Comparing the community involvement of black and white congregations. *Journal for the Scientific Study of Religion, 31*, 425-440.

Chiu, L.; Clark, M.B.; Daroszewski, E.B. (2000). Lived experience of spirituality in Taiwanese women with breast cancer/commentaries/response by the authors. *Western Journal of Nursing Research, 22*(1), 29-53.

Cohen, C.B.; Wheeler, S.E.; Scott, D.A.; Edwards, B.S. & Lusk, P. (2000). *The Hastings Center Report, 30*(3), 40-47.

Collins, R.L.; Taylor, S.E. & Skokan, L.A. (1990). A better world or a shattered vision? Changes in life perspectives following victimization. *Social Cognition, 8*, 263-285.

Comstock, G.W. & Patridge, K.B. (1972). Church attendance and health. *Journal of Chronic Diseases, 25,* 665-672.

Comstock, G.W. & Tonascia, J.A. (1977). Education and mortality in Washington County, Maryland. *Journal of Health and Social Behavior, 18*, 54-61.

Connelly, P. (1996). *Definition of Religion and Related Terms*. Available: www.darc.org/connelly/religion

Craigie, R.C.; Larson, D.B. & Liu, I.Y. (1990). References to religion in The Journal of Family Practice: dimensions and valence of spirituality. *Journal of Family Practice, 30,* 477-480.

Curbow, B.; Somerfield, R.; Baker, F.; Wingard, J.R. & Legro, M.W. (1993). Personal changes, dispositional optimism, and psychological admustment to bone marrow transplantation. *Journal of Behavioral Medicine, 16,* 423-443.

Davies, A. (1997). Survey of general practitioners' opinions on treatment of opiate users. *British Medical Journal, 314*(7088), 1173-1175.

DuPont, R.L. (2001). The Healing Power of Faith: Science Explores Medicine's Last Great Frontier. *The American Journal of Psychiatry, 158*(8), 1347-1348.

Easterbrook, G. (1999). Faith Healers. *The New Republic, 221*(3/4), 20-23.

Ellison, C.G.; Boardman, J.D.; Williams, D.R. & Jackson, J.S. (2001). Religious involvement, stress, and mental health: Findings from the 1995 Detroit area study. *Social Forces, 80*(1), 215-249).

Ellison, C.G. & Levin, J.S. (1998). The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior, 25*(6), 700-720.

Emmons, K.M.; Wechsler, H.; Dowdall, G. & Abraham, M. (1998). Predictors of moking among US College Students. *American Journal of Public Health, 88*(1), 104-107).

Erdner, C. (1997). Negative stereotyping of adult children of alcoholics by counseling professionals. *Dissertation Abstracts International Section B, 57*(9-B), 5915.

Ford, D.; Klag, M.; Whelton, P. ; & Goldsmith, M. (1994). Physician knowledge of the CAGE alcohol screening questions and its impact on practice. *Alcohol and Alcoholism, 29*(3), 329-336.

Fox, S.A.; Pitkin, K.; Paul, C.; Carson, S. & Duan, N. (1998). Breast cancer screening adherence: Does church attendance matter? *Health Education and Behavior, 25*(6), 742-758.

Freidman, A.S.; Schwartz, R.; & Utada, A. (1989). Outcome of a unique youth drug abuse program: A follow-up study of clients of Straight, Inc. Journal of *Substance Abuse Treatment, 6,* 259-268.

Gallup, G. (1994). *The Gallup Poll: Public opinion 1993.* Wilmington, DE: Scholarly Resources.

Gartner, J.; Larson, D.B. & Allen, G.D. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19,* 6-25.

Goleman, D. & Gurin, J. (1993). *Mind Body Medicine: How to Use Your Mind for Better Health.* Yonkers, NY: Consumer Reports Books.

Gordy, M. (1996). Social Support and Medical Care. Paper presented at the Internet for Doctors Conference in Geneva.

Gorsuch, R.L. & Butler, M.C. Initial drug abuse: a review of predisposing social psychological factors. *Psychology Bulletin, 83,* 120-137.

Graham, A.; Parran, T.; & Jaen, C. (1992). Physician failure to record alcohol use history when prescribing benzodiazepines. *Journal of Substance Abuse, 4*(2), 179-185.

Harkness, D.; & Contrell, G. (1997). The social construct of co-dependency in the treatment of substance abuse. *Journal of Substance Abuse Treatment, 14*(5), 473-479.

Harris, R.C.; Dew, M.A.; Lee, A.; Amaya, M.; Buches, L.D.R. & Coleman, G. (1995). The role of religion in heart-transplant recipients' long-term health and well-being. *Journal of Religion and Health, 34*, 17-32.

Harris, W.S.; G0owda, M.; Kolb, J.W.; Strychacz, C.P. ; Vacek, J.L.; Jones, P. G.; Forker, A.; O'Keefe, J.H. & McCallister, B.D. (1999). A randomized, controlled trial of the effects of remote, intercessory prayer on outcomes in patients admitted to the coronary care unit. *Archives of Internal Medicine, 159*, 2273-2278.

Hart, A.D. (1999). Take Ten Commandments and call me in the morning. *Christianity Today, 43*(13), 101-103.

Hartford Institute for Religion Research. (2002). Available: www.harfordinstitute.org

Hays, R.D.; Stacy, A.W.; Widaman, D.M.R. & Downey, R. Multistage path models of adolescent alcohol and drug use: a reanalysis. *Journal of Drug Issues, 16*, 357-369.

Health and Human Services Fact Sheet. (2000). *Substance Abuse-A National Challenge.* Available: www.thebody.org

Holland, J.C.; Kash, K.M.; Passik, S.; Gronert, M.K.; Sison, A.; Lederberg, M.; Russak, S.M.; Baider, L. & Fox, B. (1997). A brief spiritual beliefs inventory for use in quality of life research in life-threatening illness. *Psycho-oncology, 7*, 460-469.

Hopkins, T.B.; Zarro, V.J.; & McCarter, T.G. (1994). The adequacy of screning, documenting, and treating the diseases of substance abuse. *Journal of Addictive Diseases, 13*(2), 81-87.

Hughes, P; Storr, C.; Brandenburg, N.; Baldwin, D.; Anthony, J.; & Sheehan, D. (1999). Physician substance use by medical specialty. *Journal of Addictive Diseases, 18*(2), 23-37.

Hullett, C.M.; Jill, J.; & Rogan, R.G. (2000). Caregivers' predispositions and perceived organizational expectations for the provision of social support to nursing home residents. *Health Communication, 12*(3), 277-299).

Hummer, R.A.; Rogers, R.G.; Nam, C.B.; and Ellison, C.G. (1999). Religious involvement and U.S. adult mortality. *Demography, 36*(2), 273-282.

Idler, E.L. & Kasl, S.V. (1992). Religion, disability, depression, and the timing of death. *American Journal of Sociology, 97*, 1052-1079.

Ironson, G.; Solomon, G.F.; Balbin, B.S.; O'Cleirgh, M.S.; George, A.; Kumar, M.; Larson, D. & Woods, T.E. (2002). The Ironson-Woods Spirituality/Religiousness Index Is Associated With Long Survival, Health Behaviors, Less Distress, and Low Cortisol in People With HIV/AIDS. *Annuals of Behavioral Medicine, 24*(1), 34-48.

Kaplan, R.M.; Sallis, J.F. & Patterson, T.L. (1993). *Health and Human Behavior.* New York: McGraw Hill

Kelly, K.S.; Albert, K.M.; & Andrew, G. (1999). Social Support and Chronic fatigue syndrome. *Health Communication, 12* (3), 277-299.

Kendler, K.S.; Gardner, C.O. & Prescott, C.A. (1996). Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. *American Journal of Psychiatry, 154*, 322-329.

King, V.; Elder, G.H. & Whitbeck, L.B. (1997). Religious Involvement Among Rural Youth: An Ecological and Life-Course Perspective. *Journal of Research on Adolescence, 7*(4), 431-456.

Kirkland, R. (2002). *A Definition of "Religion".* Available: www.uge.edu

Koenig, H. (2000). Religion, spirituality, and medicine: Application to clinical practice. *Journal of the American Medical Association, 284*, 1708.

Koenig, H.G.; George, L.K.; Meador, K.G.; Blazer, D.G. & Ford, S.M. (1994). Religious practices and alcoholism in a southern adult population. Hospital and *Community Psychiatry, 45*(3), 225-31.

Koenig, H.G.; McCullough, M.E. & Larson, D.B. (2001). *Handbook of Religion and Health.* New York: Oxford University Press.

Larimore, W.L.; Parker, M. & Crowther, M. (2002). Should Clinicians Incorporate Positive Spirituality Into Their Practices? What Does the Evidence Say? *Annuals of Behavioral Medicine, 24*(1) 69-73.

Larson, D.B., Larson, S.S. & Koening, H.G. (2000). Research Finding on Religious Commitment and Mental Health. *Psychiatric Times, 32*(10), 1-7.

Larson, D.B.; Sherrill, K.A.; Lyons, J.S.; Craigie, F.C.; Thielman, S.B.; Greenwood, M.A. & Larson, S.S. (1992). Associations between dimensions of religious commitment and mental health. *American Journal of Psychiatry, 149,* 557-559

Larson, D.B. & Wilson, W.P. (1989). Religious life of alcoholics. *Southern Medical Journal, 73*(6), 723-727.

Leibovici, L. (2001). Effects of remote, retroactive intercessory prayer on outcomes in patients with bloodstream infection: Randomized controlled trial. *British Medical Journal, 323*(7327), 1450-1451.

Levin, J.S. (1996). How religion influences morbidity and health: Reflections on natural history, salutogenesis and host resistance. *Social Science & Medicine, 43*(5), 849-851.

Levin, J.S. & Chatters, L.M. (1998). Religion, Health, and psychological well-being in older adults: Findings from three national surveys. *Journal of Aging and Health, 10* (4), 504-531.

Levin, J.S.; Chatters, L.M.; Ellison, C.G. & Taylor, R.J. (1996). Religious involvement, health outcomes, and public health practice. *Current Issues in Public Health, 2,* 220-225.

Levin, J.S. & Vanderpool, H.Y. (1987). Is frequent religious attendance really conducive to better health? Toward an epidemiology of religion. *Social Science and Medicine, 24,* 589-600.

Levin, J.S. & Vanderpool, H.Y. (1989). Is religion therapeutically significant for hypertension. *Social Science and Medicine, 29*, 69-78.

Lewis, R.K.; Green, L.B. (2000). Assessing the health attitudes, beliefs, and behaviors of African Americans attending church: A comparison from two communities. *Journal of Community Health, 35*(3), 211-224.

Mann, D. (2000). *Religious people live longer than nonbelievers.* Available: www.webmd.com

Mathews, D.A. & Larson, D.B. (1997). Faith and Medicine: Reconciling the twin traditions of healing. *Mind/Body Medicine, 2,* 3-6.

Mathews, D.A.; McCullough, M.E.; Larson, D.B.; Koenig, H.G.; Swyers, J.P. & Milano, M.G. (1998). Religious Commitment and Health Status: A Review of the Research and Implications for Family Medicine. *Archives of Family Medicine, 7,* 118-124.

Mayo Clinic. (2002). *Alcohol and health: Weighing the benefits and risks of drinking.* Available: www.mayoclinic.com

McColl, M.A.; Bickenback, J.; Johnston, J.; Nishihama, S.; Schumaker, M.; Smith, K.; Smith, M. & Yealand, B. (2002). Spiritual issues associated with traumatic-onset disability. *Disability and Rehabilitation, 22*(12), 555-564.

McCollough, M.E.; Larson, D.B.; Hoyt, W.T.; Koenig, H.G. & Thoresen, C.E. Religious Involvement and Mortality: A Meta-Analtic Review. *Health Psychology, 19*(3), 1-20.

Mecca, A.M.; Smelser, N.J. & Vasconcellos, J. (1989). *The Social Importance of Self-Esteem.* Berkeley: University of California Press.

Mercola, J. (1998). Religious Activity may Lower Blood Pressure. *International Journal of Psychiatry in Medicine, 28*, 189-213.

Mercola, J. (2000). Strong Religious Beliefs Help Prevent Substance Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 1190-1197.

Mitchell, G.R. (1998). *Spirituality Vs. Religion.* Available: www.care-givers.com

Miller, L.; Davies, M. & Greenwald, S. (2000). Religiosity and Substance Use and Abuse Among Adolescence in the National Comorbidity Survey. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(9), 1190-1197.

Miller, N.; & Sheppard, L. (1999). The role of the physician in addiction prevention and treatment. *Psychiatric Clinics of North America, 22*(2), 489-505.

Miller, W.R. (1998). Researching the spiritual dimensions of alcohol and other durg problems. *Addiction, 93*, 979-990.

Mitka, M. (1998). Getting Religion Seen as Help in Being Well. Journal of the American Medical Association, 280(22), 1-4.

Moore, R.D.; Mead, L. & Pearson, T.A. Youthful precursors of alcohol abuse in physicians. *American Journal of Medicine, 88*, 332-336.

Morris, E.L. (2001). The relationship of spirituality to coronary heart disease. *Alternative Therapies in Health and Medicine, 7*(5), 96-98.

Moyers, T.; & Miller, W. (1993). Therapists' conceptualization of alcoholism: Measurment and implications for treatment decisions. *Psychology of Addictive Behaviors, 7*(4), 238-245.

Mueller, P. S.; Plevak, D.J. & Rummans, T.A. (2001). Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice. *Mayo Clinic Proceedings, 76*(12), 1225-1235.

Murk, C. (1995). *Self-Esteem: Research, Theory, and Practice.* New York: Springer Publishing Company.

Musgrave, C.F.; Allen, E.C. & Allen, G.J. (2002). Spirituality and Health for Women of Color. *American Journal of Public Health, 92*(4), 557-560.

Myers, D.G. (2001). *Stress and Health* (6th ed.). New York: Worth Publishers.

Najavitis, L.; Griffin, M.; Luborsky, L.; & Frank, A. Therapists' emotional reactions to substance abusers: A new questionnaire and initial findings. *Psychotherapy, 32*(4), 669-677.

National Household Survey on Drug Abuse. (2001). *The NHSDA*. Available: www.samhsa.gov

National Institute of Mental Health. (2002). Available: www.nimh.nih.gov

National Mental Health Association. (2002). Available: www.nmha.org

Nucci, L.; Guerra, N.; & Lee, J. (1991). Adolescent Judgments of the Personal, Prudential, and Normative Aspects of Drug Use. *Developmental Psychology, 27*(5), 841-848.

Ogborne, A.; Braun, K.; & Schmidt, G. (1998). Working in addictions treatment: Some views of a sample of service providers in Ontario. *Substance Use and Misuse, 33*(12), 2425-2440.

Oleckno, W.A. & Blacconiere, M.J. (1991). Relationship of Religiosity to Wellness and Other Health Related Behaviors and Outcomes. *Psychological Reports, 68*, 819-826.

Oxman, T.E.; Freeman, D.H. & Manheimer, E.D. (1995). Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery. *Psychosomatic Medicine, 57,* 5-15.

Oxman, D. & Reed, D. (1998). Religion and mortality among the community-dwelling elderly. *American Journal of Public Health, 88*, 14-69-1475.

Park, J.S.; Bauer, S. & Oescher, J. (2001). Religiousness as a Predictor of alcohol use in high school students. *Journal of Drug Education, 31*(3), 289-303.

Plante, T.G.& Sherman, A.C. (2001). *Faith and Health Psychological Perspectives*. New York: The Gilford Press.

Public Health Service. (2002). Available: www.surgeongeneral.org

Reed, P. G. (1987). Spirituality and well-being in terminally ill hospitalized adults. *Research Nursing and Health, 10*, 335-344.

Robinson, B.A. (2000). *What does the word "Religion" mean?* Available: www.religioustolerance.org

Roche, A.; Parle, M.; Campbell, J; & Saunders, J. (1996). Substance abuse disorders: Psychiatric trainees' knowledge, diagnostic skills, and attitudes. *Australian and New Zealand Journal of Psychiatry, 29*(4), 645-652.

Rose, J.R. (1998). Why doctors miss it so often in elderly patients. *Medical Economics; 75*(14), 29-30.

Rosenbaum, D.P. ; & Hanson, G.S. (1998). Assessing the effects of school-based drug education: A six-year multilevel analysis of project D.A.R.E. *Journal of Research in Crime and Delinquency, 35*(4), 381-403.

Rubin, R.H.; Billingsley, A. & Caldwell, C.H. (1994). Role of the Black Church in Working With Black Adolescence. *Adolescence, 29*(114), 251-266.

Sarason, I.G. & Sarason, B.R. (1985). *Social Support: Theory, Research and Applications*. Lancaster: Martinus Nijhoff Publishers.

Schaler, J. (1997). Addiction beliefs of treatment providers: Factors explaining variance. *Addictions Research, 4*(4), 367-384.

Schiller, P. L. & Levin, J.S. (1998). Is there a religious factor in health care utilization?: A review. Social Science Medicine, 27(12), 1369-1379.

Science News Online. (2002). Available: www.sciencenews.org

Shahabi, B.A.; Powell, L.H.; Musick, M.A.; Pargament, K.L.; Thoresen, C.E.; Williams, D.; Underwood, L.; Ory, M.A. (2002). Correlates of Self-Perceptions of Spirituality in American Adults. *Annuals of Behavioral Medicine, 24*(1), 59-68.

Sheler, J.L. (2001). Drugs, Scalpel...and faith. *U.S. News & World Report, 131*(1), 46.

Sloan, R.P. & Bagiella, E. (2002). Claims About Religious Involvement and Health Outcomes. *Annuals of Behavioral Medicine, 24*(1), 14-21.

Sloan, R.P. ; Bagiella, E. & Powell, T. (1999). Religion, Spirituality, and Medicine. *Lancet, 353*, 664-67.

Sloan, R.P. ; Bagiella, E.; Vandercreek, L, et al. (2000). Should Physicians prescribe religious activities? *New England Journal of Medicine, 432*, 1913-1916.

Sloan, R.P; Bagiella, E. & Powell, T. (1999). Religion, Spirituality, and Medicine. *Lancet, 353*, 664-667.

Sorenson, A.M.; Grindstaff, C.F. & Turner, R.J. Religious involvement among unmarried adolescent mothers: A source of emotional support? *Sociology of Religion, 56*(1), 71-80.

Stapleton, C. (1999). Health care professionals' opinions on alcoholism and their attitudes towards working with problem drinkers. *Dissertation Abstracts International Section B, 60*(1-B), 0376

Strawbridge, W.J.; Cohen, R.D.; Shema, S.J.; Kaplan, G.A. (1997). Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health, 87*(6), 957-961.

Strawbridge, W.J.; Shema, S.J.; Cohen, R.D. & Kaplan, G.A. (2001). Religious attendence increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annuals of Behavioral Medicine, 23,* 68-74.

Steffen, P; Blumenthal, J.; Hinderliter, A. & Sherwood, A. (2000). *Religious coping, ethnicity, and ambulatory blood pressure.* Paper presented at the annual meeting of the American Psychosomatic Society, Savannah, GA.

Substance Abuse and Mental Health Association. (2002). Available: www.samsa.org

Substance Abuse and Mental Health Service Administration. (1999). Available: www.samhsa.org

Scheyett, Anna. (2000). The Providers Views and Attitudes Towards Substance Abuse and Substance Abusers. University of North Carolina Internal Document.

Taricone, P. ; & Janikowski, T. (1990). A national survey of student attitudes and perceptions of substance abuse. *Journal of Applied Rehabilitation Counseling, 21*(3), 4-10.

Taylor, R.J. & Chatters, L.M. (1988). Church members as a source of informal social support. *Rev. Religious Resource, 30*, 185-207.

Taylor, R.J., Ellison, C.G.; Chatters, L.M.; Levin, J.S.; & Lincoln, K.D. (2000). Mental health services within faith communities: The role of clergy in Black Churches. *Social Work, 45,* 73-87.

The Centers for Disease Control and Prevention. (2002) Available: www.cdc.gov.

The Merriam Webster Dictionary. (1997).

The National Center on Addiction and Substance Abuse at Columbia University. (2001). *So Help Me God: Substance Abuse, Religion and Spirituality*. Available: www.casacolumbia.org

Thoresen, C.E. & Harris, A.H. (2002). Spirituality and Health: What's the Evidence and What's Needed. *Annuals of Behavioral Medicine, 24*(1), 3-13.

University of Utah Health Science Center. (2002). Available: www.uuhsc.utah.edu/healthinfo

Viejo, A.; Milstein, J.M. & Little, T.H. (2000). Invoking spirituality in medical care. *Alternative Theriapies in Health and Medicine, 6*(6), 118-120.

Wallacce, J.M. & Forman, T.A. (1998). Religion's role in promoting health and reducing risk among American Youth. *Health Education and Behavior, 25*(6), 721-741.

Wallace, J.M.; Forman, T.A. (1998). Religion's Role in Promoting Health and Reducing Rick Among American Youth. *Health Education & Behavior, 25*(6), 721-741.

Walton, M.; Blow, F.; & Booth, B. (2000). A comparison of substance abuse patients' and counselors' perception of relapse risk: Relationship to actual relapse. *Journal of Substance Abuse Treatment, 19*(2), 161-169.

Weaver, M.F.; Jarvis, M.A.; & Schnoll, S.H. (1999). Role of the primary care physician in problems of substance abuse. *Archives of Internal Medicine, 159*(9), 913-925.

Wecshler, H. & LaCoste, M. (2002). *The Bush Administrations Health Care Plan.* CDC Internal Document.

Whooley, M.A.; Boyd A.L.; Gardin, J.M. & Williams, D.R. (2002). Religious Involvement and Cigarette Smoking in Young Adults. *Archives of Internal Medicine, 162*(14), 1604-1610.

Wuthnow, R. (1994). *Sharing The Journey: Support Groups and America's New Quest for Community.* The Free Press: Maxwell Macmillam Inc.

World Health Organization. (2002). Available: www.who.org

Zellman, G; Jacobsen, P; & Bell, R. (1997). Influencing physicians' response to prenatal substance exposure through state legislation and work-place policies. *Addiction, 92*(9), 1123-1131.

Zuckerman, D.; Kasl, S. & Ostfield, A. (1984). Psychosocial predictors of mortality among the elderly poor: The role of religion, well-being, and social contacts. *American Journal of Epidemiology, 119,* 410-442.

APPENDIX

Appendix A

First Christian Church
Communication Survey

Dear First Christian Church Member:

This questionnaire is designed to find out the nature of the relationship that exists between social support, substance abuse, and religiosity. Melissa LaCoste, a graduate student, from the University of Tennessee, department of speech communication, is conducting the study. If the study is to be useful, it is important that you answer each question as thoughtfully and frankly as possible.

Your answers to these questions will be kept completely confidential. All questionnaires will be taken to the University of Tennessee for data analysis. No one from First Christian Church will have access to individual answers.

Please return the completed survey to Melissa LaCoste. If you have any questions or concerns, please do not hesitate to contact Melissa LaCoste at (974-0696) or through e-mail at (missie0423@aol.com).

Please do not put your name of the survey.

Thank you for your cooperation and assistance. I hope you find this questionnaire interesting and thought provoking.

General Instructions

Most of the questions ask you to check one of several boxes that appear on a scale under the item. Choose the answer that best matches how you feel about the statement. Then fill in the box on the questionnaire that best matches how you feel about the statement. For example, if you were asked how much you agree with the statement,

I enjoy the weather in this area

and you strongly agree, you would check the box under "Strongly Agree" like this:

47) I enjoy the weather in this area
Strongly disagree Somewhat disagree Somewhat Agree Strongly Agree

Notice that the scale descriptions may be different in parts of the questionnaire. So, be sure to read the special instructions that appear at the beginning of each section. Also be sure to carefully read the scale descriptions before choosing your answer.

Systems of Belief Inventory

For each item listed below, mark the response on the questionnaire that best indicates your attitude towards the question.

1. Religion is important in my day-to-day life.
   Strongly disagree somewhat disagree Somewhat agree Strongly agree

2. Prayer or meditation has helped me cope during times of serious illness.
   None of the time A little bit of the time A good bit of the time All of the time

3. I enjoy attending religious functions held by my religious or spiritual group.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

4. I feel certain that God in some form exists.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

5. When I need suggestions on how to deal with problems, I know someone in my religious or spiritual community that I can turn to.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

6. I believe God will not give me a burden I can not carry.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

7. I enjoy meeting or talking often with people who share my religious or spiritual beliefs.
   None of the time A little bit of the time A good bit of the time All of the time

8. During times of illness, my religious or spiritual beliefs have been strengthened.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

9. When I feel lonely, I rely on people who share my spiritual or religious beliefs.
   Strongly disagree Somewhat disagree Somewhat agree Strongly agree

10. I have experienced a sense of hope as a result of my religious or spiritual beliefs.
    Strongly disagree Somewhat disagree Somewhat agree Strongly agree

11. I have experienced peace of mind through my prayers and meditation.
Strongly disagree Somewhat disagree Somewhat agree Strongly agree

12. One's life and death follows a plan from God.
Strongly disagree Somewhat disagree Somewhat agree Strongly agree

13. I seek out people in my religious or spiritual community when I need help.
None of the time A little bit of the time A good bit of the time All of the time

14. I believe God protects me from harm.
Strongly disagree Somewhat disagree Somewhat agree Strongly agree

15. I pray for help during bad times.
None of the time A little bit of the time A good bit of the time All of the time

Substance Abuse Inventory

Directions: Please select one of the following.

For each of the following indicate the extent to which you believe that it is **acceptable within your religious community to**:
Check all that apply

Smoke	More than one pack of cigarettes a day One pack of cigarettes a day One pack of cigarettes a week One pack of cigarettes a month Not at all
Consume Alcohol	More than one drink a day One drink a day One drink a week One drink a month Not at all
Use Drugs (such as Marijuana and cocaine)	More than once a day Once a day Once a week Once a month Not at all

Defining Substance Abuse

We are interested in the way people define issues in the world. **Please provide us with your definition of substance abuse.** If you need additional space, please continue on the back of this page.

For each of the following, indicate when the usage of the following three items becomes substance abuse.
Choose only one

Smoking	More than one pack of cigarettes a day One pack of cigarettes a day One pack of cigarettes a week One pack of cigarettes a month Not at all
Drinking	More than one drink a day One drink a day One drink a week One drink a month Not at all
Drug Use (such as marijuana and cocaine)	More than once a day Once a day Once a week Once a month Not at all

Demographics

How many years have you been a member of First Christian Church? _____

Are you...
Female
Male

My age is _____

Marital Status _____

How often do you attend religious services or activities?

a. More than once a day
b. Once a day
c. More than once a week
d. Once a week
e. More than once a month
f. Less than once a month

Thank you for your participation.

Appendix B

Amount

1. Using any substance beyond slight use

2. Any substance used in excess that impairs health, ability to normally function, or endangers others around you, and could cause addiction

3. Alcohol- more than 2 drinks a day on a regular basis getting drunk. Drugs- recreational use is abuse. Not taken in accordance with prescription then it is abuse

4. The use of any substance to excess so that illness or inability to cope with activities of daily living results

5. Substance abuse- the unhealthy over use of any outside agent. "Unhealthy" includes physical, emotional, and financial. Drinking a beer may not be a bad thing, but when one beer leads to passed out drunk (therefore, kids don't eat supper, or someone dies in a DUI accident) then the beer has been abused.

6. The use or consumption of any illegal substances; or the over-indulgence of legal substances, including food and over-the counter medications, as well as alcohol and tobacco.

7. Any use of a legal or illegal drug or substance

8. Substance abuse is overusing any product in the form that a glutton would

9. Any overuse of a substance that would change you in anyway. This includes all types of drugs and/or prescription medicine

10. The continual usage of a drug and/or alcohol

11. The misuse of any substance, over indulgence of any substance. Any substance that harms the human body

12. Substance abuse-when one uses any type of drug, alcohol or cigarettes in an abusive manner

13. Anything that takes control of your life, something you feel like you can't do without

14. Overuse of any substance

15. The use of any type of drug or alcohol in excess. Using any type of drugs that are not prescribed for you by a doctor. The use of any substance that alters your ability to respond normally in situations.

16. Any use of a harmful, addictive substance

Rules/legal Illegal

1. Excessive or illegal use of illegal or legal drugs

2. Alcohol- more than 2 drinks a day on a regular basis getting drunk. Drugs- recreational use is abuse. Not taken in accordance with prescription then it is abuse.

3. The use or consumption of any illegal substances; or the over-indulgence of legal substances, including food and over-the counter medications, as well as alcohol and tobacco.

4. use of drugs beyond their intended medical purpose

5. The use of any substance in order to alter the persons senses for other than a medical purpose.

6. use of any narcotic substance for reasons other than medical use. Marijuana is not a medicine its an illegal narcotic and is should stay that way. I'm talking about drugs like Valium, and codeine, and morphine.

7. Substance abuse is taking any substance and using it in a way contrary to its suggested purpose.

8. Substance abuse is the use of alcohol or drugs to escape reality. It is using alcohol just to get drunk, rather than for the enjoyment of the drink

9. Using prescriptions not prescribed to you or using prescription or illegal drugs to illicit modified feelings or behaviors (the feed good effect)

10. Use of any drug or chemical for reasons other than legitimate health/medical conditions

11. Use of a chemical substance for a use other than what it is designed for or use of illegal drugs

12. Using something for a purpose for which it is not intended

13. The use of any drug not treating an illness or for the purpose of getting high

14. Any substance used that is not needed for healing of the body or prescribed by a doctor
15. I define substance abuse as the use of substances in a manner inconsistent with its intended application, use, or design
16. Substance abuse is when one uses a chemical or drug not recommended by a doctor (MD)

17. Use of illegal or legal substance that you can't do without is addiction. There use at all is abuse

18. Reliance on a substance for purposes other that its original or designed purpose for use

Harmful

1. I define substance abuse as the indulgence /consumption of items that will lead to the detriment of both body and soul. Illegal drugs, alcohol and prescription drugs come to mind but also in a second category I would say that items such as food, sweets could lead to, if over-indulged, the deterioration of body and soul. Trying to find relief or balance in these substances is no substitute for balanced and focused approach to life.

2. Use of drugs (legal or illegal) to the point, which damages or impairs ability to function (work, health, maintain relationships etc.)

3. Anything that is harmful to the body

4. I don't smoke, drink or do drugs, but I guess I think its acceptable as long as you don't hurt yourself or anybody else. I'm sure all could be considered substance abuse.
5. The use of a substance to the degree that it does harm to one's mind or body temporary or permanent. It is also substance abuse if its use causes harm to others, physical or emotional.
6. substance abuse is the use of a substance to the degree that is harmful to oneself or others

7. substance abuse is when the use or need of the substance is so consuming that respnsibiities are ignored or anyone is put in physical or emotional danger

8. It is using substances that will harm your state of mind and body

9. Using anything (ie any substance) in an unintended manner that causes any harm of any type

10. Substance abuse is using drugs or alcohol in a way that causes harm to yourself or others. In essence, it is using drugs or alcohol at all because that usually causes harm

11. The overuse of any substance (drug, food, etc.) which causes harm to the individual or distracts them from the key point s of there life.

12. When a person uses substances that are harmful to their own body at all

13. When it effects your budget, moral, or alters your state of mind

14. Anything that harms the body and interferes with relationship with God

15. Anything that alters ones mind

16. Over indulgence in anything that could cause physical damage

17. Substance abuse is the use of anything harmful to alter the mind to escape reality

Necessary to Live/Control

1. My definition of substance abuse is that if it controls you and you can't stop without help
2. When the use of a substance becomes a necessary part of your daily living

3. someone that is addicted to a legal or illegal substance

4. overuse of any substance where it is a need to get through the day, a way of either coping or escaping with perceived problems

5. Substance abuse would consist of an addiction out of one's control. It would be where the substance takes over one's free will

6. substance abuse to me is when you have no control, when the substance starts to control what you do and when you do it

7. The use of a drug that effects a person's mind or body to the point that it control that persons life

8. something that one has in their life- that can control their lives and can make their lives out of control

9. where you become obsessive about needing a "fix". When you lose your ability to turn it down

10. substance abuse is when something is needed to survive on a daily basis

11. substance abuse occurs when the use of any substance interferes with a person' daily activities such as work or family-or becomes the focus of ones' activities.

12. substance abuse exists when one has a physiological need for a chemical, be it caffeine, nicotine, alcohol, or some illicit drug

13. My definition of substance abuse is when an individual or group of people misuse or misunderstand the substance. They rely on the fix to get them through hard times. They need to find other ways to deal with them

14. substance abuse occurs when people allow various substances to control their lives. These addictions keep people from performing tasks expected of them and hinder their efficiency in task.

15. Substance abuse is when a person depends on a substance in order to feel a certain way

16. Use of substance that are bad for your health or when use begins to control your life, judgment etc

17. Substance abuse is taking advantage of a substance until it makes you loose control

18. Not based on frequency, the point at which the use of a substance becomes second nature or when it is used to satisfy a craving/desire

19. Substance abuse is when someone becomes dependent on drugs and alcohol to live and define who the are

20. Substance abuse occurs when one lets the practice?? Effect their life. When me has any struggle with not doing something. When thoughts of doing something (smoke, drinking, doing drugs) run through their mind on a regular basis

21. Any substance you need – even prescription drugs

22. Anything that takes control of your life, something you feel like you can't do without
23. Being addicted to substance that s beyond your control
24. A dependence on a substance which is not good to the body or mind
25. Unable to stop smoking, drinking or drugs on your own
26. I define substance abuse as the use of substances in a manner inconsistent with its intended application, use, or design
27. Substance abuse is to be dependent on any of the three at any time
28. Anytime you consume a substance (alcohol, tobacco, etc.) continually-can not go a day, hr, etc without, this is substance abuse
29. Any substance that one uses to help them "escape" their problems instead of dealing with them also any substance that inhibits motor action or alters perception
30. When one has lost their power in stopping, when your life has been unmanageable cause of the substance you are using.
31. Person who is dependant on a substance by means of mental, physical, and emotional which they cannot overcome. The abuse takes over their lives
32. Substance abuse is any dependence on a substance for emotional, physical well-being, (drinking coffee-coke can be, I am guilty of using these drugs to manipulate my body
33. Substance abuse- using alcohol or illegal drugs to an extent in which it inhibits your over all health and well being

Religious

1. People hurting, trying to ease the pain of life the inner peace they are searching for. Is the peace of God
2. Taking into your body that which goes against Gods will for your life.
3. I believe substance abuse in any form or amount would harm our Christian influence and cause much harm to our bodies, which is a temple of God.
4. Looking for something to give you peace

5. to me substance abuse is someone who does not care about themselves or their body. To me they don't realize their body is the temple or our father up in heaven. Once you have god in your heart it is possible for god to do anything for you.

Vita

Melissa LaCoste was born in Atlanta, GA on February 4, 1979. She was raised in Atlanta, Georgia attending grade school at Mount Zion Christian Academy and Smith Barnes Elementary School, then junior high at Stockbridge Junior High. She graduated from Eagles Landing High School in McDonough, GA in 1997. From there she went to the University of Tennessee, Knoxville and received a B.A. in Speech Pathology with a minor in Speech Communication in 2000.

Melissa is currently pursuing her Master's of Science in Communication at the University of Tennessee, Knoxville.