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Long term drug and alcohol treatment program: An outcome study comparing secular-based treatment with faith-based treatment for addiction

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LONG TERM DRUG AND ALCOHOL TREATMENTPROGRAM; AN OUTCOME STUDY COMPARING SECULAR-BASED TREATMENT WITH FAITH-BASED TREATMENT FOR ADDICTION

A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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ABSTRACT

The study was conducted to see if there is as much or more of a difference in outcome of treatment for addiction in faith-based treatment than secular-based treatment. The research was conducted using a sample of thirty-seven respondents from various sites in Southern California who volunteered to fill out the questionnaire. Data were collected using a self-administrated survey questionnaire.

Research employed the twelve steps meetings with the faith-based programs for treating addiction. A series of t-test were conducted to compare the means of the length of sobriety and frequency of relapse of respondents from secular-based treatment and faith-based treatment for addiction. Overall conclusion of the research is that persons in both treatment programs receive valuable treatment. The respondents indicated that persons in the faith-based treatment programs were more likely to remain sober longer without relapse than in the secular-based program. Implication for research is that social workers must prepare to include spirituality in the treatment of addiction. The study showed that the 12-steps were the number one tools for treating addiction. Practitioners must be prepared to give the clients a menu of choices.

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This has been a difficult task, with overwhelming adversity, but it is completed. My many thanks to those family members who supported me, built me up, and cheered me on in my quest for excellence. Thanks for the encouraging words, or maybe it was an occasional hug when things seemed impossible. Thanks to the friends who allowed me to express my frustrations and concerns, while still remaining supportive.

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Dedication

To honor the memory of my father Bill Fountain English, who taught me dignity, my mother Minnie English, who taught me to love thy neighbors. A very special honor to my brother Bill Fountain English Jr. who became father to me and my siblings after the death of our father, and who died before he could see me graduate. I cherish and honor each memory.

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INTRODUCTION

Problem Statement

The beginning of substance use and subsequence for addiction can be traced back for thousands of years, through 1000, B. C. (Ancient Egyptian wall painting). The Origin of alcohol (Ethyl Alcohol) is unknown, but it is believed that many ancient people first used alcohol in the form of wine (fermented grape juice) or beer (fermented cereal broth). Wine and beer were an everyday feature in classical civilization of Greece and Rome. This was an accepted tradition among both Jews and Christians, who accepted fermented beverage as part of God's gift of creation. Wine is used for many different reasons like medicine, religious symbol, and as a social beverage. In the late Middle Ages (about A.D.1200), the Europeans discovered ways to make more potent forms of alcohol called distilled spirits. These distilled spirits were to become modern day Vodka, Rum, Tequila Brandy, and Whisky (Scotch, Rye, Bourbon, and Canadian) (Hawley, 1992). Thus, the problem of widespread alcoholism began.

Drug use began with the use of medication to reduce pain. Such drugs as Morphine, Opium, Cocaine, Heroin, Amphetamines, Barbiturates, and Tranquilizers were all designed for medicinal purposes. However, continued use of these substances led to addiction. Drug use is not new to America because as far back as the late 1700s, the main

concern for the Federal Government was drug use (Alvin & Silverstein, 1991).

In the 1800s, Opium abuse began to spread during the time of advancement in technology and changing values and social upheaval (Alvin & Silverstein, 1991). People became more stressful as a result of moving to the cities and looking for work. Many of these people turned to drugs. Cocaine became widely used in Coca-Cola beverages and was known as the "wonder drug". During the turn of the century, about one and a half million Americans were drug users (Alvin & Silverstein, 1991). The second outbreak of drug abuse came in the 1960s when young men became upset and rebellious with the government over the Vietnam War.

In modern day, Americans spend more than $100 billion dollars each year on illegal drugs. The government spends more than 10 billion dollars a year in the attempt to stop the sale and entrance of drugs into the United States. Currently about 50 to 65 percent of all high school students use drugs before they graduate from high school (Alvin & Silverstine, 1991).

Drug and alcohol abuse has become one of the most major problems that the nation faces today. Substance abuse has destroyed lives of families as well as individuals. This is a problem that crosses all racial, ethnic, and social-economic barriers. As a result of substance abuse, many people have suffered physically,

emotionally, socially, and economically. This suffering has left many people feeling overwhelmed and hopeless. Substance abuse is a major factor in crimes such as rapes, homicides, suicides, aggravated assaults, spousal and child abuse. There have been many attempts to get control over the problem since drug abuse was recognized as being a problem in the beginning of the 1900's.

In spite of billions of dollars spent on drug addiction, the problem continues to expand as a personal and social tragedy. The nation's prisons, treatment centers, and self-help books have only begun to scratch the surface of the problem. Furthermore, the downplay of spirituality in counseling, and the problems with limited payment for therapy by managed care insurance companies contribute to under-treatment of many addicted people. Due to the limitations for treatment allowed by managed care agencies, and lack of knowledge of faith-based counseling, there has been a vast increase in substance abuse and crime. This has created the need to know which is a more effective type of intervention method for treating people suffering from substance abuse.

Problem Focus

This research explored two types of programs. The first type of programs is the faith-based treatment program where the therapeutic process is based on faith in God. The twelve steps are also included as a part of the

faith-based programs because they consist of spirituality and a Higher Power. The second type of program used in this research is the secular-based substance abuse program, where the therapeutic process is on the medical or behavioral model.

I chose to examine substance abuse programs with both genders because literature has shown that gender specific treatment is simply a part of the larger commitment that recognizes individual needs. Even though many men feel gender-specific programs are less complicated because they have no sexual attraction and no embarrassment when talking about failures with men (as there maybe in the presence of women), research shows no differences in the actual outcome of treatment (Tradewell, 1999).

The study attempted to determine if there is as much or more of a difference in outcome in faith-based substance abuse treatment than in secular-based treatment programs. The research helps gives useful information for the field of counseling when choosing a treatment program. This research focuses on whether the introduction of spirituality (faith in God) makes as much or more of a difference in outcome of treatment than secular-based treatment.

There are many reasons to be concerned over the problems of substance abuse and to find the most effective intervention for treatment. Poly-drug abuse (either

simultaneously or on different occasions) involving mind-altering substances is also common among the legal, political, and medical professionals, and many of these people are responsible for governing the nation. Therefore, finding the most effective treatment is important for the nation as a whole.

Moreover, it is important to research the perceived differences in treatment benefit, if there are any, and to make the finding available for clients and the professionals looking for the best treatment programs in the field. The findings can aid the professionals in choosing the most effective program to make available for the community if there is ever a need for increasing the number of counseling programs for the community.

The research will give valuable information about two affordable intervention programs that may advance treatment to an even higher level of effective treatment (as seen with the clients' point of view). This information will be helpful for administrators of the programs to consider whenever plan for expansion and changes in the approach to treatment arrive. As social workers, practitioners are interested in knowing about the most effective substance abuse treatment for their clients.

Although most of these centers provide valuable needed services for society, there are many people with

specific needs in their quest for treatment. Just as there are many people who depend on secular intervention for addiction, there are many people who rely on spirituality for coping with the harsh events of their lives. Therefore, this study asked if faith-based intervention makes as much or more of a difference in substance abuse treatment outcome than secular-based treatment outcome.

LITERATURE REVIEW

Theories and Models of Treatment

There are many pros and cons on theories of addiction. However, this literature review will take a look at five difference perspectives on theories of addiction.

Medical Theory

Freeman (1992) explains that the medical model of addiction advocates that substance abuse is a medical problem. Therefore, treatment for substance abuse is taken out of the control of the clients and the practitioners and is placed under the control of the medical professionals. The medical theory became important because it provided information about addiction when there was not much known about addiction to conduct practical research. The medical model is also valued because it provided an alternative to existing patterns of blaming the victim (Freeman, 1992). The model also introduced an overt reality toward the negative attitudes that were being directed toward the addicted person. Also, the Medical Theory indicates that addiction is the result of an underlying disease process, and is thought to cause compulsive use of a substance. Therefore, the level of use of a substance is the manifested symptoms of an illness.

Adaptive Theory

Another theory presented is the adaptive theory of addiction. This theory assumes that client's problems and conditions are a result of inadequate upbringing. For example, the clients' problems are the product of their environment, inadequacies, and inborn physical or psychological disabilities that can cause people not to develop into functioning adults. They are not able to integrate into social acceptance (Freeman 1992). The addicted person has no self-reliance and is not competent of self, the basic expectations in life.

Free Will Theory

Thombs (1994)examines the Free Will Theory that is said to account for addiction. This theory advocates that addiction is a product of free will and that all people have free will. Therefore, addiction is a freely chosen behavior that is irresponsible and deliberate. When professionals use this theory to look at addiction and why a person abuses drugs, they imply that a person can control his or her use of drugs. Free will means that addiction is a choice that is not out of that person's control.

Behavioral Theory

Thombs (1994) states that the Behavior Theory advocates addiction as a behavioral disorder that is learned. The addiction is neither willful nor is it out

of control, but a problem of behavior is clearly under the control of the environment, family, social, and it involves cognitive processes.

Non-Biological Theory

Peele (1985) writes that addiction is not exclusively a biological concept, neither is addiction any different from any other human feelings, behaviors, and actions being subject to social and cognitive influences. He names seven non-biological essential ingredients in addiction. He cited cultural, social, situational, ritualistic, developmental, personality, and cognitive factors as essential to addiction.

Peele (1985) believes that addiction is not to be seen as dependent on the effects of specific drugs and that addiction is not limited to drug use at all. Moreover, the addiction is seen as an adjustment of the individual rather than being a total self-defeating entity to his or her environment.

Addiction creates a habitual style of coping, where the individual is "able to modify the addiction with changing psychological and life circumstances" (Peele, 1985). In spite of the devastating pathological problems addiction causes for a person, "it actually represents a continuum of feeling and behavior more than it does a distinct diseased state".

In the same sense, a person's craving for drugs is not exclusively determined by physiology. The experiences a person has of "both a feeling of need, or craving for, and withdrawal from an object or involvement engages a person's expectations, values, and self-concept, as well as opportunity for self gratification"(Peele, 1985).

Thombs (1994) advocates a need for a new theory, because he believes the free will perspective is not a theory, as "theory" is understood in science. Yet, he believes that "addiction as a free will is the only perspective that is clearly understood by the majority of professionals working in the alcohol and drug abuse field today.

However, competent practitioners reject the moral model almost universally. Peele says that rejection of the free will theory is rightfully done. Moreover, in spite of the knowledge practitioners have of the free will model, he believes that the disease model is the most prevalent theoretical base for treatment which is used in the United States today.

Also, the Behavioral Science perspectives are often useful in that "they place an emphasis on faulty learning and they are represented by an array of distinctive theoretical positions. In spite of the many available theoretical perspectives, Thombs (1994) believes that some practitioners rigidly cling to their favorite theory

without fully understanding all the implications and concepts of the theory.

Peele (1995) states that the complications of addictions which he brings into the literature concerning addiction, are cited, not because he is disillusioned or rejects the notion of addiction, but because he believes it gives potential power to the arguments of the theories of addiction.

Furthermore, Peele believes that the strengthened and broadened suitability of the concepts of addiction provides a powerful description of human behavior. The description opens up important opportunities for understanding drug abuse, the compulsive, and self-destructive behavior of all kinds. He thinks that so far, the analysis of prevailing ideas about addiction has its limits. Peele and Thombs' concepts of addiction are supportive of the need for new theory.

Treatment Approaches

Although there are no known rules or treatment that will cure addiction, there are differences in philosophies held by substance abuse treatment programs on how to approach the treatment and control of drug addiction.

Secular-Based Approach The first historical attempt in the secular approach toward controlling the nation's drug problem began with law enforcement. In the late 1700s, when alcohol abuse was the main concern for the federal

government, it passed a law to ration the amount of alcohol allowed for soldiers.

Also, "The Federal Government tried desperately to stop this growing problem, first with the Pure Food and Drug act in 1906 and then, in 1914, with the Harrison Act". This act labeled all drugs that were sold without a prescription illegal (Alvin & Silverstine, 1991). Since the 1960s, drug use and the picture of addiction changed rapidly.

During the 1980s, Congress established the first official Federal Agency to be responsible for developing and coordinating the policies, goals, and objectives of the nation's programs for reducing the use of illegal drugs. Research supported that treatment was more effective than law enforcement alone.

Moreover, the study found that linking drug treatment and law enforcement to treat substance abuse were more effective. Thus, secular-based treatment programs were increased, and are now being utilized by the Federal Government in an array of areas of substance abuse control in the United States (Alvin & Silverstein, 1991). All populations throughout the nation utilize secular counseling centers.

The major component of secular-based counseling is the belief that clients should confront their denial in the addiction process and face their problems head on

without resistance. If the clients are in denial about their behavior of addiction, the clients are labeled as being resistant. Secular-based counseling is concerned about client-therapist relationship and transference verses counter-transference. However, some faith-based counselors believe this can lead to an impersonal therapeutic process and lack of empathy for the clients.

The secular-based counselors' main complaint against faith-based treatment is that faith-based counseling is shallow and does not address the core of the client's problems. They believe that spirituality will not help clients get their needs met in their treatment for addiction (Cornett, 1992).

Secular practitioners consider spiritual emphasis in recovery programs, which are based on connection to the term "spirituality" to be connected to organized religion and theology. According to Morell (1996), these are real concerns but they are not factors inherent in recognizing a spiritual dimension in the client's life.

The secular-based treatments using twelve steps believe that the twelve step programs suggested a practical therapy for everyone as a philosophy of living. People using the secular steps see the programs as being action fueled by spiritual energy from within themselves and their universe.

Therefore, in some secular treatment, it is believed that twelve step programs should be separated from any religious, faith, or Deity implications. Many secular based program using the twelve steps believe that some clients may read the steps and words like "God", "Him", "pray", and "Higher power" will not fit their beliefs. This program basically suggests a system of holistic healing which integrates mind, body, and soul but do not transcend into a spiritual belief of faith in God.

In fact, in some secular-based treatment, it is believed that spirituality is contained within the clients. By the integration of mind, body, and soul, clients approach life with a new attitude that leads to balance and contentment within themselves (Cleveland & Arlys, 1992). The secular twelve steps focus on self examination and a connection with "spiritual energy" that encourage clients to go beyond theorizing about their condition and to use the secular twelve steps as a specific, pragmatic, professional guide for recovery not as a spiritual belief in God, or a higher power.

Moreover, the program advocates that clients must think about their situation and then physically, emotionally and spiritually act on it(Cleveland & Aryls, 1992). The secular-based programs advocate that clients learn to live right here and right now, and to respect

others, and to detach from others and let them take ownership of their own lives.

In addition, Secular-based treatment programs dealing with twelve steps also advocate that the harmful compulsive behavior of addiction is inclusive of any thoughts, feeling or actions that mark clients emotional pain, which clients are unwilling or unable to change. In addition, these behaviors are the marks of the addicted persons' unhealthy self, their self- destructiveness, and these kinds of self-defeating behaviors have been their way of coping with life difficulties.

Faith-Based Approach In this research, spirituality connected with faith-based treatment refers to the Deity (All components of spirituality are established by God and all spiritual experiences come from God). According to Casco (1998), spirituality is what makes people strive for the ultimate reality and relatedness and belonging with the moral universe and union with imminent, supernatural powers that guide people

Moreover, Spirituality is multidimensional and offers many alternatives(as opposed to secular belief)of holistic approaches to the body, mind, and spirit (Casco, 1998). Spirituality has always been a part of the social work movement (Midglry 1994). This movement started when Christians began helping people who were having difficulties coping with life functions.

In fact, spirituality is considered to be universal in aiding people to work through their feelings, emotions, and behavior (Midglry 1994). Spirituality is the vehicle in which social work treatment was created. It has been accepted as a part of the human experience since the beginning of life.

Spirituality is the totality of the human process of development that encompasses and transcends its bio-psycho-social spiritual concept of humanness. "Spirituality is what makes a person a 'though' a person being with inherent dignity, rather than an 'it', a mere object or thing" (Midglry, 1994). This spiritual belief forms the foundation that encompasses the history of Christian counseling and it stems back from the beginning of social work.

Christianity is indicative of spirituality and is considered by many to be interpreted as meaning a moral responsibility for social services. It is considered to be the inspiration of social work and is seen as being instrumental in the development of charitable organizations in the United States (Zastrow and Kirst-Ashman, 1997).

The helping profession is "based on Judaeo-Christian Charity Values and the teachings of Jesus as practiced in the early centuries of Christianity" (Day, 1997). These teachings of values are non-sectarian and social, and

their major thrust is that those in need have a right to be helped and that society has an obligation to provide for those citizens (Day, 1997).

However, since the separation of church and state and the removal of prayers in public places (e.g. public schools), spiritual counseling has been pushed to the backdrop of secular counseling. Spiritual counseling has gotten a new name as faith-based counseling in order to accommodate those who do not want to be affiliated with a particular belief or practice. During the upheaval over spiritual counseling and the interest in secular-based counseling, drug and substance abuse have increased.

Nevertheless, the non-secular twelve step programs advocate spirituality treatment for substance abuse. These faith-based twelve steps have a strong connection with "God", "him", "pray", and "higher power" and are more likely to be used by faith-based treatment programs.

Moreover, in most faith-based counseling programs the philosophy of the therapeutic treatment is that clients must focus on both subjective and objective transactions between inner and other realities, which are constantly developing processes (not static). Counselors believe that clients' use of spirituality as a weapon in their coping arsenal is precisely where many will draw their strength to fight their addiction (Sermakeikian, 1994).

Also Karger and Midglry (1994) argue that spirituality is the totality of the human process of development that encompasses and transcends it bio-psycho-social, spiritual aspect of humanness. People are three part beings: body, mind, and soul (spirit), and all three may be in need of attention. A person is not an isolated being but is respected as "an ever-changing self-social unity", who is an object of the prevailing social order, and a subject able to move beyond that order.

Furthermore, people are the ones who construct themselves out of their own experiences, including the dynamics of class, race, and gender. They are free to search and experience their ethnic, racial, class background and their spiritual traditions to the totality of their experiences. The knowledge of those experiences is important for a source of comfort for one's self in the process of fighting addiction (Bisman, 1995). The personal self is injured by the social world; self-love requires transcending this injury. In faith-based treatment, the traditions and spirituality practices (e.g. rituals like praying and so forth) provide ways to experience self beyond self-hatred and to not ignore the external causes of self-loathing (Morell, 1996).

The faith-based treatment using the spiritual approach advocates that addiction is seen as a deficiency in spirit and power. The spiritual approach to treating addiction

includes a person's psyche, conscious, and unconsciousness that is called the human soul (Cascio, 1998).

Therefore, in the same instance, the medical aspect of the addiction is not denied or ignored, but it is understood as not being all encompassing of the addiction. Therefore, substance abuse is a condition that needs to be released from domination by a foreign power such as a substance, a psychological condition, or a social order. This process requires both a change in consciousness and a change in circumstances.

Faith-based counseling uses five basic principles. These principles are to "express empathy, develop discrepancy, avoid argumentation, roll with resistance, and support self-efficacy". Linking the resources of client and worker develops the bio-psychosocial perspective, which includes their faith and spirituality as weapon, creating the coping strength clients need to overcome their addiction (Cornett, 1992). The intention is that the worker and the client become co-investigators linking client's thoughts, feelings, and behavior to the problem situations (Morell 1996).

Current Perspective Whatever the agency philosophy may be, in general, society gives mixed messages about drug abuse. Clients are told that drugs are bad, but on the other hand, drugs are glorified when many abusers are public heroes in sports, music, and the entertainment

field. Taking substances to relieve physical and psychological problems is an accepted and ingrained behavior for modern day treatment of addicted people.

Furthermore, for the average clients who are addicted, low self-esteem and self-loathing are the major characteristics of their drug use and many of these clients are given drugs to treat these symptoms. Many scientists believe there is a strong link between depression and addictive behavior (e.g., a person engaging in self-destructive substance abuse becomes even more depressed).

Basic treatment for occasional drug use began with groups like cocaine anonymous and narcotics anonymous, and these groups are sufficient enough for treating the occasional drug users. These groups are made up of ex-addicts who share their stories and help educate each others on how to fight their addiction and remain drug free (Alvin & Silvenstein, 1991). Educational and nutritional information is an integral part of these treatment programs. These clients are usually required to meet every day in the beginning of treatment.

More serious problems mean that the clients should attend a professional outpatient program for four to six months. These clients usually go to school or work and attend treatment in the evenings. Clients receive individual and group therapy, as well as educational

support. When a more serious problem exists and these models do not work, clients must be removed completely from the present environment and placed in an inpatient facility (e.g., hospital or residential facilities like faith or secular based facilities).

Also, the average inpatient treatment of this kind lasts for about a month. The first step in treatment of any kind is detoxification, where the addicted person receives no drugs, or the person may be gradually weaned off the drugs. This process can cause severe pain for some clients and require constant medical supervision.

Once the clients are drug free, they receive extensive therapy in both individual and group treatment. These treatments include educational and nutritional classes. Physical activities are also stressed (Alvin & Silverstein, 1991). Many of these clients need more intense treatment, which can last from one to two years in a therapeutic community. There are many people who never recover from drug addiction and many times the drug abuse result in death.

Need for New Model

The literature of the above-mentioned theories indicates lack of empirical evidence in both causes and treatment of addiction. Thus, after examining this and other literature, like the faith-based treatment and secular-based treatment, it became evident that more

research is needed about what the clients believe they need in their treatment of addiction. The research is conducted to see if there is as much or more of a difference in faith-based treatment outcome than there is in secular-based treatment for addiction. The research should indicate if there is the need for a totally new theory on model of treating addiction.

I believe that there should be a model developed for treatment from the clients' perspective, because they are the ones suffering from the addiction. The clients' needs and beliefs should be an important component in developing a new model for treating addiction.

The model should be flexible where components from the free will theory, behavioral theory, and the medical theory can be utilized. The model should also consider what Peele has to contribute to the philosophy of addiction. Some of his ideas seem to concentrate on the person's behavior and value system, which may be learned from his or her environment.

The model should allow for flexibility where the therapeutic processes can be adaptive to each individual's needs and beliefs during treatment. This philosophy will give the clients and professionals a greater choice in choosing a program and treatment plan for the clients. The new model may create a higher chance that clients will respond to treatment much better, especially if they

can find elements in treatment that are indicative of their feelings, wants, and beliefs. Using the clients' perspective to create a new theory may strengthen the programs for substance abuse treatment and increase the opportunity to help many clients overcome their addiction.

METHODOLOGY

Research Design

The purpose of the research was to compare differences in outcome of secular and faith-based treatment for substance abuse. This research employed a questionnaire survey design using a self-administered questionnaire as a method of data collection.

A total of 37 subjects were recruited for this research. Data were collected from 15 subjects from the AA programs using the twelve steps in treatment and other faith-based treatment programs. Data were also collected from 17 subjects from secular-based programs and 5 subjects from AA and any other program.

Participants were recruited using a systematic non-probability sampling. Specifically, the study's sample was drawn from various participants from secular and faith-based treatment programs and who were living in the surrounding community.

Sampling

The sample consisted of 37 subjects who have successfully participated in a secular or faith-based treatment program for 2 month or more. Subjects were selected based on age and length of the subjects' participation in the programs. All subjects resided in Southern California. The sample consisted of 15 participants from the faith-based treatment programs (AA)

and 17 participants from the secular-based treatment programs. There also were 5 participants who attended both AA and secular-based programs.

The subjects were recruited from (a non-probability sampling method)the faith-based and the secular-based substance abuse programs in the Inland Empire. Sampling sites were intended to increase the representativesness of the sample with respect to diverse demographics and socioeconomic characteristics of the subjects.

Data Collection

Data were collected by means of a structured self-administered questionnaire. The questionnaires were distributed to participants to fill out in a group or individual setting and the questionnaires were returned to the investigator.

The subjects were asked about their length in the programs, such as how long did they participate in the programs. How many times had the respondents experienced relapse since they sobered up in the programs? How long had the respondents participated in the programs before they sobered up? Or did the respondents sober up prior to joining the programs?

In addition, the subjects were asked about their demographics, socioeconomic status, education, spirituality, beliefs in God, health status, and their informal social supports. The questionnaire was created by

the investigator to meet the specific needs of this research. The completion of the questionnaire took about 15 minutes. The investigator did data collection, coding, cleaning, and data retainment.

Measurement Instruments

This study's independent variable was whether the subjects participated in a Faith-based or a Secular-based program. The dependent variable was the subjects' belief about differences of outcome between secular and faith-based treatment programs that the respondents attended. The dependent variable was measured by the number of times they relapsed, length of sobriety, and The Spirituality Belief Scale, an existing spirituality scale which was included in the questionnaires

Data Analysis

Data analysis included descriptive statistics such as frequency distribution, central tendency, and dispersion bivariate statistics, which were obtained by using a series of t-test to determine if there were statistically significant differences between the means of two programs.

A series of t-tests were utilized to compare the spiritual belief of the participants with the beliefs of those in the secular programs. A series of bivariate analyses were conducted to assess the relationship between the independent and the dependent variables

Procedures

Subjects were contacted by visiting the Alcoholics and Narcotics programs where the subjects were asked to participate in the study, (or arranged by group members). The investigator visited the facilities of the twelve step programs and the secular-base programs and administered the questionnaires to the subjects who participated in the study.

Participants completed the questionnaires and returned them to the investigator. On some occasions the questionnaires were administered to the subjects by the program personal and returned to the investigator.

Protection of Human Subjects

Human participants were informed of potential risk and benefits, if any, by informed consent. Subjects were informed that this research comply with confidentiality which is included in the code of ethic to protect participants.

The participants were informed that if any information were obtained in connection with the study that could identify with respondents, it would remain confidential. Subjects were informed that any information would be disclosed only with subjects' permission, or as required by law. They were assured that confidentiality would be maintained by means of keeping data (questionnaires) private and anonymous. The

questionnaires contained no identifying information like first name, telephone number, and case ID number.

FINDINGS

Demographic Characteristics of the Respondents

Table 1 illustrates the demographic characteristics of the respondents. The sample consists of a total of 37 respondents. Twenty respondents (54.1%) were females and seventeen (45.9%) of the respondents were males. The age range of the respondents in the sample was 18 to 64 years. Approximately 32.4% of the respondents were between the ages of 18 to 35, and over half of the respondents (56.8%) were between the ages of 36 to 49. There were about 10.8% of the respondents between the ages of 50 to 64.

In terms of ethnic distribution of the respondents, Caucasians were overwhelmingly represented by about 67.6% of the respondents. There were five African Americans respondents and four respondents (10.8%) were Hispanic/Latino; others were represented by about 8% of the respondents.

Assessing respondents' economic status, the majority of the respondents (70.3%) reported that they were employed and (29.1%) of the respondents indicated that they were not currently employed. With respect to marital status, over a third of the respondents indicated that

Table 1. Demographic characteristics of the respondents

Variable	Frequency n	Percentage (%)
Gender (N=37)		
Female	20	(54.1%)
Male	17	(45.9%)
Age (N=37)		
18 - 35	12	(32.4%)
36 - 49	21	(56.8%)
50 - 64	4	(10.8%)
Ethnicity (N=37)		
Hispanic	4	(10.8%)
African American	5	(13.5%)
Caucasian	25	(67.6%)
Other,	3	(8.1%)
Employment (N=37)		
Employed	26	(70.3%)
Not employed	11	(29.7%)
Marital Status (N=37)		
Divorced	12	(32.4%)
Single	10	(27.5%)
Co-habituating	7	(18.9%)
Married	7	(18.9%)
Education (N=37)		
College graduates	15	(40.5%)
Some college	7	(18.9%)
High school completed	5	(13.5%)
Less than high school	9	(24.3%)
Health (N=37)		
Very good	12	(32.4%)
Good	21	(56.8%)
Fair	4	(10.8%)

they were divorced, while less than 19% of the respondents reported that they were married. There were an equal number of respondents who were living together (co-habitating), as there were respondents who were married (18.9% vs. 18.9%). Twenty-seven respondents were single.

A slightly larger percentage of respondents were divorced (32.4%) than there were single (27.0%) respondents.

In terms of education, over 59% of the respondents indicated that they had some college education, while 13.5% of the respondents reported that they had completed high school. There were 24.3% of the respondents who had less than a high school education. This sample showed that the majority of the respondents received at least some college education and that a high number of respondents were employed than not. Over seventy percent of the respondents were employed. Nine respondents (24.3%) had less than a high school diploma.

With respect to health status, slightly more than half of the respondents (56.8%) indicated that their health was good. There were about 32% of the respondents reported that their health was very good and about 10% said their had poor health.

Type and Rating of Respondents' Programs

Table 2 shows the type of programs the respondents attended and how the respondents rated the particular programs they attended. In terms of the type of substance abuse treatment programs the respondents used, seventeen respondents (49.9%) attended secular-based treatment programs. About forty percent of the respondents attended AA programs.

Table 2. Type and rating of respondents' programs

Variable	Frequency n	Percentage (%)
Type of program (N=37)		
Secular drug treatment program	17	(45.9%)
AA and AN	15	(40.5%)
AA and other program	5	(13.5%)
Rating of program (N=37)		
Very good	28	(75.7%)
Good	7	(19.9%)
Fair	1	(2.7%)
Poor	1	(2.7%)

There were seventeen respondents (49.9%) who attended secular-based programs, and about 13.% of the respondents attended both AA and secular-treatment programs (named other programs).

In evaluating the effectiveness of the programs respondents attended, over seventy percent of the respondents reported that their programs were very good. A little less than twenty percent said their programs were good. A little over two percent rated the programs as fair and about 2% respondents rated the programs as poor.

Contribution to Respondents' Success

Table 3. shows respondents perception of what contributed most to helping them succeed. Twenty-six respondents believed that the twelve steps contributed the most to their success, and seventeen respondents (21.3%) indicated that the drug treatment programs alone

contributed the most to their success. Eleven respondents (13.8%) reported church as contributing to their success and eleven respondents (13.8%) said that their sponsors contributed the most to their success.

Around 10% of the respondents indicated that family support contributed to their success, while four (5.0%) of the respondents reported other things contributed to their success. Slightly more than one percent of the respondents reported that Prayers, God, and pastors, respectively, contributed the most to their recovery from substance abuse. Twenty-six respondents reported that the overwhelming contribution to their success were the 12-steps.

Table 3. Contribution to respondents' success

Variable	Frequency n	Percentage (%)
Contributed (N=37)		
12 step meetings you attend	26	(32.5%)
Church	11	(13.8%)
Sponsor	11	(13.8%)
Your drug treatment program	17	(21.3%)
Family support	8	(10.0%)
Other	4	(5.0%)
Prayer	1	(1.3%)
God	1	(1.3%)
Pastor	1	(1.3%)

Successful Aspects of Programs

Table 4 shows the respondents' belief about what aspects of the programs contributed to their success. Fifteen (24.6%) believed that the 12-steps were the most successful aspect of the programs. Twelve respondents (19.7%) reported sharing with other members as the most effective aspect of their programs. About nineteen percent

Table 4. Successful aspects of the programs

Variable	Frequency n	Percentage (%)
Success (N=37)		
Working the 12-steps	15	(24.6%)
Sharing	12	(19.7%)
Friends	6	(9.8%)
God	5	(8.2%)
Group	5	(8.2%)
All aspects	3	(4.9%)
Higher Power	2	(3.3%)
Letting go of place, Things, and people	2	(3.3%)
Meditation/prayer	2	(3.3%)
Sponsor	2	(3.3%)
No aspects	1	(1.6%)
Being able to be powerless over addiction	1	(1.6%)
Christian background	1	(1.6%)
Recovery program	1	(1.6%)
Structure	1	(1.6%)

of the respondents said friends were the biggest contribution for them. Six (9.8%) of the respondents indicated that friends were where their success came from.

Three were about eight percent of the respondents who said that all aspects of the programs were the most successful aspect, while about 3.3% of the respondents

said that a higher power was the contributing aspect of the program for their success.

Two respondents (3.3%) reported that their sponsors were the contributing factor in their success. About 2% of the respondents said maintaining structure was the successful aspect of the programs. Five respondents (8.2%) reported that God was the contributing aspect of the programs for them.

Prayers and meditation respectfully contributed to the success for over three percent of the respondents. Group meetings contributed the most success for about 8% of the respondents. Letting go of place, things, and people was the main aspect of success for about 3% of the respondents.

Slightly over one percent of the respondents said testing, recovery programs, being able to be powerless over addiction respectively, were the aspects, which helped respondents, succeed the most in their programs.

Respondents Learned In Programs Sobriety

Table 5 shows twenty-nine respondents (78.5%) reported that they learned something in the program for over-coming addiction. Approximately 11.% of the respondents said they learned how to abstain from drugs and the drug infested environment (while in the programs). A little over

Table 5. Respondents learned in program sobriety

Variable	Frequency n	Percentage (%)
Learned (N=37)		
Must work the steps	5	(11.6%)
Prayer/connection to God	5	(11.6%)
Abstinence/change environment	5	(11.6%)
Don't need to use drug	4	(9.3%)
Learned a lots of things	4	(9.3%)
Want to live/and not die	4	(9.3%)
Must attend program	3	(7.0%)
Taking one day at a time	2	(4.7%)
Belief in after life	2	(4.7%)
Honest	2	(4.7%)
How to live on life's terms	2	(4.7%)
Helping others make amends	2	(4.7%)
I can stop using drugs	1	(2.3%)
A greater power than me	1	(2.3%)
Sharing with family and friends	1	(2.3%)
Taking responsibility	1	(1.3%)

two percent of the respondents indicated that they learned that friends helped them in their programs.

Three respondents (8.2%) indicated that they learned from all aspects of the programs, which were successful for them, while around 3% of the respondents said they learned that a higher power contributed to their success in the programs.

Thirty three percent of the respondents said they learned that their sponsors were the contributing factor for success in the programs. Slightly over 1% of the respondent learned that said maintaining structure was the successful aspect of the programs for them. Five (8.2%) of

the respondents indicated they learned that God was the aspect of the programs that kept them clean and sober.

About 3.3% learned that prayer and meditation were successful for them in the programs. Over eight percent of the respondents learned how to use the group meeting to succeed in the programs. Letting go of place, things, and people was what about 3% of the respondents learned in the programs.

Five respondents (11.6%) learned that they must attend the programs to remain clean/sober. Sharing with family and friends were what over 2% of the respondents learned. Over 5% of the respondents learned that they did not need to use drugs for any reason. About 9% of the respondents said they learned that they wanted to live and not die in jail. Eleven respondents (11.6%) indicated they learned they must work the steps in order to remain clean and sober.

Approximately 11% of the respondents said they learned about prayers and how to have a connection to God. Helping others and making amends were learned by around 4% of the respondents, while less than 6% of the respondents indicated that they learned a lot on how to remain clean and sober. Slightly over two percent of the respondents learned how to take responsibility for their own actions.

Also, there were about 2.% of the respondents who learned how to live on life's term. Over two percent

learned that he or she could just stop using drugs, and about 2% of the respondents learned to take it one day at a time. More than 4% of the respondents said they learned to have a belief in an after life.

Less than three percent of the respondents indicated that they learned that there is a greater power than they are. When comparing the respondents' responses in table 4 to table 5, again the 12-steps received the greatest responses for what they learned and what contributed to respondents' success the most in the program.

Respondents' Coping Strategies

Table 6 shows what the respondents reported as their coping strategies. Again, sixteen respondents said they used the 12 steps as their coping strategies, while about 12.9% said sharing in the 12 step

Table 6. Respondents' coping strategies

Variable	Frequency n	Percentage (%)
Coping strategies N=37		
12 steps	16	25.8%)
Connection with God	8	(9.7%)
Sharing in meetings	6	(9.7%)
Sponsor/counselor	5	(8.1%)
Prayer mediation	5	(8.1%)
Sharing with family & friends	5	(8.1%)
Higher power	4	(6.5%)
Don't want to go to jail/change Environment	3	(4.8%)
Listening	2	(3.2%)
Relaxation	2	(3.2%)
Hospital after care	2	(3.2%)
Don't use	1	(1.6%)
Don't sweat the small stuff	1	(1.6%)
One day at a time	1	(1.6%)
Reading AA book	1	(1.6%)

programs was their main coping strategy in their treatment for substance abuse. Eight (12.9%) said that having a connection with God was their coping strategies. Over 8% of the respondents used a sponsor or a counselor to help them cope with overcoming drug abuse.

Also, around 8% of the respondents use prayer and mediation for their coping strategies, while almost 8% of the respondents utilized a higher power for their coping strategies. There were 6.5% of the respondents who reported not wanting to go to jail and changing their environment were their coping strategies, while less than

two percent of the respondents said they learned to cope without using drugs, or alcohol anymore.

Less than 4% of the respondents reported having the ability to listing was their coping strategy. Hospital after care, not sweating the small things, and reading the AA books respectively were used by over 2% of the respondents for their coping strategies.

Two (3.2%) of the respondents use relaxation for coping in their recovery treatment.

Respondents' Relapse

Table 7 shows that over 32 % of the respondents had relapsed after they started the treatment programs for substance abuse. Over sixty percent of the respondents said they had never relapsed after they started treatment in the programs.

Table 7. Respondents' relapse

Variable	Frequency n	Percentage (%)
Relapsed (N=37)		
Yes	12	(32.4%)
No	24	(64.9%)

Respondents' Length in Programs Before Sobriety

Table 8 shows the length of stay in the program before becoming sober and clean. Almost thirty percent (29.7%) of respondents were in the program less than a

year before they sobered up, while over 5% were in the program

Table 8. Respondents' length in program before sobriety

Variable	Frequency n	Percentage (%)
Length (N=37)		
Less than a year	11	(29.7%)
One year	2	(5.4%)
Two years	5	(13.5%)
Discontinued prior to enrolling in the program	3	(8.1%)
Others	13	(35.1%)
Missing	3	(8.1%)

for one year before sobering up. There were about 8% of the respondents who discontinued using drugs before they enrolled in the program. Over 13 of the respondents were in the program two years before they sobered up, and thirteen (35.1%) answered other.

Months/Years of Stay For Respondents

Table 9 shows the number of month and years the respondents bad been in the program. There were about 40% of the respondents who reported 0 to 12 months (less than 1 year) of being in the program. Also, over 21% of the respondents reported being in the program for 13 to 36 months (2 to 3 years). There were 10.8% of the respondents who had 37 to 72 months (4 to 6 years) of attending the program, while 27.0% of respondents reported 73 to 204 months, (7 + years) in the program.

Table 9. Months/years of stay for respondents

Variable	Frequency n	Percentage (%)
Month/years (N=0)		
0-12mo (less than 1 year)	15	(40.5%)
13-36mo (2-3 years)	8	(21.7%)
37-72mo (4-5 years)	4	(10.8%)
73-204mo (7+ years)	10	(27.0%)

Length of Sobriety After Sobering Up

Table 10 shows the length of sobriety after the respondents sobered up. Approximately 27.8% of the respondents had been sobered for 0 to 12 months (lest than one year) since they sobered up.

There were about 13% of the respondents who had been sobered for 13 to 36 months (2 to 3 years). Also, a little over 16% of the respondents had been sobered for 37 to 72 months (4 to 6 years). Close to 27% of the respondents had 73-204 months (7+ years) of sobriety.

Table 10. Length of sobriety after sobering up

Variable	Frequency n	Percentage (%)
Length/Sobriety (N=37)		
0-12mo (less than 1 year)	10	(27.8%)
13-36mo (2-3 years)	5	(13.9%)
37-72mo (40-6 years)	6	(16.7%)
73-1mo (7+ years)	15	(41.7%)

Spiritual Level of Respondents

Table 11 shows how the clients felt about their spiritual faith and how it influences their lives and

Table 11 Spiritual level of respondents

Spirituality	Frequency n	Percentage (%)
Spiritual/belief (N=37)		
I feel that in many ways turning my life over to God has actually set me free.		
Strongly agree	27	(73.0%)
Agree	7	(18.9%)
No opinion	2	(5.4%)
I know that all the best things in my life come to me through God.		
Strongly Agree		
Agree	24	(64.9%)
Disagree	9	(24.3%)
No Opinion	3	(8.1%)
I believe God blesses me with many gifts I do not deserve		
Strongly Agree	11	(29.7%)
Agree	9	(24.3%)
Disagree	4	(10.8%)
No Opinion	3	(8.1%)
I feel it is important to thank God when I manage to do the right thing		
Strongly Agree	21	(56.8%)
Agree	11	(29.7%)
Disagree	1	(2.7%)
No Opinion	3	(8.1%)
It's only when I stop trying to play God that I can begin to learn what God wants for me		
Strongly Agree	23	(62.2%)
Agree	7	(18.9%)
Disagree	1	(2.7%)
No Opinion	4	(10.8%)

Table 11. (cont.) Respondent' spiritual level of belief

Spirituality	Frequency n	Percentage (%)
I know I am able to meet life's challenges only with God's help		
Strongly Agree	23	(62.2%)
Agree	10	(27.0%)
No Opinion	3	(8.1%)
I know that forgiving those who have hurt me is important for my spiritual health		
Strongly Agree	25	(67.6%)
Agree	10	(27.0%)
Disagree	1	(2.7%)
I believe there are many ways to know God and my way is not the only way.		
Strongly Agree	28	(75.7%)
Agree	4	(10.8%)
Strongly Disagree	2	(5.4%)
No Opinion	2	(5.4%)

helped them recovery from addiction. Twenty-seven of the clients strongly agreed with the statement that in many ways turning their lives over to God has actually set them free. Approximately 18% of respondents agreed and almost 5% of them had no opinion. Twenty-four respondents (64.9%) strongly agreed that they knew that all the best things in their lives come to them through God. There were nine (24.3%) of the respondents who also agreed, and about 8.1% who had no opinion.

Eleven respondents (29.7%) strongly agreed that God blessed them with many gifts they did not deserve, and 24.3% of the respondents agreed. Four respondents (10.8%)

disagree and three (8.1%) of the respondents strongly disagree.

Twenty-one of the respondents (56.8%) strongly agreed that it is important to thanks God when they manage to do the right thing, and Eleven respondents (29.7%) agreed. Less than 3% of the respondents disagreed and about 8% had no opinion.

Over 62% of the respondents strongly agreed with the statement that only when they stop trying to play God that they begin to learn what God wants for their lives, and seven respondents (18.9%) agreed. Less than three percent of the respondents disagreed and about 10% had no opinion.

Twenty-three respondents (62.2%) strongly agreed that they were able to meet the challenge in their lives only with God's help and about 27% of the respondents agreed. More than 8% of the respondents had no opinion about the statement.

Over half, about 70% of the respondents strongly agreed that they knew forgiving those who had hurt them was important for their spiritual health. There are ten respondents (27.0%) who agreed, less than three percent of the respondents disagreed with the statement. About 3% of respondents had no answer.

Approximately 76% of the respondents strongly agreed that there are many ways to know God and that their way is not the only way. About 10% of the respondents agreed,

while 5.4% disagreed. Less than 3% of respondents had no opinion.

An overwhelming majority of the respondents indicates that including spirituality in faith-based treatment make as much or more of a difference in the outcome of substance abuse treatment than using only secular-based treatment.

In fact, a t-test was conducted to compare the means of the length of sobriety of secular-based treatment and faith-based treatment programs for addiction.

Results has shown that respondents who participate in faith-based programs are more likely to remain sober longer than respondents who participate in the secular-based programs S($t=2.084$, $df=35$, $p.<.05$).

Another t-test was conducted to compare the means of frequency for relapse of the respondents. The findings ($t=1.99$, $df=34$, $p=.23$) showed no statistically significant difference when comparing length of means of faith based programs to the means 22 of secular-based treatment for drug addiction. Results found in this research could be because the respondents from the secular-based programs were also visiting the (12-steps) faith-based programs.

DISCUSSION

Demographics

Thirty-seven males and females from various substance abuse treatment programs, in various areas of southern California, and from various social backgrounds, participated in this research. The participants have an average age between 36 and 49.

Typical participants were college educated Caucasians. Since the population as a whole consists of more college educated respondents than non-college uneducated respondents, an indication that the more educated people are the more likely they will seek treatment for addiction than those with lesser education.

Also, the research showed that a high divorce rate is a dominant factor of the respondents in this study and could be an indication of the negative effects of substance on marriages.

In addition, the employment rate were much higher than the unemployment rate, which leads to the speculation that the more educated people are, the more likely they posses the ability to maintain some type of employment.

Program Effectiveness: Faith-Based Vs Secular-Based

The findings of the study have shown that secular-based treatment is an effective way to help people with their addiction. Moreover, the findings show that (for many people) faith-based programs are more effective than

secular-based programs in the overall treatment of substance abuse. For example, when respondents were asked to rate their programs, overwhelmingly more respondents rated the faith-based programs as good, or very good, as oppose to the respondents from secular-based programs. Furthermore, the respondents indicated that the longer they stayed in the faith-based programs, the less likely they were to relapse than the respondents in the secular-based programs. This finding supports Fiorentine's (1999) study that 12-step programs are effective in helping addicted people maintain abstinence during and after drug treatment.

Moreover, there were a much higher percentage of respondents in the faith-based programs that indicated they had not relapsed than in the secular-based program. This finding was statistically significant and indicates that the component of spirituality in substance abuse makes a difference.

The reasons being, all people have a component of Spirituality within their psyche and substance abuse totally takes over the addicted person's psyche. Therefore, most people who are addicted need something outside of themselves to hold on to, and to bring balance back into their lives. They need programs that will treat their addiction and offer hope from both within and outside of themselves.

Faith-Based programs probably make a difference because they offer treatment that addresses the inner and outer spirit (the total psyche) of people. They also offer people hope that comes from God or their higher power. Moreover, an overwhelming majority of respondents indicated that their faith in God is what gives them the ability to cope and succeed with in their lives challenges.

Results of the findings could also mean that treatment programs offering only secular-based interventions for the clients, addressees only the inner spirit and fail to offer hope for something beyond themselves. It fails to address the total needs of many people suffering from addiction.

Implications for Social Work Practice

The study indicates that counselors need the knowledge to provide interventions in both secular and faith-based programs as part of treating addiction. Because many addicted people incorporate their spiritual beliefs as part of their coping strategy, the social work professionals need to develop the necessary programs that will offer these clients the treatment that best meet their needs.

Furthermore, faith-based (or spirituality) treatment is a growing area of social work which calls for sensitivity and acceptance from the profession. Faith-

Based treatment is what many clients need and want, therefore, counselors need to seek the training necessary in order to offer professional treatment programs that cater to the self-determination of the clients. The study implies that faith-based treatment shouldn't bee seen as a taboo but as a choice.

Limitations

However, the small number of respondents limits the generalization of the finding to the general public. Therefore, because the population represented in this sample consists of mostly educated Caucasians, the study may not fully represent other ethnic groups. African American and Hispanics were underrepresented in spite of the diversity of the areas and programs utilized in the sample. This will possibly compromise the veracity of the findings of the study.

Therefore, more research is needed with a larger Sample. The reason why this occurred is one of the many issues, which need to be researched on a larger scale. In addition, the population to conclude the feasibility of combining comprehensive programs using secular-based and faith-based treatment interventions. The study should investigate the need for advanced accelerated programs

that will give the clients a menu of choices (Spirituality of Secular-interventions) and must be targeted to meet the needs of all clients.

Secular-based counselors are concerned that spiritual interventions will not meet the clients needs and the spiritual-based counseling are concerned that the clients will not acquire the skills to cope with the harsh events of life.

Using combined treatment interventions that are both secular and spiritual will help make available more effective programs for the addicted persons and eliminate their needs to attend secular treatment by day and spiritual treatment by night. Treating the totality of the human psyche and giving hope for addiction means people will have choices under one roof.

CONCLUSION

Research was conducted as a study to see if faith-based treatment programs made as much or more of a difference in outcome of treatment than secular-based treatment for addiction. Various respondents were randomly selected from various areas of Southern California who have participated in various treatment programs.

The survey consisted of 25 questions administered by questionnaires. The responses of thirty-seven respondents indicated that people in the secular-based programs tend to also attend the twelve steps faith-based programs in the afternoon and on the weekends.

The respondents also indicated that people attending faith-based programs tend to remain in treatment longer, and the longer they are in the program, the longer they remain sober. This is not an indicator of secular-based treatment.

The overwhelming majority of the respondents (both faith-based and secular-based respondents) believes that they can meet life's challenges only with help from God. The overall results of the study seems to indicate that faith-based treatment programs make as much or more of a difference in treatment for some people than secular-based

programs. This study indicates the need for more research to examine the need for combined treatment programs of both faith-based and secular-based treatment.

APPENDIX A

Long term Drug and Alcohol Treatment Programs: An Outcome study comparing Secular-based treatment With Faith-based Treatment

You are asked to participate in a research study conducted by Ruby L. Adams MSW student from the Department of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board of California State University San Bernardino.

The results of the study will contribute to her thesis. You were selected as a possible participant in this study because you have participated in treatment for substance abuse for two months or more. Your participation in this study is voluntary.

- **PURPOSE OF THE STUDY**

This study is designed to assess differences in the outcome between faith-based and secular-based treatment for substance abuse. The study will also assess the length of sobriety since participating in the treatment program.

- **PROCEDURE**

If you agree to participate in the study, you will have a self-administered questionnaire at the time and place of your meeting. The questionnaire will take about 15 minutes. Questions in the questionnaire will asked about length and sobriety, your areas of stress and coping strategies, what you think is special to your program that leads to your success.

APPENDIX B

- **POTENTIAL RISKS AND BENEFITS**

It may be uncomfortable to answer some personal or family background questions such as age, and education level. Some questions included in the questionnaire regarding substance use like relapse, sobriety, and coping may cause you discomfort. A potential benefit you may receive by participating in this study is to familiarize your self with information on various social and financial services available to you. Another potential benefit you may have is to sort out your

Feelings by having the opportunity to discuss important areas of your life with an interested listener.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and be disclosed only with your permission or as required by law.
Confidentiality will be maintained by means of keeping data (questionnaires) privately in the possession of the investigator. No one other than the investigator has access to the collected data. Once the interview has been completed, and the data have been entered into a computer file, the questionnaires will be destroyed. Thereafter, raw data in the computer data file will be identifiable only by case ID numbers.

APPENDIX C

- **PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without penalty. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

- **IDENTIFICATION OF INVESTIGATOR**

If you have any questions or concerns about the research, please feel free to contact Janet Chang, Ph.D. Professor, and Master of Social Work Program at California State University, San Bernardino, Phone (909) 880-5184.
By my Mark below, I acknowledge that I have been informed of, and understand the nature of the study.
I acknowledge that I am at least 18 years of age

_____: Date_____

APPENDIX D

DEBRIEFING STATEMENT

Thank you for your participation in this study. The information you have given me is greatly appreciated. Your answers will help me to learn more about the service drug treatment, which are the most effective in the treatment of substance abusers.
I wanted to explore whether Faith-based treatment for substance abuse makes more of a difference, in treatment and outcome than Secular-based treatment outcome.
To assure anonymity, individual results will not be available to any one other than the researcher. However, you may obtain a summary of my findings in June 2000 through the Department of Social Work at California State University, San Bernardino. If you would like a summary of the conclusion of this study, or have any further questions or concerns, you may contact the researcher, Ruby L. Adams (909) 880-5184.
You may also contact Dr. Janet Chang in the Department of Social Work at (909) 880-5184. Thank you for participating in this research.

Sincerely,

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