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ABSTRACT

Adolescent substance abuse has been on the rise for the past few decades, constituting a major personal and social problem. According to researchers, the causes are many, including biological, temperamental, psychological, behavioral, and environmental factors. Yet, only a few intervention methods have proven effective. Numerous studies demonstrated that religious beliefs and practices exert a deterrent effect on substance abuse among teens. However, there is little information available that applies specifically to Jewish adolescents from an orthodox background. This pilot study was conducted with a group of substance abusing Jewish adolescent boys attending an alternative religious high school, to examine the influence of religiosity of substance abuse therapy outcome. The assumption was that the religious environment would influence the boys to better respond to therapy, adding another weapon in the war against teens' substance abuse. Three appendixes contain a religiosity questionnaire, diagnostic schedule, and data table. (Contains 72 references.) (Author)

The Effect of Religiosity

on Therapy Outcome

for Substance Abusing Adolescents

By

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Thesis

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The Effect of Religiosity on Therapy Outcome

For Substance Abusing Adolescents

Introduction

Adolescent substance abuse has been on the rise for the past few decades, constituting a major personal and social problem. According to researchers, the causes are many, including biological, temperamental, psychological, behavioral and environmental factors. Yet, only a few intervention methods have proven effective. Numerous studies demonstrated that religious beliefs and practices exert a deterrent effect on substance abuse among teens. However, there is little information available that applies specifically to Jewish adolescents from an orthodox background. This pilot study was conducted with a group of substance abusing Jewish adolescent boys attending an alternative religious high school, to examine the influence of religiosity on substance abuse therapy outcome. The assumption was that the religious environment would influence the boys to better respond to the therapy, adding another weapon in the war against teens' substance abuse.

Review of the Literature

The problem

The prevalence of substance abuse has greatly increased in recent years, especially in younger age groups. According to annual data from the Monitoring the Future Study, funded by the National Institute on Drug Abuse [(NIDA), 1999], substance abuse has been on the rise since 1975. Another survey by the Youth Risk Behavior Surveillance, conducted by the Center for Disease Control (1995a), yielded similar findings. According to both studies, about fifteen percent of adolescents reported frequent smoking, and by the end of eighth grade nearly four in ten have tried an illicit drug. By twelfth grade, more than fifty percent have done so. Among high school seniors, marijuana use in the month prior to the study nearly doubled, climbing from 13.8 percent to 23.7 percent in 1997, and almost one third reported having five or more drinks in a row at least once in the two week period prior to the study.

In addition, other types of substance use were on the rise, including hard drugs such as cocaine, ecstasy, heroin, and inhalants. According to the National Household Survey on Drug Abuse (1996), the number of heroin users almost tripled in the past few years, indicating an epidemic. Many of the users were adolescents, with 20 percent of eighth graders reporting that the drug was easily accessible to

them. The following two examples demonstrate the severity of the problem. In the small town of Plemo, a middle class community in Texas, twelve adolescents died from overdose of heroin over a period of eighteen months, and in Fairfax County in Virginia, another middle class community, adolescent drug-related arrests increased ten times in the past ten years (Bruner & Fishman, 1998). It is claimed that the United States has the highest percentage of drug use among youth in the industrialized world (Botvin, Baker, Dusenburg, Tortu, & Botvin, 1990), and in some groups, experimentation with drugs has become so accepted that many adolescents view it as part of a rite-of-passage.

Adolescent substance abuse constitutes a major social and health problem in the United States, and many adolescents claim that it is the most serious problem they face. The high rate of high school dropout has been connected in great part to early adolescent drug use (Lynsky & Hall, 2000). Results of a study by Ellickson, Bell and McGrigan (1998) indicated that cigarette smoking by seventh graders predicted dropping out of high school for Asians, blacks and whites, controlling for family structure, academic orientation, early deviance, and school environment. For Latinos, early marijuana use predicted the same. This is not surprising considering the effect of drugs on short-tem memory and other cognitive functions. According to NIDA (1999), chronic abuse of MDMA (ecstasy) appears to produce long term damage to serotonin-containing neurons in the brain, causing a variety of behavioral and cognitive consequences.

In addition, there seems to be a relationship between drug abuse and psychiatric disorders. Brook, Cohen and Brook (1998) found a significant

relationship between early adolescent drug use and later depressive and disruptive disorders when controlling for early psychiatric disorders. For example, use of alcohol, tobacco and marijuana was related to later depressive disorders.

A strong comorbidity was found between youth substance abuse and suicide attempts. Forman and Kalafat (1998) stated that many studies found a significant overlap between these two behaviors, reporting increased incidents, serious intents and lethality among youth who use drugs, particularly alcohol. A study of Dutch secondary school students, conducted by Garnefsky and Jan De Wilde (1998), revealed a direct positive relationship between the heaviest drug use and highest prevalence of suicide attempts. Other common problems resulting from use of illegal drugs by adolescents involve engaging in activities such as driving, playing sports, and fighting while intoxicated, and in risk-taking behaviors such as weapon carrying and overall violence. In addition, seizures and fatal arrhythmia can be caused by inhalants (Bruner & Fishman, 1998), and overdose of many drugs may lead to coma, respiratory arrest, convulsions, and death. When used by means of needles, some drugs may cause infections with HIV and the hepatitis virus. Unfortunately, uncertainties about the chemicals used to manufacture some of those drugs make it difficult to determine toxicity and resulting damage (NIDA, 1999).

Reasons

Numerous studies were conducted with emphasis on understanding mediating factors that serve to increase susceptibility to drug use. Researchers have identified various risk factors, including genetic, biological, temperamental, psychological, behavioral, family and social-environmental factors, and the

likelihood of substance abuse increases with the number of those characteristics present (Newcomb, Maddahian & Bentler, 1986). Studies of adopted children suggest that having a biological parent who is an alcoholic often predicts substance abuse by the offspring, and antisocial personality disorder by the biological parent may increase chances of conduct disorder, leading to substance abuse as well (Forman & Kalafat). Some characteristics of high risk children may stem from biological factors, which interfere with cognitive functions such as self-regulation and difficulties with planning, attention, abstract reasoning, judgment and self-monitoring, all of which may eventually lead to substance abuse (Weinberg, Randert, Colliver, & Glantz, 1998).

Family variables are also considered to be of great significance in connection with substance abuse. Factors such as ineffective parenting, lack of attachment, and family stress seem to increase risk, while strong bonds with family and parental monitoring with clear rules are identified as protective factors (NIDA, 1997). The National Longitudinal Study of Adolescent Health (as cited by Epstein, 1998) surveyed 90,000 adolescents across the United States and found that adolescents who felt loved and nurtured at home, were less likely to use alcohol and drugs. The study stressed the importance of children feeling connected, loved and understood by their parents.

Of special mention are children with learning disabilities (LD). A study by Wong and Trembath (1998) on frequency of alcohol and drug use of adolescents found that adolescent drug use tended to be higher among LD students. Lambart and Hartsough (1998) conducted a study comparing adolescents with Attention

Deficit Hyperactive Disorder (ADHD) with non-ADHD youngsters for use of illicit substances. They found that ADHD participants began smoking regularly at an earlier age – shortly after fifteen, compared with non-ADHD participants who did not start smoking regularly until age seventeen, and were heavier smokers. The rates of cocaine dependence were 21 percent for those with ADHD compared with 10 percent for students without the disorder.

Goff and Goddard (1999) investigated the relationship of terminal core values with substance abuse. They found that values such as self-respect and being respected by others, a sense of accomplishment, self-fulfillment and feelings of belonging were associated with reduced substance abuse. They also found that promoting academic esteem could serve as a buffer against peer pressure and influence of social groups, lowering the probability of alcohol consumption. A similar study by McNeal and Hansen (1999) looked into the difference between adolescents who initiated drugs and those who did not. The results showed that initiators placed lower values on mediators such as normative beliefs, manifest commitment, beliefs about consequences and resistance skills.

Scheier and Botvin (1998) confirmed the assumption that low self-worth and high self-derogation are major causes of drug use, and that adolescents with a need to improve self-worth in school were more likely to join deviant subgroups in the absence of bonds to normative institutions, such as schools. They suggested that, in order to promote resistance to peer pressure, drug prevention programs should concentrate on improving cognitive strategies that provide a foundation for building self-esteem.

Winfree and Bernat (1998) utilized two different theories to give insight into the problem of substance abuse. First, the social learning theory (Akers, 1985), emphasizes the influence of delinquent peers, powerful social reinforcers and the absence of social punishers, while the second, the self-control theory based on Gottfredson and Hirschi's "Theory of Crime" (1990), claims that children became delinquent due to inadequate parenting and poorly developed self-control. According to this second theory, human behavior is motivated by self interest, which is expressed by pleasure-seeking, interest in materialistic rather than spiritual concerns, and a tendency to concentrate on selfish needs over the needs of others. These characteristics may produce a behavior of rule-challenging and risk-taking, including substance abuse. According to both theories, good parenting, proper punishments and positive caregiver affect are needed to counterbalance those tendencies. Winfree and Bernat found that high levels of guilt about illicit conduct predicted less substance abuse, while low levels of parental monitoring and high impulsiveness predicted the opposite.

Of special interest is a study by Anderson and Mott (1998) which viewed peer influence from a different perspective. Their approach was based on the assumption that there exists a strong connection between identity concerns and deviant behavior. Children who experience stigmatizing events, such as loss, divorce, or a learning disability, which change their status in a negative way, may be 'marginalized' from normative groups. As a result, they might be motivated to change their identity. The social approval that peers in the drug-subculture offer is

instrumental in making those youngsters feel comfortable with their new identity, resulting in increased deviant behavior.

Intervention

The United States Public Health Service has issued Year 2000 Health Objectives for substance use reduction (Paine-Andrews et al., 1996), and the American Medical Association's 1994 guidelines recommended that all adolescents receive annual health guidance to encourage avoidance of drug use. However, when it comes to adolescent treatment, the situation is very disappointing (Bruner & Fishman, 1998). There is a need for a variety of services including counseling of the family, remedial education and community outreach. Managed-care policy does not promote treatment quality and availability. The status of primary prevention has been described as uncoordinated, with each of the areas of social, emotional and health treated separately, causing programs to compete with each other for a place in the school curriculum (Elias, 1995). This situation is confusing for students, especially those at high risk who have cognitive difficulties (Forman & Kalafat, 1988). A review of 127 drug abuse prevention programs evaluation by Schaps, DiBartolo, Moskowitz, Palley and Churgin (1981), found that those programs produced a minor effect on drug use behavior, and of the many substance abuse programs implemented in schools, only a few have been effective.

The following are two of the effective programs that have been reviewed by Forman and Kalafat (1998).

(1) Life-Skills Training teaches students social coping skills, emphasizing resistance to substance abuse. The program is conducted in seventh grade with

booster sessions in eighth grade. A decision-making skill component and a social-skills component teach how to address influence of substance-using peers. A number of studies documented the effectiveness of Life Skill Training as producing lower levels of tobacco, alcohol and marijuana use (NIDA, 1997).

(2) Project STAR (Students Taught Awareness and Resistance) is a comprehensive community-based intervention. It also focuses on resistance skills, but in addition to students, it involves family members, community leaders and mass media networks. Evaluation of project Star also has shown positive immediate and long-term results (Forman & Kalafat, 1998).

Botvin et al. (1990) however, concluded that prevention strategies were effective only when ongoing intervention activities were provided throughout the critical junior high school period. According to their study, the findings were limited because of the fact that the population consisted mostly of white middle-class suburban and rural students. They also claimed that those school programs do not reach youth who are at greater risk since they are more likely to be absent or to drop out of those programs.

The situation is worse once drug use is identified, and the standard treatments for adolescents are quite primitive (Bruner & Fishman, 1998). While many clinical trials have been conducted with medical treatments for adults, little is known about the effectiveness of medication on adolescents (Weinberg, et al. 1998). Cognitive-behavioral approaches such as social control, contracting, problem solving, and coping-skill training have shown positive results for the first few

months after discharge from treatment, but most require further follow up and refinement (Weinberg et al.).

The Center for Substance Abuse Treatment (cited in Winters, 1999) has recommended the following more recent approaches: Therapeutic Communities (TC) for adolescents, family therapy, and the 12-step-based treatment. Following is a summary of those programs:

- The Therapeutic Community (TC) is a residential program treatment that was developed for use with adults and has been adjusted to treat adolescents. The goal of this approach is to promote holistic lifestyles by learning from fellow residents and other figures of authority. The TC treatment has been used to treat youth who need long-term care such as substance-using juveniles incarcerated in the justice system.
- Family Therapy is based on the assumption that adolescence substance use disorders are affected by interactions among family members. Over the years, treatment programs have worked with "family based therapy", "family-centered therapy" and just "family therapy". According to data from recent studies (cited in Winters, 1999), there is a connection between changes in family function and changes in substance use problems of adolescents. The aim of family treatment is to work on the problem not only within the family, but also between the family and social systems such as schools and peer groups. Extended systems are believed to help maintain interaction in families. Recent research shows that implementation of family therapy together with outpatient

programs, which are the primary setting for adolescent substance use treatment today, are effective in reducing drug use (Winters, 1999).

- The 12-step-based program is a "drug free" approach that follows the philosophy of Alcoholics Anonymous [AA (1976)], which the Narcotics Anonymous (NA) adjusted with a few small changes. Its principles are: Admitting to being powerless to overcome the problem and believing that only a greater power could help, asking G-D for help, taking a personal inventory of the wrongs committed towards others and making amends to them, praying for knowledge of G-D's will and the power to carry it out, and commitment to try and carry the message of spiritual awakening to other addicts. Over the years, parts of the 12-step model were incorporated into social model programs and family therapy. Providers treating adolescent with the 12-step program adjust it accordingly. The final goal is to encourage the adolescent to continue with the group meetings after treatment.

The American Psychiatric Association Practice Guidelines for the treatment of patients with substance use disorders (1995) stated that, although little has been published about the efficacy of self-help groups, clinical experience shows that they are an important supplement to treatment. Research reports by Langabaugh, Wirtz, Zweben and Stout (1998) concluded that, in the long term, Twelve Step Facilitating Therapy (TSF) may be the treatment of choice for alcohol–dependant clients with networks supportive of drinking.

The groups, which are generally based on the 12-step approach of Alcoholics Anonymous, can provide crucial support for patients in recovery. The participants

can always count on other members who encourage them to stay sober and remind them of the self-destructive outcome of substance abuse. Members may attend meetings as often as necessary, particularly at times of high risk for relapse, such as weekends and holidays and during periods of emotional distress. The programs and its volunteers are always available free of charge. The program has spread all over the world with over one million members, many of them teens, meeting in over ninety countries (Alcoholics Anonymous, 1976). As Chappel and DuPont (1999) stated, this has occurred because people were touched by the honesty and tolerance in which members shared their experiences regardless of gender, race, religion or socioeconomic differences. Some of the key components of the program, according to Chappel and DuPont, were the integration of professional staff with recovering alcoholics, the focus on the disease concept of addiction, family involvement and the continued care after treatment.

The theory behind the 12-step program recognizes that willpower alone is not enough to sustain sobriety, and long-term recovery is a process of spiritual renewal (Nowinski, 2000). In his letter to the third edition of Alcoholics Anonymous (1976), Dr. W. D. Silkworth wrote, "...we doctors have realized for a long time that some form of moral psychology was of urgent importance to alcoholics but its application presented difficulties... with our scientific approach to everything, we are perhaps not well equipped to apply the powers of good that lie outside our synthetic knowledge" (forward to third edition).

In 1951, Alcoholics Anonymous received the Lasker Award for its unique and highly successful approach. The award committee stated that the emphasis on

alcoholism as an illness was crucial to removing the social stigma associated with this condition. They added that this was "a new therapy based on the kinship of common suffering; one having a vast potential for the myriad other ills of mankind" (Alcoholics Anonymous, 1976, p. 573).

Religion

A related area of importance is the relationship between religion and drug use. While it is usually assumed that religion has an inhibitory effect on crime, some scholars are skeptical as to the accuracy of this assumption. One of the more publicized studies in this area is the one by Hirschi and Stark (1969), who drew their sample of over four thousand students from junior and senior high schools in California. They measured delinquency by self report and through review of police records, and religiosity was determined by church attendance. After examining the data, they concluded that students who regularly attended church were as likely to commit delinquent acts as students who attended church very rarely or not at all.

While some sources stated similar opinions (Benson, 1960; Falk, 1961; Sutherland & Cressey, 1974), many later findings consistently supported the traditional view that religion does have an impact on deviant behavior (Burkett & Warren 1987; Chadwick & Top, 1993; Cochran 1988; Grasmick, Bursik & Cochran 1991; Perkins 1985; Rohrbaugh & Jessor, 1975; Tittle & Welch, 1983). In fact, the evidence was so convincing that Stark (1984) changed his opinion, stating that religion was indeed negatively associated with some forms of delinquency. A recent meta-analysis by Baier and Wright (2001) confirmed this view. After examining 60

studies, they concluded that religious beliefs and behaviors had a moderate deterrent effect on criminal behavior.

Scholars have since offered different explanations for the contradictory research outcomes on the religiosity – delinquency association. Burket and White (1974) conducted a study similar to the one by Hirschi and Stark, adding one variable – adolescents' self report of alcohol and marijuana use. Whereas they found no association between religiosity and other crimes, there was a negative relationship between religiosity and the use of alcohol and marijuana. These findings led them to the conclusion that the former results applied only to offences against persons and property, and not to victimless crimes, such as marijuana and alcohol use. Similar conclusions were reached by McIntosh, Fitch, Wilson and Nyberg (1981), as well as by Linden and Currie (1997) who partially replicated the work of Hirschi and Stark with Canadian adolescents, adding self-reported drug use. All of those studies found that although generally, adolescents who attended church were as likely as others to commit crimes, when it came to drug use religion had an inhibitory impact.

Along similar lines, Cochron, Wood and Arneklev (1994) stated that the challenge to the religiosity-delinquency association came from two major sources. Arousal theorists (Ellis, 1987) claimed that some people were neurologically predisposed to criminality, and their stimulus-seeking behavior directed them away from religiosity. Social control theorists (Elifson, Peterson & Hadaway, 1983) argued that religion did not constitute an inhibitory force in itself; rather, it was mediated by peers and familial influences. Cochran et al. tested the association

between religiosity and deviance, controlling for impulsiveness and for secular means of social control. Their data too showed that, although the effect of religiosity was greatly reduced for other crimes, it remained significant with regard to legalized substances. Similar results were reached by Kendler, Gardnere, and Prescott (1997) in a study with female twins.

Another argument offered to explain the contradictory outcome in the religiosity – delinquency studies stated that while religion was a complex, multileveled construct, many researchers reduced it to just one or two variables such as church attendance or religious salience. When the multidimensional nature of religion was taken into consideration, the results clearly pointed to a negative relationship between religiosity and deviant behavior, specifically drug use and dependence (Chadwick & Top, 1993; D'onforio et al., 1999; Kendler, Gardner & Prescott, 1997; McIntosh et al., 1981; Mullen & Francis, 1995). In addition, some claimed that even in studies where substance abuse was included, the focus was often on alcohol and marijuana only, ignoring the complex forms of drug use by adolescents today (Cochran 1991; McIntosh et al., 1981; Mullen & Francis, 1995), an approach that may lead to the wrong conclusions.

In spite of the above-mentioned shortcomings, most existing research has shown that religiosity does play a role in inhibiting substance use by adolescents. There are, however, differences of opinion as to the mechanisms by which this influence is mediated. The CASA (Center on Addiction and Substance Abuse) National Survey of American Attitudes on Substance Abuse IV (1998) revealed dramatic differences in substance abuse between teens who attended religious

services regularly and those who rarely attended. In the words of Joseph Califano Jr. "For three years in a row the survey has shown that religion – Catholic, Protestant, Jewish, Muslim – is a key factor in giving our children the moral values, skill and will to say 'no' to illegal drugs and alcohol" (p. 2).

Rohrbaugh and Jessor (1975) stressed the role of religion in adding meaning and purpose to one's life, in affording social contacts with individuals of the same values, and in serving as a standard for right and wrong. The authors conducted a study to examine the function of religiosity against transgression, based on two parallel longitudinal studies of high school and college students. The data demonstrated a significantly positive correlation between religion and measures of personal control, as well as with the number of reasons stated against marijuana use. Similarly, data from a study by Linden and Currie (1977) with Canadian adolescents demonstrated that religious ties were a factor in reducing elicit drug use. The authors explained that adolescents who frequented church activities, developed stakes in conformity by associating with people of conventional values.

In a later address on risk behavior in adolescents, Jessor (1991) suggested that risk behaviors, including drug use, may be motivated by positive outcomes such as social acceptance by peers, a sense of autonomy and maturity, and a way of coping with frustration and stress. In that case, drug use was not likely to be abandoned in the absence of alternative behaviors that will bring about similar results. Jessor pointed out that many adolescence who grew up under adverse conditions and intense pressure towards deviance were able to overcome those conditions. Their successful transition to adulthood was due to the fact that the

exposure to risk experiences was countered by protective factors, such as models for conventional behavior and an environment of strict social control. Those protective experiences can be provided by conventional institutions such as the church, and serve as a vehicle for lifestyle change to protect against risk factors.

Some researchers tested the influence of religiosity in comparison with other factors of social control. A study by McIntosh et al. (1981) regarding the influence of religion on rural and urban students' drug use, included other social control factors, such as peer and parental drug behavior to determine the relative effect of religiosity. Their findings suggested that religious commitment was one of the more powerful forms of social control helping to prevent drug use. Amoateng and Bahr (1986) also compared the effects of parents' education, mother's status, number of parents in the household, gender, race and religiosity on use of alcohol and marijuana. Levels of religiosity had the most significant association with levels of use, and involvement in a religious network reduced the probability of ever trying those substances. A later study by Bahr, Maughan, Marcos and Li (1998) confirmed religion to be a protective factor against friends who used drugs and alcohol.

Yorland (1999) conducted a similar study to examine cocaine use by Miami adolescents. She included religiosity, family related influences, and awareness of the risks associated with cocaine use. She also added school related factors such as involvement in music, participation in school clubs and academic success. She too found religion to be the only statistically significant variable to inhibit the use of cocaine. Surprisingly, her data demonstrated that awareness of the risks of the

drug did not decrease, and occasionally even increased its use, suggesting that those adolescents who used drugs were not always capable of making rational decisions concerning cocaine use. Inspired by this outcome, Yorland suggested that some level of tolerance by school administrators towards religious beliefs of students might help with the enormous dilemma of drug use.

Other studies took into consideration the multileveled nature of religion and the complexity of drug use. One of those conducted by Mullen and Francis (1995) utilized a multilevel test of religiosity in association with a range of drugs. Their data demonstrated that when measuring religiosity in terms of both implicit and explicit dimensions, it proved to be a significant predictor of attitudes toward drug use by adolescents.

Similar results were reached by Miller, Davis and Greenwald (2000), who found that a feeling of a personal relationship with the Divine and affiliation with fundamentalist religious denominations were inversely associated with substance use and dependence across a range of substances, including alcohol, marijuana, cocaine or any contraband drug. The authors elaborated on the potential effect of religion on the adolescent who was at a stage of search for identity, meaning and purpose in life. According to studies on AA and NA, personal devotion enhanced spiritual fulfillment and emotional well being. The authors cited Groeschel (1983) who referred to this stage as a window of spiritual "awakening and struggle." In the absence of religion, the struggling adolescent who is yearning for mystical inspiration may turn to substance abuse, in the false hope of satiating his thirst for spirituality.

Bargin, Stinchfield, Gaskin, Maters and Sullivan (1988) reported results of a case-by-case assessment of religious college students, in a study concerning relations between religion and mental health. The participants followed a life-style entailing self-control, with religion being their major guideline. The following are some of their remarks. L., a young woman who said that the scripture guided every aspect of her life, stated: "I know where I'm going and I know the overall plan." She said that she lived a well-regulated life in which self-discipline was balanced with self-expression. S., another woman, stated that making decisions or monitoring self-control in the face of temptation was no problem for her. She added that religion was the most stable element in her life, a fact of extreme importance to her since she grew up in an unstable family. E. was a young man who grew up in a family with a great deal of violence and chaos, resulting in a personal sense of alienation. He performed badly in school and became rebellious and angry. After joining a religion on his own initiative, he became involved with the social system of that religion, developed friendships and ended up being elected president of his school's student body. G., another student, stated that in his earlier years his parents provided him with love, but not with parental guidance. He was susceptible to peer pressure and started using drugs. Although he enjoyed the freedom, his life had no real direction or meaning. At some point he joined a religion and his lifestyle changed from one of substance abuse, depression and lack of self-esteem to a life of meaning and purpose. This study demonstrates the capacity of religion to provide guidance, meaning and a sense of self-worth to one's life.

Purpose of the Study

Adolescent substance abuse has been on the rise for the past three decades, constituting a major social and health problem in this country. It has been connected to high school drop out, delinquency and teen suicide. Studies revealed the reasons to be of a wide range including learning disabilities, lack of self-worth and purpose in life, absence of bonds to normative institutions and interest in materialistic rather than spiritual concerns. In spite of great efforts, interventions are scarce and only a few have shown to be effective.

Researchers have found religion to be an important factor in reducing involvement with substance abuse. Both by virtue of its moral values and as a means of social and personal control, it seems to serve as a buffer against substance abuse.

The primary hypothesis of this study is that drug-abusing adolescents will have a better chance of recovery if, in addition to conventional drug therapy that relies heavily on the 12-step program, they will also receive religious guidance, in this case, within their school. This type of school affords the opportunity to provide a holistic approach to treatment, dealing with many of the basic causes of drug abuse. As a result, it is expected to enhance moral values and to provide a sense of purpose in life, and through its social network to induce feelings of belonging, self-fulfillment and a motivation to stay drug free.

Due to the small number of participants, the purpose of this investigation is to serve as a pilot-study, to test the contribution of a religious context to therapy outcome in substance abusing adolescents. Although many studies examined the

association between religion and adolescent substance abuse, no study has measured both religiosity and drug use at baseline and at the end of therapy, to compare the relative increase or decrease of one against the other. In addition, this study is unique in terms of the participants who were Jewish orthodox adolescents. Furthermore, religiosity was considered from a multilevel perspective, measuring both religious principals and practices. A similar approach was applied in measuring dependence and abuse, taking into consideration the complex nature of alcohol and drug use by today's adolescents.

Method

Participants

The school where the study took place was a parochial alternative high school for Jewish adolescent boys, involved in drug and alcohol abuse. The majority of students were from Brooklyn, some from other New York metropolitan areas, and a few from out of state urban settings. All were Caucasians of diverse populations, from low to middle class income. Some of the students had additional problems such as learning disabilities, emotional difficulties and a background of broken homes. Most qualified for Section - 504 accommodations, and a few were diagnosed with Special - Education qualifications. In the fall of 2000 the school enrolled sixteen students in grades nine through twelve, with the mean age of 15.7, all of whom participated in the study. Most came from religious homes and originally attended strictly religious yeshivas, but because of academic and behavioral problems, as well as involvement with drugs and alcohol, they were asked to leave. Most of them transferred from one school to another, while their addiction increased and their academic performance worsened until no school was willing to accept them, at which point they enrolled in the alternative high school. The following is a description of the school by the school psychologist:

"The students take Hebrew subjects in the morning which include prayer, Jewish law and Jewish philosophy, given by Rabbis with whom they develop a close relationship. Additionally, they take secular classes in the afternoon to prepare them for a high school diploma. The heart of the program consists of therapeutic

intervention to help towards recovery, while providing a supportive environment. The school works together with an agency that provides a comprehensive treatment program for chemically dependent persons and their families. The boys get individual counseling and group therapy as well, consisting mainly of the 12-step approach of abstinence, one-day-at-a-time, and spiritual awareness. In addition, there is a comprehensive community meeting that takes place every morning, and another brief one at the end of the day, in the course of which important issues are raised and relationships amongst students and between students and staff are nourished. There are mandatory family meetings as well on a weekly basis, to discuss substance abuse and other issues pertaining to those students. At times of crisis, a student and his family may be confronted and made to realize that a bottom has been reached and residential care will be beneficial.

The high school program is diploma - bound. The students' records are carefully reviewed and a multi-year plan is developed. Academic support services are available. Every student is given a psycho-educational screening and, when a learning disability is suspected, a full battery is administered. The results are used to develop an IEP for each student. For the students who enroll in the older grades with very few credits, completion of the GED is planned.

The school has been very successful with most of the students. The few who are too attached to their substance abuse habits and who don't try hard enough to conform to all the rules and to fully participate in the therapy program, eventually weed themselves out. However, the majority of the students stay on and usually, after the second year, begin to demonstrate progress in their substance abuse

problems which carries over to their academic performance. As a result, the majority of the students graduate, and a later follow-up shows that they all are functioning very well. Most are in college; some take Hebrew studies in different yeshivas, and some are working and going to school, but all have a serious commitment to abstinence, health, and spirituality. Some become role models held in high-esteem by the young students of the school, and occasionally speak at conferences on youth-at-risk. According to the staff, it is the most rewarding feature of the entire experience to see those nineteen year olds flourish, and come back to offer support and encouragement to pupils enrolled in the program."

Questionnaires

Two Likert-type questionnaires were used. The first, the Student Religiosity Questionnaire, was developed and tested by Katz (1988) for research with samples of individuals of the Jewish religious tradition. The test contained twenty items reflecting two dimensions of religiosity: religious principles and religious practices. Both were assessed on a 5- point scale ranging from 'minimal agreement' to 'maximal agreement' for the religious principles, and from 'minimal observance' to 'maximal observance' for the religious practices. The scale yielded a Cronbach's alpha of .89 when tested on a sample from South Africa and .91 for a sample of eleventh grade Israeli students.

The second questionnaire was taken from the SUDDS-IV (Substance Use Disorders Diagnostic Schedule) by Hoffman and Harrison (1995), and contained two detailed questions. One question measures alcohol consumption in terms of frequency of use, number of drinks and the length of time since last intoxicated. The

second question dealt with drug abuse, including use of cannabis, cocaine, amphetamine, sedatives, heroine, inhalants, PCP, hallucinogens and other prescription medicine, assessing frequency of use and length of time since last taken (see appendices A and B).

Procedure

Both questionnaires were administered to the students twice, the pretest in December and the posttest in June. Parents were notified, students' names were omitted, using numbers instead, and the students participated willingly after confidentiality was assured. Sixteen students took the pretest and fourteen took the posttest since two of the students were no longer in the program by the end of the school year. The data were analyzed using dependent t tests, followed by Chi – square analysis to determine the significance of change between December and June. In addition, this study looked at the relationship between changes in religiosity and changes in substance abuse, which was the subject of the primary hypothesis. This was analyzed with a Chi-square, to determine the significance of the religiosity-substance abuse association.

Results

A comparison between the pretest and the posttest, in reference to alcohol use, revealed that seven boys reduced their intake, three stayed unchanged and four increased their use of alcohol. However, in reference to drugs, eleven students decreased their use and only three students increased it. (see appendix C for raw data)

Two dependent t tests were performed to determine if the decrease in alcohol and drug use between December and June was significant. The results were as follows:

The mean alcohol use for December was 13.1 and the mean alcohol use for June went down to 11.5. This difference was not statistically significant at the .05 level ($t = 1.47, 13$, ns). A one way Chi – square was then performed, to examine whether the number of people who improved was statistically different from the number of those whose use increased or stayed unchanged. The results were non-significant and confirmed the t test.

For drug use, the December mean was 44.86 and the June mean decreased to 38.21. This was not significant at the .05 level ($t = 1.83, 13$, ns). However, a one way Chi-square which compared the eleven students who reduced their drug use with the three who increased or remained the same, indicated a significant difference between December and June (Chi-square = 4.57, 1, .05).

The results were impressive considering that this was not a residential program, and all students returned home at the end of the day. In addition, although great emphasis was put on drug and alcohol therapy, there was a full

program of religious and secular studies accredited by the New York State Board of Regents, and over the past two years, most of the twelfth grade students have graduated with a high school diploma, continuing in different colleges and yeshivas.

Analysis of the data on the connection between religiosity and substance abuse, using Chi – square, showed that there was an inverse relationship between religiosity and drug use. Four of the participants went up in their religiosity, and all of them showed decrease in drug use. The other ten participants went down or did not change in their religiosity. Of those, eight showed a decreased in their drug use while two showed an increase. (The results are presented in table 1).

Therefore, whereas the primary hypothesis was not supported, there was a trend that warranted further investigation. It is important to take into consideration the fact that even the students whose religiosity did not increase, were nevertheless treated within a religious environment.

Table #1

	Religiosity up	Religiosity same or down
Drugs up	0	2
Drugs down	4	8

Chi-Square = 8.80
p = <.05

The same trend, however, did not emerge concerning alcohol use. While the sample as a whole decreased their alcohol consumption, there was no relationship between changes in religiosity and changes in alcohol abuse. Some of the students

whose religiosity increased went down in alcohol consumption, but others went up or stayed unchanged.

Discussion

Numerous studies have found religiosity to be negatively related to substance abuse. The current study tried to take this claim one step further, to investigate whether increased religiosity in adolescence is associated with substance abuse therapy outcome.

The results, while not confirming this hypothesis, do offer suggestive data that none of the adolescents who increased their religiosity increased their drug use. However, there was no relationship between religiosity and alcohol use. A number of inferences and questions emerge, some with implications for therapy, as well as for future research regarding substance-abusing adolescents.

In light of the studies mentioned in the literature review, a stronger impact of religiosity was anticipated. As suggested by the above- mentioned researchers, religion might exert a direct influence in providing more guidance, and in adding purpose and meaning to one's life. Or, as others suggest, its influence may be mediated by means of social control. It has been claimed that the impact of religion is more evident when treated as a complex construct, considering its multileveled function. In addition, some scholars point out the special receptiveness of teens, who are at a stage of spiritual awakening to the influence of religiosity.

The Jewish religion contains all of the above qualities. With its many commandments it provides constant guidance, embracing every aspect of life, yet rather than taxing it is potentially fulfilling. The requirements are not geared to restrict the individual but to actualize the full potential of the human personality. As stated by the great Jewish philosopher, Rabbi Yehuda Halevi (1100) in his

renowned work the Kuzari, "The Torah does not burden us with abstinence, rather provides balance, giving every aspect of body and soul its appropriate share without overindulgence..." (p. 113).

The orthodox Jewish community is a close-knit one, with a well-organized network. This provides many social opportunities for the young adolescent to form friendships with youth who share the same beliefs, enhancing each other's values in the process.

Finally, the Jewish religion is sensitive to the spiritual and emotional needs of the adolescent. Unlike other societies, the rite-of-passage occurs at an early age, 13 for boys and 12 for girls, corresponding to the intellectual and emotional development of this age. The teenager is granted full responsibility to keep the commandments, and is considered an adult in almost every aspect of life. Rather than celebrating his maturity by providing him with materialistic privileges, the Torah is sensitive to his spiritual and emotional needs as well, enhancing his genuine sensitivity and nurturing his budding moral judgement before it is corrupted by society.

A possible reason as to why the results have not confirmed the hypothesis is the small number of participants and the fact that there was a difference between the way drug therapy and religious teachings were presented. The therapy was constantly enforced and monitored. The boys were administered drug tests regularly with consequences when not passing them, and it was made clear to them that they would be sent to rehabilitation if they did not comply. The religious portion was delivered with a different method. The boys were not made to comply

with religious observances, and they continued to behave as they previously had. This approach was based on the expectations that as the process was happening, the students were gradually imbibing the religious values and a change was taking hold of them little by little, out of their own conviction, until it became effective.

Since there were only six months between the pretest and the posttest, the boys who came to the school as 'rebels' against their previous Yeshivas and the religion they associated them with, did not yet view themselves as religious at that point. However, they were apparently influenced by the religious environment they were in which might have affected their substance abuse. Although they did not view themselves as being more religious when taking the posttest, anecdotal data showed that most increased their religiosity within the following year.

One obvious question resulting from the above findings concerns the fact that there was no impact of religiosity on alcohol use, and while this study found that religion was associated with drug use, it failed to do the same for use of alcohol. Considering that both are unhealthy, addictive substances, and assuming that they were treated to the same extent, it would be sensible to expect similar results. What then could account for the gap between the findings regarding alcohol and drug use? Some of the more extensive studies in this area have touched on the same question, and their findings may provide insight that will help explain the difference.

Different studies demonstrated that the controlling effect of religion grows with the seriousness of the drugs, and that specific beliefs about the sinfulness of drugs mediate the relationship between religiosity and substance abuse.

Accordingly, while religious salience and affiliation with the church were among the most powerful predictors of hard drug use, the effect was only modest when it came to soft drugs (D'Onofrio, et al., 1999; McIntosh et al., 1981). Similarly, the study by Mullen and Francis (1995) demonstrated that although religiosity is a significant predictor of attitudes towards drug use, the attitudes varied considerably from one drug to another. While four out of five adolescents believed that it is wrong to use heroin or marijuana, only half believed that it is wrong to become drunk. Cochron (1991) reached an interesting conclusion when he observed a stronger impact of religiosity on adolescent drug use than on the use of alcohol. He suggested that data on alcohol may be affected by the use of wine, which is viewed differently than the use of alcohol in general, due to its ceremonial and recreational use. Along similar lines, different studies demonstrated that various denominations defer markedly in their position on the legitimacy of moderate alcohol use, and as a result the use varies according to denominational identification. The religious group that taught abstinence from alcohol had the lowest rate of alcohol use (Amoateng & Bahr, 1986; Nelsen & Rooney, 1982).

The above findings may explain the resulting difference of religion's impact on drug and alcohol abuse. The Jewish religion has an interesting approach to the use of wine. On the one hand, wine is used in many religious ceremonial occasions, including opening and closing of the Sabbath, every holiday, weddings and similar occasions and is considered a medium for happiness (Psalms 104). At the same time, the Torah stresses the danger of over-indulging with wine. The book of Genesis relates the two detailed incidents of Noah and Lott who drank too much wine and

the dreadful results they suffered (Genesis 9 and 19). The Torah even advises that when a person feels that he is getting out of control, he should temporarily abstain from wine (Numbers 6). A similar view concerning indulgence with wine is found in the Prophets (Isaiah 5), in the Mishnah (Avos 3) and numerous times in the Talmud. This approach is in line with the way the Torah views human nature, recognizing the vulnerability and at the same time the great potential of man. When concentrating on his own self-awareness, each individual is expected to find the right balance between abstinence and over-indulgence.

Another question that arises is the following: Since religion can have a positive impact on the effectiveness of drug therapy, why didn't it prove effective in preventing these youngsters, who have a religious background, from getting involved with drugs in the first place? There may be a few answers to this question:

- As mentioned before, some of the students were learning disabled. As such, they had cognitive problems which made it harder for them to generalize new concepts. They were more susceptible to peer-pressure as well. Although they had been in religious schools, they had not been taught explicitly about the dangers involved in drug use and how to resist pressure to join drug-abusing peers.
- Religious commitment has generally led the observant to become morally strong and emotionally healthy (Koenig, Kvale, & Ferrel, 1988). However, it is important for parents and educators to be aware of the many pitfalls today's youngsters face, and the mixed messages they are subjected to. While the Torah emphasizes that man is responsible for his own deeds and is obligated to seek truth and follow it, society leads him to believe that he may act in whichever way that 'feels' right,

discouraging him from inner search and from seeking the right advice. As a result, many youngsters will not agonize about the appropriateness of drug use or its ramifications. It is therefore important to provide clear guidance, specifying the rules concerning drug and alcohol use and explaining the reasons behind them.

Scholars offered additional explanations to the involvement of adolescents with religious background in drug use. Worthington (1989) posits that not all parents are equally effective in conveying religious beliefs to their children. Moreover, parents who exert pressure on children to fit a specific mold, may cause them to rebel and adopt a "negative identity" (Arikson, 1968) seeking alternative, even deviant lifestyles.

One of the issues many adolescents deal with is their search for identity. This may be even more of an issue for boys who have been stigmatized due to their low academic achievement, or their dysfunctional home background. According to the study mentioned earlier by Anderson and Mott (1998), drug related identity change begins with experiences of inferiority that cause identity discomfort. When not meeting the desirable religious expectations of their parents and the community, some adolescents are motivated to search for an identity of their own in which the standards are more easily met. From that point on the downhill road to the drug sub-culture is hard to avoid. A vicious cycle then emerges where in order to reduce guilty feelings, the adolescent diminishes his religiosity (Benda 1997), which increases his level of comfort in this new behavior. This phenomenon should alert parents and teachers to be less rigid and more accepting when the teenagers'

behavior does not meet the highest standard, in order to avoid pushing them further away.

The school tries to address the above problems. Being a small private school where many of the boys have learning problems, there are no separate classes for L.D. students, and as a result they don't feel stigmatized while their needs are being met. In addition, the school teaches religious ideology and practices in a precise and explicit way, explaining the commandments in detail and showing how they are derived from their Biblical sources, and the relevance and benefits of observing the commandments are emphasized using concrete examples. In doing so, the school is utilizing Vygotsky's principle (cited in Braten, 1986) that school instructors should induce generalization of learning by teaching concepts systematically, rather than relying on the student to form his own "spontaneous concepts." To instill values, questions are encouraged, unlike in some other yeshivas, and lively discussions ensue about right and wrong. These discussions led by the teachers expose the students to higher levels of moral reasoning, which according to Kohlberg (cited in Worthington, 1989) can stimulate them to reach a higher stage of moral judgment.

Significance of study

Since adolescent substance abuse constitutes a major problem in the United States, and few intervention programs have been found to be effective, positive results of this study can add an important contribution to current intervention programs.

The implications can be of particular importance to school psychologists, who are in a position to consult, recommend, and intervene regarding substance

abusing adolescents. When in the right setting, such as a parochial school, it is important to be aware of any additional instrument that could be used in this important battle.

Limitations

This study was limited by the small number of students that participated, and by the fact that they were all boys of the Jewish faith. Additional research is needed to investigate whether the same methods will work with girls, and with youth from different religious backgrounds in other setting. It would also be important to investigate this issue with the inclusion of control groups, for example, to compare aspects of morality, ethics, and values associated with or independent of specific religious backgrounds, and their effect on substance abuse.

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Appendix A

Student Religiosity Questionnaire

Directions: For the following activities, rate your degree of observance from 1 (minimal observance) to 5 (maximal observance).

1	2	3	4	5	Sabbath observance
1	2	3	4	5	Inter-sex socializing
1	2	3	4	5	Dietary laws—observance at home
1	2	3	4	5	Dietary laws—observance out of home
1	2	3	4	5	Observance of days of mourning
1	2	3	4	5	Observance of fast days
1	2	3	4	5	Grace before meals on Sabbath
1	2	3	4	5	Sabbath prayers
1	2	3	4	5	Tabernacles festival observance
1	2	3	4	5	PASSOVER observance

Directions: For the following religious principles, rate your degree of agreement from 1 (minimal agreement) to 5 (maximal agreement).

1	2	3	4	5	Biblical miracles
1	2	3	4	5	Rabbinical authority
1	2	3	4	5	Reward and punishment
1	2	3	4	5	Individual supervision by God
1	2	3	4	5	Resurrection of the dead
1	2	3	4	5	Creation ex nihilo
1	2	3	4	5	Oral law
1	2	3	4	5	Messianic era
1	2	3	4	5	Divine law
1	2	3	4	5	Prophecy

Appendix B

Substance Use Disorders Diagnostic Schedule

16. During the past 12 months, on average how often do you drink alcohol?

    1 Never drank alcohol *(Go to #22)*
    2 Have not had a drink in the past year *(Go to #20)*
    3 Less than once a month
    4 At least once a month
    5 1 to 2 days a week
    6 3 to 4 days a week
    7 5 to 6 days a week
    8 Every day

17. When you drink, how many drinks do you usually have?

    Note: "Drink" refers to a mixed drink, bottle/can of beer, glass of wine, or the equivalent of about ½-ounce of pure alcohol.

    1 1 or 2
    2 3 or 4
    3 5 or 6
    4 7 or more

18. How long has it been since you had a drink?

    1 Within the past day
    2 2 to 7 days
    3 8 to 30 days
    4 1 to 6 months
    5 7 to 12 months
    6 More than a year ago

19. How long has it been since you were last intoxicated?

    1 1 to 7 days
    2 8 to 30 days
    3 2 to 6 months
    4 7 to 12 months
    5 Over a year ago

In the past 12 months, how often did you use (drug)?
Code frequency of use according to the following:
1 = Every day
2 = 5 to 6 days a week
3 = 3 to 4 days a week
4 = 1 to 2 days a week
5 = At least 12 times a year
6 = Fewer than 12 times a year
7 = Never used

☐ Cannabis (Hashish, Marijuana, Pot, Grass)
1 2 3 4 5 6 7

☐ Cocaine (Coke, Crack)
1 2 3 4 5 6 7

☐ Amphetamines - Stimulants (Speed, Uppers)
1 2 3 4 5 6 7

☐ Sedatives -- Hypnotics -- Tranquilizers (Barbiturates, Sleeping Pills, Seconal, Quaaludes, Tranquilizers, Valium, Librium, Xanax)
1 2 3 4 5 6 7

☐ Heroin - Opioids (Codeine, Demerol, Morphine, Methadone, Darvon, Opium, Dilaudid)
1 2 3 4 5 6 7

☐ Inhalants (Huffing, Paint, Glue, Aerosols, Butane)
1 2 3 4 5 6 7

☐ PCP (Angel Dust)
1 2 3 4 5 6 7

☐ Hallucinogens (LSD, Mescaline, Peyote, Psychedelics, Psilocybin, DMT)
1 2 3 4 5 6 7

☐ Other, Unknown, or Mixed (other prescription medications, steroids, antihistamines)
1 2 3 4 5 6 7

For each substance used ask:
How long ago did you last use (drug)?
Code recent use according to the following:
1 = Within the past day
2 = 2 to 7 days
3 = 8 to 30 days
4 = 1 to 6 months
5 = 7 to 12 months
6 = More than one year
7 = Never used

Cannabis (Hashish, Marijuana, Pot, Grass)
1 2 3 4 5 6 7

Cocaine (Coke, Crack)
1 2 3 4 5 6 7

Amphetamines - Stimulants (Speed, Uppers)
1 2 3 4 5 6 7

Sedatives -- Hypnotics -- Tranquilizers (Barbiturates, Sleeping Pills, Seconal, Quaaludes, Tranquilizers, Valium, Librium, Xanax)
1 2 3 4 5 6 7

Heroin - Opioids (Codeine, Demerol, Morphine, Methadone, Darvon, Opium, Dilaudid)
1 2 3 4 5 6 7

Inhalants (Huffing, Paint, Glue, Aerosols, Butane)
1 2 3 4 5 6 7

PCP (Angel Dust)
1 2 3 4 5 6 7

Hallucinogens (LSD, Mescaline, Peyote, Psychedelics, Psilocybin, DMT)
1 2 3 4 5 6 7

Other, Unknown, or Mixed (other prescription medications, steroids, antihistamines)
1 2 3 4 5 6 7

IF NO USE OF A DRUG IS REPORTED, BUT ALCOHOL USE WAS REPORTED, GO TO #24. CONTINUE INTERVIEW ABOUT ALCOHOL

Appendix C

Changes in Drugs & Alcohol intake from December to June				
Subject	Drugs		Alcohol	
	Dec.	*June*	*Dec.*	*June*
# 1	67	*40* *	21	12 *
# 2	26	53	19	23
# 3	46	33 *	14	14 *
# 4	46	39 *	15	10 *
# 5	47	37 *	14	12
# 6	29	26 *	2	2
# 7	22	23	13	17
# 8	69	27 *	8	2 *
# 9	29	26 *	16	13 *
# 10	23	18 *	1	1
# 11	69	66 *	13	17
# 12	40	44	19	14 *
# 13	45	28 *	13	14
# 14	84	75 *	16	10 *
* Substance use went down				

CG

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