CEU MATRIX
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

FAITH-BASED SUBSTANCE ABUSE TREATMENT

3 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Beginning

Course Author: Robert A. Shearer, Ph.D.

Last Updated: 2026

Approved by such credentialing bodies as:

• National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564

• National Board of Certified Counselors (NBCC) #6310

All approval bodies are listed at ceumatrix.com/accreditations

For questions or to request accessibility accommodations please email us at: support@ceumatrix.com

Welcome to CEU Matrix. We have been committed to supporting the continuing education of behavioral health professionals since 2007. Please reach out with any questions, ideas, or feedback.

Do the best you can until you know better.
Then when you know better, do better.

— Maya Angelou

COPYRIGHT

ABOUT THE INSTRUCTOR

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of Interviewing: Theories, techniques, and practices, 5th edition published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the Journal of Addictions and Offender Counseling as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

Faith-Based Substance Abuse Treatment: Current Research and Evolving Evidence

The framework for understanding faith-based substance abuse treatment described in this course, spanning definitions of faith-based programming, the distinction between religiosity and spirituality, the faith-crime relationship, cognitive restructuring through 12-step programs, and the critical issues surrounding program effectiveness, has been significantly advanced by recent empirical research. Since this course was published, studies with substantially larger samples, longer follow-up periods, validated measurement instruments, and cross-cultural designs have produced findings that both strengthen and complicate the evidence base for integrating spiritual and religious elements into substance use disorder treatment.

The question of whether spirituality actually reduces craving, a mechanism this course identifies as central to the incompatibility and addicted-self models, was examined in the largest study of its kind to date. A 2026 latent change score analysis of 25,735 participants across 73 treatment centers found that spirituality levels increased and craving levels decreased during the first month of substance use disorder treatment. However, the relationship was not what many practitioners would expect: spirituality did not predict subsequent changes in craving. Instead, higher baseline craving predicted smaller increases in spirituality early in treatment, suggesting that the intensity of early-treatment withdrawal and craving may interfere with clients' capacity to engage with spiritual programming (Rabinowitz et al., 2026). For practitioners in faith-based programs, this finding has direct clinical implications. The first week of treatment represents a critical therapeutic window, but clients experiencing the most severe craving may be the least able to benefit from spirituality-focused interventions during that period. Programs that front-load spiritual content before addressing the acute biological dimensions of craving may be working against the natural trajectory of early recovery.

The concept of "Surrender to God", a construct closely aligned with the 12-step emphasis on acknowledging powerlessness and turning one's will over to a higher power that this course describes in detail, was examined in a 2026 longitudinal study tracking 177 participants from a Christian treatment facility across one year with assessments at 1, 6, and 12 months post-discharge. The researchers measured surrender both explicitly through self-report and implicitly through an association task. Implicit measures of surrender predicted decreased odds of relapse at longer follow-up periods, while explicit self-report measures showed stronger predictive value for short-term relapse risk (Seesink et al., 2026). For the faith-based treatment framework described in this course, this finding is clinically important: clients who verbally endorse spiritual surrender may be demonstrating compliance rather than internalization, precisely the distinction this course raises when discussing sincere versus insincere motivations for faith-based program participation. The implicit measures may be capturing a deeper level of spiritual integration that self-report alone misses, and this distinction matters for program evaluation. Treatment programs relying exclusively on clients' verbal endorsement of spiritual transformation may be overestimating genuine change.

The cross-cultural applicability of the spirituality-recovery relationship, a question this course addresses primarily within the American context, received important evidence from a 2025 cohort study of 120 methamphetamine users in a Japanese 12-step residential treatment program followed over five years. Higher spirituality was significantly associated with long-term methamphetamine abstinence, and substance use severity did not moderate this effect. The authors concluded that spiritual development

supports recovery regardless of cultural context (Ofuchi et al., 2025). For the theoretical framework in this course, which acknowledges that faith-based approaches have shown "limited success outside traditional Judeo-Christian populations," the Japanese findings suggest that the spiritual mechanisms underlying 12-step recovery may operate across religious and cultural traditions more broadly than previously assumed. The 12-step framework's emphasis on a "higher power" rather than a specific deity may provide sufficient flexibility for cross-cultural adaptation, a finding relevant to the multiculturalism and diversity considerations this course identifies as a critical issue for faith-based programming.

The experience of spiritual awakening in 12-step recovery, the transformative shift this course describes through the lens of cognitive restructuring and the maintenance steps, was examined in a 2023 study of 115 residential aftercare residents. Individuals who reported experiencing a spiritual awakening demonstrated greater self-efficacy and hope compared to those without this experience, along with increased AA involvement and reduced negative facility exits (Bell et al., 2023). For the cognitive restructuring framework this course presents, mapping the 12 steps to the process of challenging distortions, restructuring powerlessness, and maintaining recovery, the Bell et al. findings provide empirical grounding for what the course describes theoretically. Spiritual awakening does not merely represent a subjective religious experience; it correlates with measurable psychological resources, self-efficacy and hope, that the broader addiction treatment literature identifies as protective factors against relapse. The finding also supports this course's discussion of the threshold effect: sufficient engagement with the 12-step process may be required before the spiritual transformation produces measurable changes in psychological functioning.

The faith-based residential treatment model, which this course defines across the spectrum from faith-saturated to faith-secular partnership, was evaluated in a 2026 retrospective cohort study of 380 women at The Lovelady Center, a large faith-based residential recovery program in Birmingham, Alabama serving women with substance use disorders and histories of incarceration and abuse. Length of stay was a key predictor of successful completion with sustained sobriety, and all-cause mortality at 24 months was lower among program graduates who remained in residence (1.35%) than in the initial cohort of clients still progressing through the program's phases (3.45%) (Dooley et al., 2026). For the critical issues this course raises, particularly selection bias, effectiveness measurement, and the challenge of determining whether program effects are due to faith content or to the structure and duration of residential treatment, the Dooley et al. study illustrates both the promise and the methodological limitations of faith-based program research. The dose-response finding (longer stays predicting better outcomes) is consistent with the threshold effect this course describes, but the retrospective design cannot determine whether the faith component specifically drove outcomes or whether any structured residential program of equivalent duration would produce similar results. This is the core evaluation challenge this course identifies, and it remains unresolved.

The measurement of religious coping in substance use disorder populations, essential for the kind of rigorous program evaluation this course advocates, was advanced by a 2026 validation study of the Brief Religious Coping Scale among 1,290 residential treatment participants. Confirmatory factor analysis supported a two-factor structure distinguishing positive religious coping (turning to God for comfort and meaning) from negative religious coping (feeling abandoned or punished by God). The instrument demonstrated reliability across sex and time, and the two coping types showed differential associations with psychological outcomes (Manzler et al., 2026). For the skills, knowledge, and attitudes framework this course describes for faith-based program staff, the validated distinction between positive and negative religious coping has direct clinical application. Clients in faith-based programs who exhibit

negative religious coping, viewing their addiction as divine punishment or feeling abandoned by God, may be experiencing the distorted religious views this course discusses in the section on faith-based cognitive programs. Identifying these maladaptive religious cognitions through validated instruments, rather than clinical impression alone, gives faith-based program staff a systematic tool for targeting the cognitive restructuring that this course positions as central to effective treatment.

Does the 12-Step Approach Actually Work?

This course treats the 12-step model as the dominant faith-influenced approach to substance use treatment, and the question of whether it actually works has now been answered with unusual rigor. Kelly, Humphreys, and Ferri (2020) conducted a Cochrane systematic review, the highest standard of evidence synthesis, examining Alcoholics Anonymous and 12-step facilitation for alcohol use disorder across 27 studies involving 10,565 participants. The finding was striking, because it overturned a longstanding assumption that 12-step approaches were popular but unproven. Manualized 12-step facilitation, meaning a structured clinical intervention designed to engage clients with Alcoholics Anonymous, produced higher rates of continuous abstinence than other well-established treatments including cognitive behavioral therapy, with a relative benefit of about 21 percent at twelve months, and that advantage held at twenty-four and thirty-six months. The review also found that 12-step facilitation produced healthcare cost savings compared with other treatments.

Two clarifications keep this finding accurate. First, the review concerned alcohol use disorder specifically, so its conclusions apply most directly to alcohol rather than to all substances. Second, the strongest results came from manualized 12-step facilitation delivered as a structured clinical intervention, not simply from telling a client to attend meetings. The distinction matters for a faith-based program. Referral works best when it is active and structured, meaning the counselor helps the client connect to a group, prepares them for what to expect, and follows up, rather than issuing a passive instruction to go find a meeting.

For the faith-based treatment framework this course presents, this evidence resolves a tension the course itself raises about program effectiveness. The 12-step approach, with its explicit reliance on a higher power and spiritual surrender, is not merely a popular folk remedy tolerated for lack of alternatives. On the best available evidence it performs at least as well as, and for sustained abstinence often better than, the secular clinical treatments it is usually compared against. This gives faith-based programs empirical grounding for an approach they have long used on faith. It also raises the evaluation question this course emphasizes, since the review could not fully separate the specific contribution of the spiritual content from the structure, fellowship, and behavioral change that 12-step involvement also provides. What is clear is that the model works. Precisely why it works remains partly open.

Religiosity and Spirituality as Protective Factors

Beyond formal treatment, this course examines the broader relationship between religiosity, spirituality, and substance use, and the population-level evidence on that relationship has now been quantified at a scale that earlier research could not approach. Koh and colleagues (2026) conducted a meta-analysis of 55 longitudinal cohort studies, together following 540,712 participants over time, to

test whether spiritual and religious engagement protects against harmful or hazardous substance use. The result was consistent and directional. Higher spiritual or religious engagement was associated with about a 13 percent reduction in the risk of harmful or hazardous alcohol and other drug use, and the protection was stronger, about 18 percent, among people who attended religious services more than weekly. The protective association held across alcohol, tobacco, marijuana, and other drugs, and the authors noted that virtually all of the many effects they examined pointed in the protective direction rather than the harmful one.

The consistency of this evidence is its most important feature. A single study showing that religious people use fewer substances could be explained away, but 55 longitudinal studies following more than half a million people, nearly all pointing the same way, describe a genuine and reliable pattern. Because these are longitudinal studies, which measure religiosity first and substance use later, they are stronger than simple snapshots, though they remain observational and cannot by themselves prove that religion causes the reduction.

For this course, the finding supports one of its central premises while demanding honesty about a limit. The premise it supports is that religiosity and spirituality are real protective factors, not sentimental add-ons, and that a client's faith can be a genuine recovery resource worth engaging rather than ignoring. The limit is causal. The studies cannot rule out that people already inclined toward stability and self-control are both more religious and less prone to substance problems, so a program should treat faith as a resource to support rather than as a guaranteed cause of recovery. The practical stance this evidence recommends is to take a client's religious and spiritual life seriously as part of their recovery capital, to help willing clients draw on it, and to do so without overpromising that faith alone will produce the outcome.

Integrating Spiritual and Religious Content Into Treatment

This course asks how faith-based approaches compare with and might integrate with cognitive behavioral therapy, and a meta-analysis of controlled trials speaks directly to that question. Hai and colleagues (2019) reviewed 20 randomized controlled trials, together enrolling roughly 3,700 participants, of interventions that deliberately integrated spiritual or religious content into treatment for substance use problems, including spiritually modified cognitive behavioral therapy and 12-step facilitation. Compared against other active treatments, the spiritual and religious interventions produced a small but statistically significant benefit, with an effect size of about 0.18. Compared against inactive controls such as no treatment, the effect was larger but did not reach statistical significance, in part because fewer studies made that comparison.

Honesty about the size of the effect matters here. An effect of 0.18 is small. It means that integrating spiritual content into treatment produces a real but modest additional benefit over other good treatments, not a dramatic transformation. The authors were candid about this and specifically called for more high-quality trials of spiritually integrated approaches that are not based on the 12 steps, because the evidence base for non-12-step spiritual integration remains thin.

For the faith-based practitioner, this evidence carries a balanced and useful message. It supports the legitimacy of integrating spiritual and religious content into treatment, since doing so adds measurable benefit rather than detracting from outcomes, which is not a foregone conclusion and refutes the concern

that faith content might dilute an evidence-based approach. At the same time, it cautions against overselling. Spiritually integrated treatment is a reasonable, evidence-supported option that modestly improves outcomes, and it can be combined with cognitive behavioral methods rather than opposed to them. It is not, on the current evidence, a categorically superior approach that should displace established clinical treatment. The most defensible practice is integration, drawing on the structure and skills of cognitive behavioral therapy while incorporating the spiritual content that many clients find meaningful and that the evidence shows adds value.

The Legal Boundary: The Establishment Clause and Coerced Faith-Based Treatment

This course identifies the separation of church and state as a critical legal issue for faith-based substance abuse treatment, and the case law on this point is now settled clearly enough that every practitioner in a faith-based or corrections-linked program needs to understand it. The governing principle comes from the Establishment Clause of the First Amendment, which prohibits the government from compelling participation in religious activity. Because Alcoholics Anonymous and Narcotics Anonymous rely explicitly on a higher power and on spiritual surrender, courts have repeatedly held that they constitute religious activity for constitutional purposes, however welcoming and nondenominational they may be in practice.

A consistent line of decisions has followed from this. In Griffin v. Coughlin (1996), New York's highest court held that conditioning a valuable prison benefit on participation in an Alcoholics Anonymous based program, with no secular alternative, violated the Establishment Clause. In Kerr v. Farrey (1996), the Seventh Circuit held that requiring an inmate to attend Narcotics Anonymous or face adverse parole consequences was unconstitutional coercion. In Warner v. Orange County Department of Probation (1997), the Second Circuit reached the same conclusion about Alcoholics Anonymous imposed as a probation condition. And in Inouye v. Kemna (2007), the Ninth Circuit held that a parole officer who forced a Buddhist parolee into Alcoholics Anonymous lost his qualified immunity, because the unconstitutionality of such coercion was by then clearly established law. Legal scholarship reviewing this line of cases, such as Meissner (2006), draws the same conclusion the courts did.

The unifying rule these cases establish is simple and practical. A government actor, meaning a court, a probation or parole officer, a prison, or a publicly funded program acting on the state's behalf, may not compel a person to attend Alcoholics Anonymous, Narcotics Anonymous, or any comparably religious program without offering a genuine secular alternative. A client mandated into treatment must have a real, non-religious option available, and choosing the faith-based program must be a true choice rather than the only path to avoiding a penalty.

For the faith-based practitioner, especially in the corrections-based settings this course discusses, the implications are concrete. Programs that receive court or corrections referrals must ensure that clients are offered a secular alternative and are not penalized for declining religious content. Documenting that clients were informed of alternatives and chose freely protects both the client's constitutional rights and the program's legal standing. This is not a reason to abandon faith-based work, which remains lawful and valuable when it is genuinely voluntary. It is a reason to build informed, documented choice into any program that operates in partnership with the justice system, so that the spiritual heart of the

program is offered rather than imposed.

Serving Clients Who Do Not Fit the Religious Model

This course acknowledges that faith-based approaches have shown limited success outside traditional religious populations, and the practical question that follows is what to offer clients for whom a higher power framework does not fit. The evidence now supports a clear answer, which is that effective secular alternatives exist and that clients can be matched to them. Zemore and colleagues (2018) conducted a national longitudinal study of 647 adults with alcohol use disorder, following them over a year, to compare the secular mutual-help groups Women for Sobriety, LifeRing, and SMART Recovery against traditional 12-step groups. The finding was reassuring for anyone trying to serve a diverse population. The secular alternatives produced abstinence and drinking outcomes broadly comparable to those of 12-step groups. What predicted better outcomes was not which group a person attended but how involved they became in it, along with holding a goal of complete abstinence.

This finding reframes the choice between faith-based and secular mutual help. The active ingredient common to all these groups appears to be involvement itself, meaning regular attendance, participation, and the social support and accountability that come with it, rather than the specific spiritual or secular philosophy of any one group. A client who cannot embrace the higher power language of Alcoholics Anonymous is not thereby cut off from the benefits of mutual help. They can find comparable benefit in a secular group built on self-directed change and mutual support.

For the faith-based practitioner, this evidence encourages a stance of genuine choice rather than a single prescription. Offering a client a menu of mutual-help options, faith-based and secular alike, and helping them find the one they will actually engage with, is more likely to produce involvement, and therefore recovery, than pressing every client toward the same group regardless of fit. It also aligns with the legal principle described above, since offering secular alternatives is not only constitutionally required in coerced settings but clinically sound in all settings. A program committed to its faith mission can hold that mission sincerely while recognizing that for some clients the path to recovery will run through a secular group, and that supporting them in finding it is part of serving their wellbeing.

Matching Clients to the Right Recovery Support

The evidence assembled here points toward a practical skill that is central to faith-based work but rarely made explicit, which is the ability to match a given client to the recovery support most likely to help them. The research supports matching on two dimensions at once, the client's readiness and severity, and the client's openness to spiritual content.

On readiness and the timing of spiritual engagement, the craving research already discussed in this course is instructive. Because severe early craving can interfere with a client's capacity to engage with spiritual programming (Rabinowitz et al., 2026), the counselor should not assume that a client who seems unresponsive to spiritual content in the first days of treatment is rejecting it. They may simply be overwhelmed by the acute biology of early withdrawal. The practical move is to stabilize the client first, attending to the physical and emotional intensity of early recovery, and to introduce or deepen spiritual

content as that intensity subsides and the client has the capacity to engage with it. Front-loading spiritual programming before a client can absorb it risks producing exactly the disengagement a faith-based program most wants to avoid, and misreading that disengagement as spiritual resistance can lead a counselor to push harder at precisely the wrong moment.

On openness to spiritual content, the mutual-help evidence provides the guiding principle. Because involvement matters more than which group a client attends (Zemore et al., 2018), and because secular alternatives produce outcomes comparable to 12-step groups, the counselor's goal is not to steer every client toward the same group but to find the group each client will actually engage with. For a client with an existing faith or an openness to spirituality, a 12-step or explicitly faith-based group may be the natural and effective choice, supported by strong evidence for the 12-step model (Kelly et al., 2020) and by the protective role of religiosity more broadly (Koh et al., 2026). For a client who cannot accept a higher power framework, pressing the point is likely to reduce involvement and therefore reduce benefit. A secular group offers a better path to the involvement that actually drives recovery.

This matching stance asks the counselor to hold two things together, a sincere belief in the value of the faith-based approach and a clear-eyed recognition that it is not the right fit for everyone. Assessing a client's spiritual openness at intake, discussing the available options honestly, and helping the client choose the support they will genuinely engage with is more likely to produce recovery than a one-size-fits-all referral. It also embodies the respect for client self-determination that professional ethics require and that, as the legal section describes, the Constitution demands in coerced settings. Matching is not a dilution of the faith-based mission. It is the form that mission takes when it is genuinely oriented toward the client's recovery rather than toward the program's preferences.

What Faith-Based Counselors Need to Know

This course identifies the knowledge, skills, and attitudes that counselors need for faith-based substance abuse treatment, and the recent evidence gives that competency framework sharper content. Several specific capabilities emerge from the research.

The first is the ability to assess religious and spiritual life systematically rather than by impression. The validation of the Brief Religious Coping Scale in a substance use population (Manzler et al., 2026) gives counselors a validated tool for distinguishing positive religious coping, in which a client draws comfort and meaning from their faith, from negative religious coping, in which a client feels abandoned or punished by God. This distinction is not academic. A client mired in negative religious coping, who experiences their addiction as evidence of divine rejection, is carrying a specific and treatable form of distorted thinking. A counselor who can recognize it, ideally with a validated instrument rather than intuition alone, can target it directly, helping the client move from a punitive image of God toward the supportive faith that the protective-factor research associates with better outcomes. Assuming that any religious client is automatically drawing strength from their faith misses those for whom faith has become a source of shame, and those are often the clients who most need the counselor's attention.

The second competency is the ability to tell genuine spiritual engagement from surface compliance. The research on surrender found that implicit, less consciously controlled measures of spiritual surrender predicted longer-term abstinence, while explicit self-report predicted only short-term outcomes (Seesink et al., 2026). The practical lesson is that a client's verbal endorsement of spiritual transformation,

however sincere it sounds, may reflect a wish to please the program rather than a deep internal change. A skilled counselor treats verbal declarations as a starting point rather than as proof, looking for evidence of genuine integration in how the client actually lives and responds over time, and remaining patient with the slow, uneven process by which real spiritual change tends to occur. This guards against a subtle failure mode in faith-based settings, in which clients learn the language the program rewards and staff mistake fluency in that language for transformation.

The third competency is the capacity to integrate spiritual content with evidence-based clinical methods rather than treating them as rivals. The meta-analytic evidence that spiritually integrated interventions add measurable benefit (Hai et al., 2019) supports a both-and rather than an either-or approach. The competent faith-based counselor can offer the structure, skills, and cognitive techniques of established clinical treatment while incorporating the spiritual content that gives many clients meaning and motivation, drawing on each without sacrificing the other. A counselor who can only offer spiritual encouragement, or who regards clinical technique as a threat to the spiritual mission, is less equipped than one who can weave the two together.

The fourth competency is legal and ethical literacy. A counselor working in or alongside the justice system must understand that coerced religious programming is unconstitutional without a secular alternative, and must be able to offer genuine choice and document it. This is not merely a compliance exercise. It reflects the same respect for the client's autonomy and dignity that good clinical practice requires in every setting. A faith-based counselor who combines rigorous assessment, discernment about genuine change, skillful integration of spiritual and clinical methods, and clear legal and ethical grounding is equipped to offer faith-based treatment at its best, sincerely, effectively, and with full respect for the people it serves.

Conducting a Spiritual Assessment in Practice

The competencies described above become usable only when a counselor can translate them into a concrete conversation with a client, and a structured spiritual assessment is the vehicle for doing so. The goal of such an assessment is not to evaluate the correctness of a client's beliefs, which is neither the counselor's role nor clinically useful, but to understand what place faith and spirituality currently hold in the client's life, whether that place is a source of strength or of distress, and how it might be engaged in service of recovery. A few practical principles make the assessment productive.

The first is to approach the client's spiritual life with genuine curiosity rather than assumption. A client who identifies as religious may be drawing deep sustenance from their faith, or may be carrying a punishing image of a God who has rejected them, and only inquiry reveals which. Open questions work better than a checklist: asking what role, if any, spirituality or faith plays in the client's life, how it has figured in their struggles with substances, and whether it feels like a resource or a burden invites the client to describe their actual experience rather than to supply the answer they think the program wants. The distinction between positive and negative religious coping that the validated measures capture can be heard directly in these answers, and a client who speaks of their addiction as evidence of divine punishment is signaling a specific and workable clinical target.

The second principle is to keep the assessment client-led rather than counselor-led. In a faith-based program especially, a client may sense that endorsing spirituality is the expected and rewarded response,

and a counselor who signals the desired answer will elicit compliance rather than truth. Holding a neutral, accepting stance, making clear that there is no right answer and that a client's skepticism or unbelief is as welcome as devotion, produces a more honest picture and models the respect for self-determination that both ethics and, in coerced settings, the Constitution require. The counselor is assessing the client's spirituality, not recruiting the client to the program's.

The third principle is to connect the assessment to the treatment plan rather than filing it away. What the assessment reveals should shape what follows. A client with a vibrant, supportive faith and openness to spiritual programming is a natural fit for a 12-step or explicitly faith-based track, and the plan can draw on that faith deliberately as recovery capital. A client mired in negative religious coping needs the distorted, punitive image of God addressed directly as part of the cognitive work, not left to fester beneath the surface of an otherwise spiritual program. A client for whom faith holds no meaning, or who has been wounded by religion, is better served by a secular path, and the assessment that surfaces this early prevents the disengagement that pressing spiritual content on an unreceptive client tends to produce. The assessment, in short, is the mechanism by which the matching principle described earlier becomes real, and it should be revisited over time, because a client's spiritual life is not static and the acute distress of early treatment can mask an openness that emerges as stabilization proceeds.

The final principle is to document the assessment and the choices that flow from it, particularly in corrections-linked settings. Recording that the client was informed of both faith-based and secular options, and chose freely among them, protects the client's autonomy and the program's legal standing at once, and it turns the constitutional requirement described earlier into a routine part of good practice rather than an afterthought. A spiritual assessment conducted with curiosity, kept honest by a neutral stance, connected to the plan, and properly documented is the practical foundation on which competent faith-based treatment is built.

The Evaluation Challenge: What the Evidence Can and Cannot Settle

This course places heavy emphasis on the difficulty of evaluating faith-based programs, and the recent research both advances and confirms that challenge in ways worth making explicit, because a clear understanding of what the evidence can and cannot show protects a program from both false modesty and overclaiming.

The central methodological problem is that faith-based treatment bundles several things together, and the evidence usually cannot separate them. When a faith-based residential program produces good outcomes, as the study of a large women's program did, with longer stays predicting successful completion and lower mortality among graduates than among clients still progressing through the program (Dooley et al., 2026), the result is encouraging but ambiguous. The retrospective design cannot determine whether the faith content specifically drove the outcomes, or whether the structure, duration, supervision, and social support of any comparable residential program would have produced similar results. The dose-response pattern, in which longer stays predict better outcomes, is real and consistent with the threshold effect this course describes, but it does not isolate the spiritual ingredient from everything else a long residential stay provides.

This confound runs through even the strongest evidence. The Cochrane review found that 12-step facilitation outperformed other treatments for sustained alcohol abstinence (Kelly et al., 2020), but

12-step involvement delivers structure, fellowship, behavioral change, and social accountability alongside its spiritual content, and the review could not fully disentangle which of these produces the benefit. The protective-factor evidence is large and consistent (Koh et al., 2026), but observational, so it cannot rule out that people already disposed toward stability are both more religious and less prone to substance problems. Even the meta-analysis of spiritually integrated interventions, which did use randomized trials, found only a small effect over other active treatments (Hai et al., 2019), leaving the specific added value of the spiritual component modest and somewhat uncertain.

A selection problem compounds the confound. Clients who choose and remain in faith-based programs may differ systematically from those who do not, in motivation, in existing social and religious support, and in the severity of their circumstances. Programs that report outcomes only for those who complete, or that compare completers to non-completers, can make an intervention look more powerful than it is, because the comparison partly reflects who stayed rather than what the program did.

None of this is a reason for discouragement, and it is emphatically not a reason to dismiss faith-based treatment, which the evidence shows to be effective. It is a reason for a particular kind of honesty. A faith-based program can say truthfully that its approach works, that its clients often achieve and maintain recovery, and that spirituality and religious involvement are supported by a large body of evidence as protective factors. What it cannot say, on current evidence, is that the faith content specifically, rather than the structure and support that accompany it, is the proven active ingredient. Holding that distinction does not weaken a program. It makes its claims credible, guides honest evaluation, and keeps the focus on what actually helps clients recover, which is the question that matters most.

Faith-Based Programs in Corrections Settings

Corrections-based faith programs, which this course treats as a distinct category, sit at the intersection of every issue raised in this update, and they deserve specific attention because the stakes, both legal and clinical, are highest there. Incarcerated and justice-involved people are frequently referred or assigned to substance use programming, and faith-based options are common in jails, prisons, and community supervision. This creates both an opportunity and a hazard.

The opportunity is real. The 12-step model that anchors many corrections-based faith programs has strong evidence behind it for sustained abstinence (Kelly et al., 2020), and religiosity and spiritual involvement are protective factors that a period of incarceration, with its enforced pause and its openness to reflection, can sometimes activate. For a justice-involved client genuinely open to it, a faith-based program can provide structure, meaning, community, and a framework for change at a moment when those things are scarce.

The hazard is the one the legal section describes. In a corrections setting, the line between an offer and a command is easily blurred. When a faith-based program is the only substance use programming available, or when declining it carries consequences for privileges, classification, or parole, participation is no longer voluntary, and the Establishment Clause is violated. The case law is unambiguous that a person cannot be compelled into Alcoholics Anonymous, Narcotics Anonymous, or a comparably religious program without a genuine secular alternative. For a corrections-based faith program, this is not a peripheral legal technicality but a design requirement. The program must ensure that a real secular

option exists, that clients know about it, and that choosing the faith-based program carries no advantage while declining it carries no penalty.

The mutual-help evidence makes this requirement easier to satisfy in good conscience, because it shows that secular alternatives work about as well as faith-based ones, with involvement mattering more than the group's philosophy (Zemore et al., 2018). A corrections program does not have to choose between constitutional compliance and effective treatment. It can offer both a faith-based track and a secular one, confident that each can support recovery, and let clients choose the one they will actually engage with. This turns a legal constraint into a clinical strength, since genuine choice tends to produce the involvement that drives outcomes.

For the counselor working in these settings, the practical stance follows directly. Verify that clients have a real secular alternative, document that they were informed and chose freely, watch for the subtle coercion that scarce alternatives can create, and treat each client's spiritual openness as something to assess and respect rather than assume. Handled this way, a corrections-based faith program can offer the genuine benefits of spiritual recovery within the constitutional and ethical boundaries that protect the people it serves.

From Evidence to Practice

Taken together, the research assembled here sharpens the framework of this course in several ways and points toward a coherent practice.

The first lesson is that faith-influenced approaches are genuinely effective, not merely popular. The 12-step model performs at least as well as established clinical treatments for sustained alcohol abstinence (Kelly et al., 2020), religiosity and spirituality are reliable protective factors across a very large body of longitudinal evidence (Koh et al., 2026), and integrating spiritual content into treatment adds a small but real benefit (Hai et al., 2019). A faith-based practitioner can work with confidence that the spiritual dimension of recovery is supported by evidence, not merely by tradition.

The second lesson is that honesty about mechanism and magnitude strengthens rather than weakens this work. The 12-step evidence cannot fully separate spiritual content from structure and fellowship, the protective-factor evidence is strong but observational, and the benefit of spiritual integration over other good treatments is modest. Presenting faith-based treatment as effective and evidence-supported is accurate. Presenting it as a uniquely powerful cure that surpasses all alternatives is not, and the credibility of the field is better served by the accurate claim.

The third lesson is that voluntariness is both a legal requirement and a clinical asset. The Establishment Clause forbids compelling religious programming without a secular alternative, and the mutual-help evidence shows that secular alternatives work about as well as faith-based ones, with involvement mattering more than group type. A program that offers genuine choice, documents it, and helps each client find the path they will actually engage is on solid ground legally, clinically, and ethically.

None of this diminishes the value of faith-based substance abuse treatment. It grounds that value in evidence and law, and it equips the practitioner to offer the spiritual heart of the work with integrity, to

the clients who want it, alongside real alternatives for the clients who need something else. That combination, sincere faith offered freely and matched to the person, is the version of faith-based treatment the current evidence most strongly supports.

Introduction

America is a land of many paradoxes and one of the most troubling paradoxes is the relationship between religion and substance abuse. A very high percentage of Americans believe in God and are affiliated with a specific religion. On the other hand, America is awash in legal and illegal drugs, and many young people and adults are seriously addicted to alcohol or drugs.

This course is designed and has been created for students to gain a better understanding and greater knowledge of faith-based substance abuse treatment. The course focuses on both community and institutional, correctional and free-world programs designed to treat drug and alcohol addiction. The course was designed for substance abuse counselors working both in and out of faith-based treatment programs. Nevertheless, the course is also designed for individuals working in faith-based programs that do not specifically address substance abuse, such as clergy and other pastoral ministers.

Long before there was significant government sponsorship of programs and services to meet this country's human needs, faith-based organizations, other voluntary community associations, individuals, and families played a large role in meeting some of these needs. Indeed, many governmental and other secular social welfare institutions in communities across the nation have their origins in faith-based and community-based organizations established as long as 100 or 150 years ago.

Even as government at all levels has assumed greater responsibility for policies and programs to address human needs, the American tradition of faith-based and other community organizations providing social welfare and educational programs has continued. They play a unique role today. They have access to motivated staff and similarly motivated volunteers. They often enjoy trust within their communities. There are many reports that the spiritual dimension of faith-based organizations provides a powerful ingredient for needed change for people otherwise unreachable, including some with multiple barriers.

Thus, the human service delivery system in the U.S. is an amalgam of resources and programs of the public sector and the private sector; the latter including both faith-based and secular service organizations. Fully half of all government-funded social services are in partnership with private non-profit organizations.

Faith-Based Definitions

A starting point for this course is the definition of “faith-based” programs. The definitions appear to be many and varied. Some of these definitions are:

- Congregations, national networks, freestanding religious organizations, or other urban or social ministries providing some community service.
- Grass roots groups involving networks of local congregations, small nonprofit organizations, and neighborhood groups that spring up to respond to a crisis
- Faith-based means (a) linkage to an organized faith community, (b) the presence of a particular ideology, and (c) staff and volunteers drawn from a particular religious group.
- The presence of implicit or explicit religious and/or spiritual content underlying program activities.
- The degree to which a program is imbued with religious and/or spiritual content or a continuum ranging from “faith-saturated” to “faith-secular partnership.

The line between secular and faith-based substance abuse treatment programs is quite blurred for several reasons.

- Many programs not associated with any organized religion endorse 12-step conceptions of spirituality and the existence of a “higher power.”
- Recovery programs endorsing 12-step philosophy typically emphasize “spiritual transformation” as fundamental to the recovery process.
- Traditional medical and psychosocial treatment programs may incorporate the 12-step philosophy or other spiritual content to some extent.
- The credentials of program staff may vary amongst faith-based substance abuse treatment programs. Twelve-step oriented treatment programs often recruit staff members who are in recovery or who graduated from their program. Traditional treatment programs are more likely to have professional, licensed staff.

Based on the above definitions and issues, substance abuse treatment programs can be defined by the degree to which importance is assigned to the following:

- Spiritual (SA). Spiritual activities and beliefs.
- Structure (SD). Structure and discipline.
- Environment (SE). Supportive and affirming environment.
- Modeling (MM). Role modeling and mentoring.
- Synergy (SN). Group activities and cohesion.
- Transfer of Experience (TE). Work readiness and referrals.
- Professional Treatment (PT). Traditional treatment modalities.

Philosophical Propositions

Several philosophical propositions underlie and support the faith-based movement that ultimately leads to faith-based substance abuse treatments. The *Working Group on Human Needs and Faith-Based and Community Initiatives* has identified five primary propositions:

- America can't adequately overcome poverty and social dysfunction with the resources now being dedicated to this mission
- Addressing our communities' needs is not just governments' job. It is everyone's job.
- Religious faith is a powerful force in our society, and it needs to be connected more firmly to the work of social regeneration.
- Recognition of the variety of religious characteristics of faith-based organizations is needed to help bring greater clarity to the ongoing public debate on these issues.
- Closer collaboration between government and community (particularly faith-based) groups will require a tenacious search for pragmatic, tailored, occasionally messy, but typically American solutions.

These propositions were addressed primarily to public officials at all levels, to business and philanthropic leaders, and to faith-based and secular providers of human services. Consequently, they serve as a broad philosophical foundation for faith-based substance abuse treatment programs and a spring board for the content of this course in faith-based substance abuse treatment.

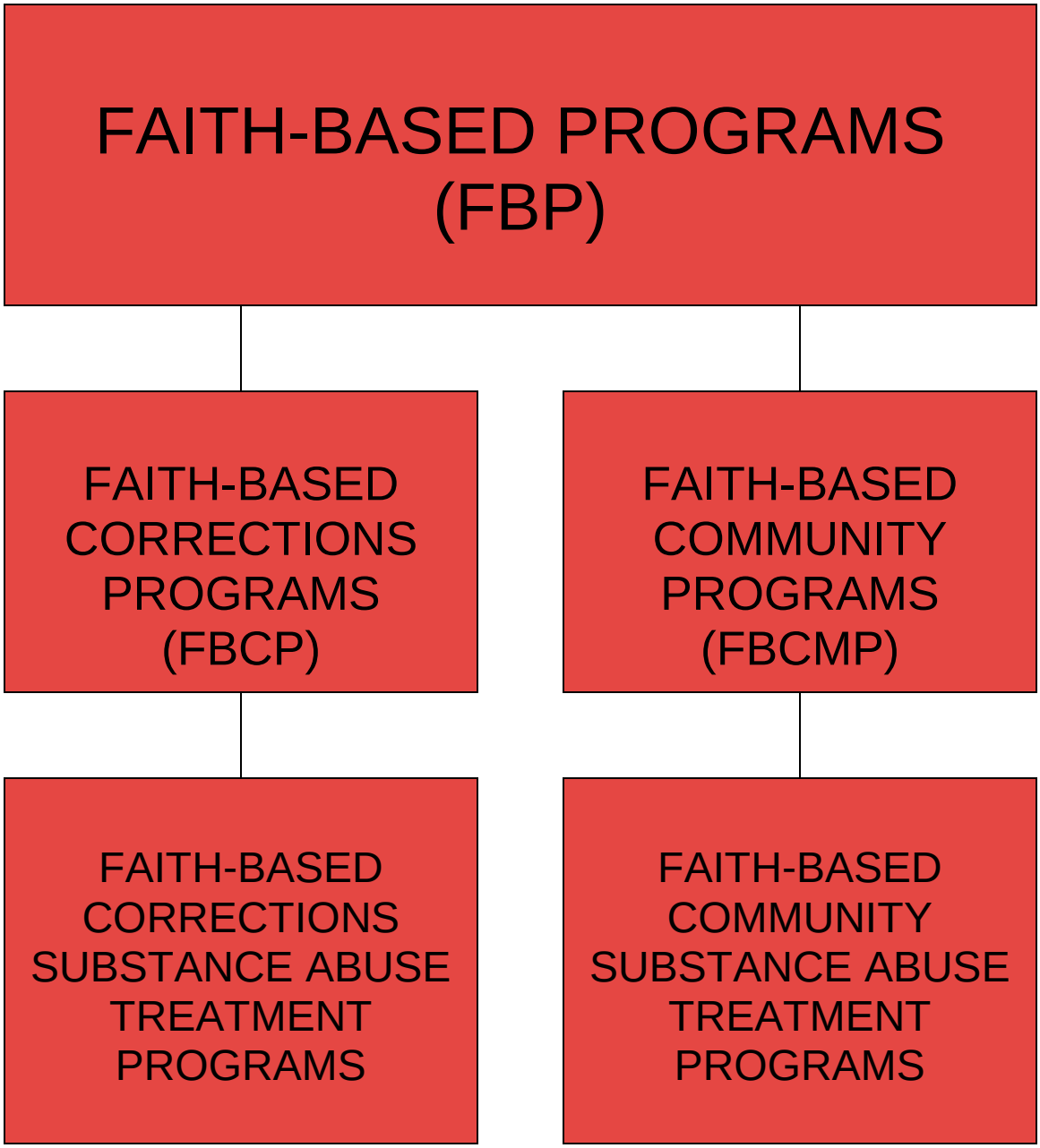
Faith-Based Community and Corrections Programs

Faith-based programs and organizations tend to be divided into four main types according to their focus:

- Faith-Based Corrections Programs (FBCP). These are programs in prisons and jails that are designed to treat the general criminal tendencies of offenders.
- Faith-Based Corrections Substance Abuse Treatment Programs. These are programs in prisons and jails designed specifically to treat alcohol and drug abuse. These programs include transitional treatment, both pre- and post-release.
- Faith-Based Community Programs (FBCMP). These are programs and organizations that are designed to treat general criminal or delinquent tendencies of offenders in the community. These are also known as community action programs.
- Faith-Based Community Substance Abuse Treatment Programs. Many faith-based organizations and programs are designed to treat alcohol and drug abuse in the community.

Figure 1 presents a visual representation of these four types of programs and illustrates how all four are Faith-Based Programs (FBP). The focus of this course is on community and corrections substance abuse treatment programs.

Figure1
Faith-Based Programs (FBP)



Religiosity and Spirituality

Religiosity and spirituality are core concepts for faith-based substance abuse treatment programs. Unfortunately, the two are poorly understood and involve complex issues. Empirical studies of the two concepts suggest two independent dispositions. Many definitions of the two can be found.

Religiosity

- A system of beliefs in a divine or superhuman power, and practices of worship or other rituals that imply community activity to bind or tie people together.
- A faith community with teachings and narratives that enhance the search for the sacred and encourage morality.
- Religiousness-Components
    1. Private religious practices
       "I often pray privately in places other than church, mosque, or synagogue"
    2. Organized religiosity
       "I often attend religious services"
    3. Self-rated religiosity
       "I consider myself a religious person"

Spirituality

- A subjective experience of the sacred
- A transcendent dimension within human experience discovered in moments in which the individual questions the meaning of personal existence and attempts to place themselves in a greater meaning for his/her existence.
- A search for meaning, unity, connectedness to nature, humanity, and the transcendent.
- Associated with mystical experience and New Age beliefs and practices.
- Spirituality involves a synergistic belief system that aids in the self-examination of values that serve as standards for behavior.
- Spirituality- Components
    1. Daily Spiritual Experiences
       "I believe in a God who watches over me."
    2. Forgiveness
       "I know that God forgives me."
    3. Positive Coping
       "I am sure my life is part of a larger spiritual force."

Mysticism

Mysticism is similar to spiritualism, but tends to include paranormal experiences and experiential/phenomenological (E-P) events or occurrences.

Superstitiousness - secular

These are irrational beliefs and experiences including psychokinesis (out-of-body experiences), astrology, reincarnation, spells, and psychic powers.

Superstitiousness – religious

These are irrational beliefs and experiences including ghosts, angels, miracles, vision, voodoo, fairies, and evil spirits. In many cases, the distinctions between religious and secular superstitions are vague depending on a particular spiritual or religious orientation. In addition, many popular but medieval superstitious characters, such as werewolves, witches, and vampires, are not included in these categories.

Intrinsic Religiosity

This term refers to people who have a high commitment to religious activities and beliefs, treating religion as an end in itself.

Extrinsic Religiosity

This term refers to people who use religion as a means to a desired personal end such as social status or comfort.

Exoteric Religiosity

Some forms of religion emphasize form; and they tend toward literalistic dogmas, a claim to exclusive possession of the truth, sentimentality, and an emphasis on morality and personal salvation, provided in a manner that makes religion attractive to many people.

Esoteric Religiosity

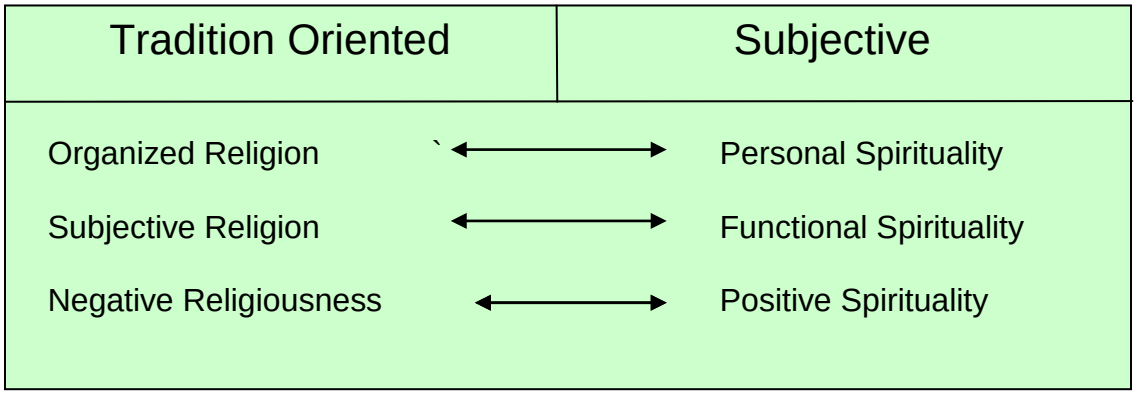
Other forms of religion emphasize the metaphysical, contemplative, knowledge, wisdom, unification with divinity and the spirit and not the letter of religious teaching.

Whatever the definition, spirituality and religiosity serve as the foundation for faith-based substance abuse treatment programs.

Figure 2 presents a visual representation of how these two concepts can be understood on three continua that can translate to a variety of program emphases.

The Spiritual Transformation Self-Inventory in the appendix provides an instrument for program participants to explore their spirituality and religiosity.

Figure 2
The Religious-Spiritual Continuum



Faith-Crime Relationship

When faith-based substance abuse treatment involves offenders and prisoner reentry to the community, the theoretical and practical issues of the connection between faith and crime become very important. How do faith-based treatment programs work for offenders? The answer to this question is largely unknown. Consequently, several questions arise:

- How do faith-based substance abuse programs for offenders work?
- Are faith-based programs more effective than no program?
- Are faith-based programs more effective than "business as usual" programs?
- How do you separate the faith component of effectiveness from secular services that are already known to be effective?
- What is the result if faith-based programs are compared to known effective secular programs?
- How do you uncover the faith effect when we know the relationship between religion and crime is modest to small?

With these questions in mind, it is possible to identify several types of causal effects in the faith-drugs-crime relationship.

- *Direct*. The direct crime-faith relationship suggests that faith may have a direct causal effect that contributes directly to improved outcomes for offenders, such as decreased recidivism or relapse rates. This

relationship would suggest that participation in faith-based substance abuse programs would lead offenders to believe that certain behaviors are morally wrong. This belief would subsequently reduce the chances that the offender would engage in criminal behavior or substance abuse.

- *Indirect*. The effect of faith may operate indirectly through some other intervening variable, known or unknown. Faith-based substance abuse treatment programs may reduce crimnogenic factors. This reduction may ultimately reduce recidivism and relapse. A variety of indirect factors can contribute indirectly to crime reduction.
    1. Moral order
        a. Moral directives
        b. Spiritual experiences
        c. Role models
    2. Learned competencies
        a. Community and leadership skills
        b. Coping skills
        c. Cultural capital
    3. Social and organizational ties
        a. Social capital
        b. Network closure
        c. Extra-community skills

In all of these factors, the connection between faith and crime is that faith changes each of these factors, and these factors lead to a more effective life adjustment in the areas of crime and substance abuse.

- *Interactive*. The effect of faith on crime may be interactive such that the influence of faith programs varies with the occurrence of some other factor. For example, a meaningful job may provide for more opportunities to put faith lessons into effect. The equation then becomes: faith-employment-law abiding.

- *Conditional*. The conditional crime-faith relationship suggests that a causal faith is contingent on the existence of other factors. For example, the causal effect of attending faith-based substance abuse treatment programs may be contingent on participants attending professional substance abuse counseling, mental health counseling, employment counseling, or drug/alcohol education classes. Many substance abuse treatment programs are multi-faceted, multi-dimensional, and multi-phasic, and the determination of the contingencies is a very complex undertaking.

- *Threshold*. An intriguing relationship between crime and faith is the suggestion that the effect of faith may arise only after a threshold has been crossed. This threshold is viewed as a sufficient faith dose that has

been achieved. This is referred to in professional substance abuse treatment as "program dose," and it involves:

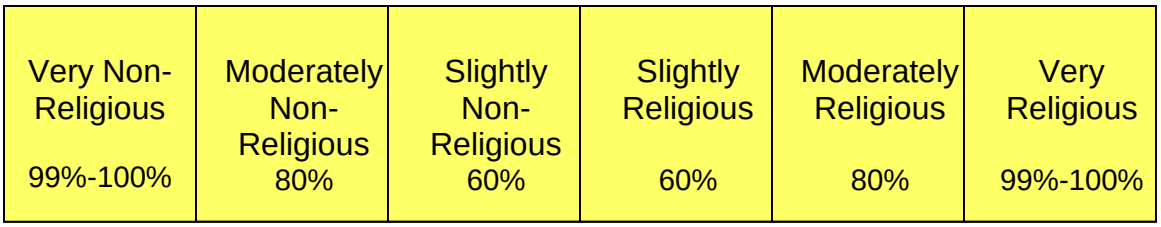
1. Consistent cohort
2. Attendance
3. Program fidelity
4. Treatment manual

This threshold effect leads to several critical questions about faith-based substance abuse programs:

1. Is it sufficient to be *exposed* to faith-based programming?
2. Does a profound inner change have to occur for program success?
3. What is the quantity-quality relationship in faith-based programs?
4. How can pseudo conversions to faith and the importance of a higher power be separated from true conversions?
5. How can faith-based substance abuse treatment programs maintain treatment consistency with the deemphasis on traditional program structure and treatment manuals. In other words, how can these programs combat consistency and fidelity drift (program dose)?

- *Nonlinear*. It has been suggested that the possible effects of faith in reducing relapse and recidivism may not be a linear process. In order to understand this relationship it is helpful to look at the following continuum in Figure 3. In this figure, for example *very nonreligious* represents an individual who is 99-100% nonreligious, *moderately nonreligious* represents an individual who is 80% nonreligious, and *slightly nonreligious* represents an individual who is 60% nonreligious. Correspondingly, *slightly religious* represents an individual who is 60% religious, *moderately religious* represents an individual who is 80% religious, and *very religious* represents an individual who is 99-100% religious.

Figure 3
The Religious-Non-Religious Continuum



In this figure, the movement from being *very non-religious* to being *moderately religious* may not be of the same magnitude as movement from *slightly religious* to *very religious*. The figure is drawn in a linear fashion with geometric distances the same, indicating an equal magnitude of movement. Nevertheless, the relationship may be *non-linear* with varying degrees of magnitude. Similarly, the magnitude of initial faith changes may be easier and more likely than later or greater changes to affect someone's behavior.

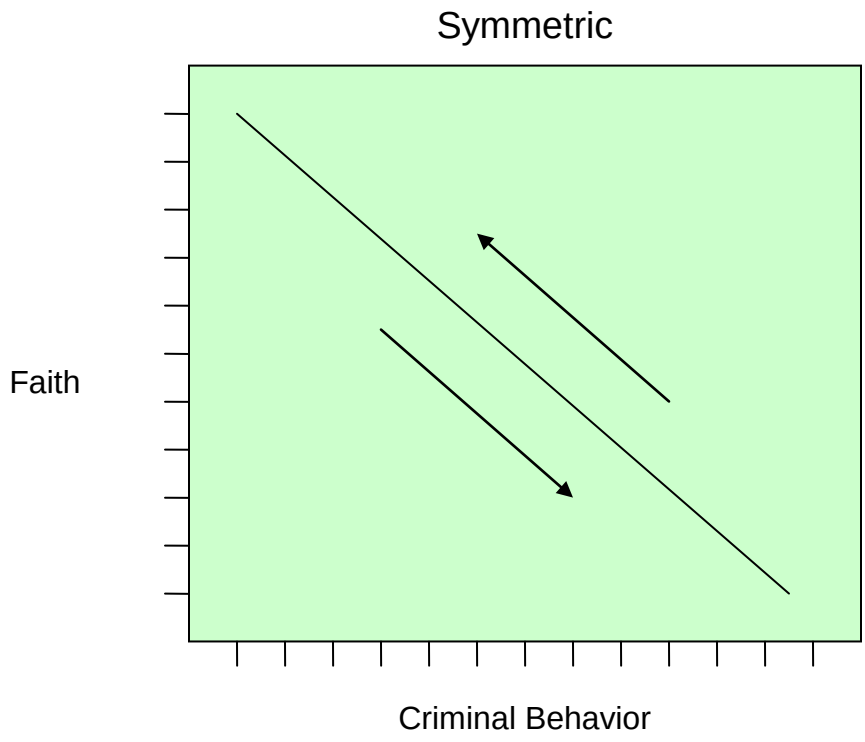
- *Symmetry*. In addition to the previously identified causal relationships, it is possible that they could be symmetric or asymmetric.
    1. Symmetric—An increase in faith leads to a decrease in criminal behavior, but a decrease in faith leads to an increase in criminal behavior.
    2. Asymmetric—An increase in faith may decrease criminal behavior, but a decrease in faith may not increase criminal behavior. Figure 4 presents a visual graph of these relationships.

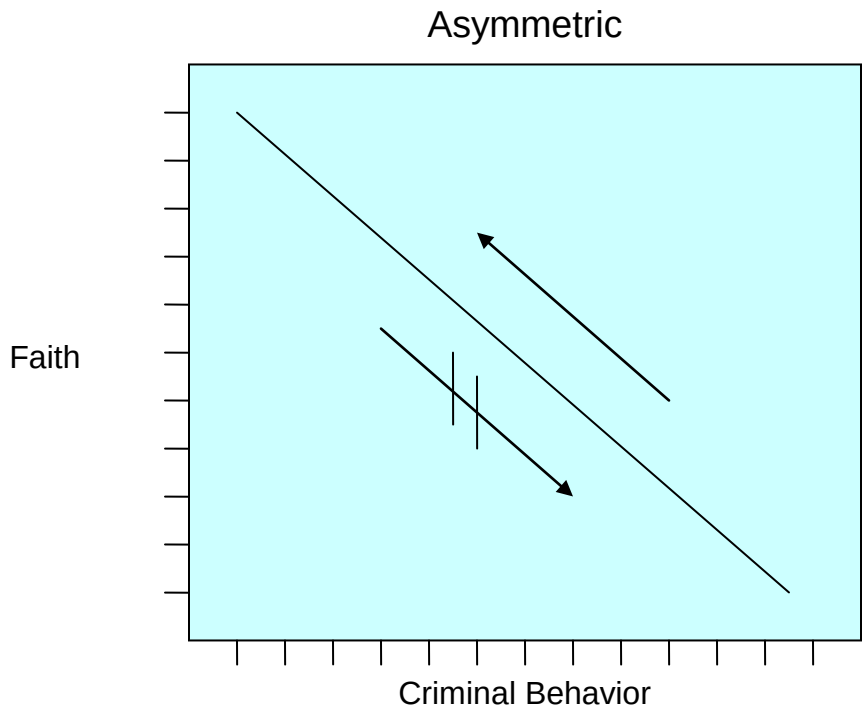
  It is possible that in faith-based substance abuse treatment programs, the effect of faith is one way and is irreversible. But, it is possible that participation in faith-based substance abuse treatment programs in later life may be incapable of overcoming a life of drugs and crime.

- *Negative*. It is possible to think about the negative effect that faith may have on criminal behavior and/or substance abuse. Note the following possibilities:
    1. Openly revealing past harmful behaviors may be difficult for some people to accept. Out of frustration, they may revert to previous behaviors, including drugs, alcohol, or crime.
    2. Accepting that a higher power has control over a person's life could lead to a belief that one is not responsible for harmful and destructive behaviors.
    3. If accepting a particular faith program results in failure, the offender may be more prone to commit crime.

Finally, the relationship between faith and crime is, like much of social behavior, not simple and easy to understand. In the final analysis, there may be many causal effects that contribute to crime.

Figure 4
Faith-Crime Symmetry





Types of Faith-Based Programs

In 2002, *The Working Group on Human Needs and Faith-Based and Community Initiatives* identified five typologies of faith-based organizations:

- In "faith saturated" organizations, religious faith is very important at all levels, and most staff share the organization's faith commitment. "Faith-saturated" programs involve explicit, extensive, and mandatory religious content integrated throughout the program.

- "Faith-centered" organizations were founded for a religious purpose, and the governing board and almost all staff are required to share the organization's faith commitment. Faith-centered programs include explicit religious messages and activities but are designed so that participants can readily opt out of these activities and still expect positive outcomes.

- "Faith-related" organizations were founded by religious people and may display religious symbols; but they do not require staff to affirm any religious belief or practice, with the possible exception of executive leadership. Faith-related programs have no explicitly religious messages or activities, although religious dialogue may be available to participants who seek it out.

- "Faith-background" organizations tend to look and act secular, even though they may have a historical tie to a faith tradition. "Faith-background" programs have no explicit religious content or materials.

- Lastly, "faith-secular partnerships" have no explicit reference to religious content. Religious change is not necessary for outcomes, but it is expected that the faith of participants from religious partners will add value to the program.

The W*orking Group…* emphasized several key points about faith-based organizations.

- It is very difficult to reach agreement on rules of general application to faith-based organizations.

- The language is very confusing so that "church" and "religious activities" are misunderstood and confused.

- Non-profit organizations are very diverse in the services they provide.

- Not all organizations that provide social services with tax dollars and charitable funds have to possess all the characteristics of more established faith-based organizations.

- The more an organization resembles more traditional and established organizations, the more equipped it will be to compete for and manage programs and grants.

In addition to these points, faith-based programs need to address real needs. They need to meet the same rules as other not-for-profits. Their work must not be taken on faith alone, but on results: Are at-risk kids staying in school, are addicts getting off drugs, are parolees staying out of prison?

Spirituality and Substance Abuse

Many researchers have examined the specific role of spirituality in substance abuse recovery. Some studies have suggested that spiritually based treatment programs have limited success outside traditional Judeo-Christian populations. Other studies have produced more favorable results. In these studies, participants who indicated a higher level of spirituality in the recovery process have greater success in reaching and maintaining sobriety.

The possible connections between spirituality and substance abuse could be:

- *Incompatibility*. This explanation suggests that a drug could be occupying the place of a spiritual higher power. Consequently, a treatment program using spirituality could undermine the power of the substance and replace the dependency with dependency on a higher power.

- *The addicted-self model*. This model suggest that extensive participation in spiritual based recovery activities may promote abstinence because they reinforce the theory that controlled use of alcohol and other drugs is not possible. Participants tend to have low controlled use self-efficacy which is associated with extensive participation in both counseling and spiritual programs. Controlled use self-efficacy is characterized by agreement with statement such as:

  “I know I cannot use drugs in the future without losing control.”
  “I can’t drink socially without getting too drunk.”
  “I can’t use drugs recreationally.”

  The addicted-self model is consistent with the accepted stages of change models in the addiction field. For example, it assumes that individuals

who cease their addictive behaviors will typically move through a series of stages.

- *Internal-external model*. This approach suggests that internally controlled individuals can control and discontinue substance use. They are less likely to rely on an external control treatment program based on spirituality. On the other hand, externally controlled individuals are less likely to control the use of substances and more likely to need to rely on an external control program.

  This dichotomy does not imply that external control is not desirable. Instead, it may be helpful to look at the following levels of control:

  1. Internal control. This control originates from internal sources, such as self-efficacy, self-esteem, and self-confidence.
  2. External control. This control originates from external sources such as a higher power, the group, the cult, the family, or a significant other person.
  3. Ambivalent/inconsistent control. Many individuals exercise control sometimes and in some situations. Their control isles predictable from time to time and across similar situations. For example, individuals in many organized crime groups tend to be very religious in some situations.
  4. No control. Some individuals seem to lack any control over behavior and tend to be somewhat psychopathic or sociopathic and socially, morally, legally, or interpersonally out of control.

  Some studies of substance abuse treatment programs have provided some evidence on the relationship between substance abuse and spirituality. Caution has to be exercised in interpreting this relationship because there is a distinct difference between *correlation* and *causation*. There may be a strong relationship (correlation) between spirituality and recovery, but this association does not indicate whether there are other variables confounding the relationship. In addition, a relationship between spirituality and recovery cannot determine whether spirituality is actually protective against substance abuse (causation).

Concerning the relationship between substance use and spirituality, research has indicated the following:

- Strong spiritual beliefs are negatively associated with current substance abuse symptoms. This would indicate that the more spiritual individuals become, the less they are associated with substance abuse. Also, it indicates that increasing reliance on substances is associated with decreasing spirituality.

- High levels of participation in treatment and spiritual programs promote abstinence because these activities reinforce the notion that controlled use is not possible for dependent alcohol and drug users.
- The majority of addict clients in a TC program believed that the program should feature more spirituality in treatment.

- Adolescents respond to treatment differently. Specifically:
  1. Adolescents in a TC program are less likely than adults to prefer spiritually based programs.

  2. Proneness to marijuana tends to be consistent with less religiosity. Youths who report a lifetime of marijuana use were less spiritually oriented than their peers who had used marijuana less frequently.

  3. Adolescent treatment needs to be vastly different from those of adults.

  4. Traditional forms of substance abuse treatment may not be appropriate.

One possible explanation for these results is the reluctance of adolescents to embrace changes that will affect the rest of their lives. In addition, the results may indicate that the previously held belief that intoxication is related to mystical states of being is highly overrated.

Finally, it may be relatively easy for treatment program participants to slip into the spiritual mode because of the extensive exposure of children to religion, the widespread number of religious programs on television, the lack of behavioral accountability in many programs, and the tremendous social rewards for an instant conversion to a more acceptable life style. In essence, participants can get decriminalized and unaddicted quite easily and quickly, i.e. pseudo rehabilitated, through participation in faith based programs by “playing the game” of superficial verbalizations and declarations. The two most critical concepts are:

- Compliance. The individual accepts influence because he/she hopes to achieve a favorable reaction from another person or group. The individual tends to behave only when he/she is being watched or monitored by the person or group influencing them.
- Internalization. This takes place when the person actually believes in the efficacy of the newly acquired behavior. The new behavior is intrinsically rewarding and useful in meeting the person’s needs.

Consequently, if clients in faith-based programs only “play the game” and become ”treatment wise,” many observed gains in their treatment may be situational, superficial, and limited to the faith-based treatment setting. They may no longer be in denial, but there will be little transfer of observed change to the client’s post treatment life.

Faith-Based and Cognitive Programs

In faith-based programs, cognitive therapy techniques and religious ideas can be blended to provide an effective healing environment. Cognitive therapy helps in the healing partnership by giving the client a rationale for treatment procedures, encouraging self-awareness and teaching new ways of thinking more flexibly and productively.

Cognitive therapy encourages clients to examine their thoughts, attitudes, beliefs, and feelings and to discover the connection between these mental processes and their involvement with substances and other people.

Nevertheless, thinking patterns are typically deeply ingrained and difficult to change. Thinking patterns that are faulty can shape a clients view of reality and lead to:

- Interpersonal conflicts
- Depression
- Anxiety
- Substance abuse
- Anger and aggression
- Cravings
- Low frustration tolerance
- Self condemnation
- Cognitive rigidity

These errors in thinking and reasoning are called cognitive distortions which create problems for individuals and present blocks and barriers to effective coping, rational behavior, and therapeutic change.

In the context of substance abuse treatment, clients can exhibit and maintain *distorted religious views*. This distortion occurs when the individual rejects a personal religious philosophy of renewal, repentance, restoration, redemption, forgiveness, grace, and mercy. On the other hand, the same individual has a cognitive religious doctrine that promotes guilt, shame, unworthiness, interpersonal destruction, and self-destruction.

In the end, distorted religious views promote, in the client, a view of religion that is spiritually and emotionally oppressive rather than a liberating force. Distorted religious views cause the person to miss important interpersonal and thinking cues that provide for a healthier adjustment to self, others, and the world.

Many lists of faulty thinking errors have been identified, but most of the lists are related specifically to criminal thinking errors. Substance abusing clients

may exhibit these errors to some degree. Substance abusing offenders may exhibit these errors to a greater degree.

The list that is offered in this course is:

- *Arbitrary Inference*: Developing a specific conclusion without supporting evidence or developing a conclusion in spite of contradictory evidence.
- *Selective Abstraction*: Conceptualizing a situation on the basis of a detail taken out of context and ignoring other information.
- *Overgeneralization*: Abstracting a general rule from one or a few isolated incidents, applying it too broadly, and relating it to unrelated situations.
- *Magnification and Minimization*: Seeing something as more or less significant than it actually is.
- *Personalization*: Attributing external events to oneself without evidence supporting a causal connection.
- *Dichotomous Thinking*: Categorizing experiences, people, behavior, and one's self in one of two extremes, i.e. good or bad.

Faith-based cognitive therapy can analyze the cognitive assumptions that a client has developed related to God, religion, and spirituality. These programs show good promise as an additional treatment modality for treating substance abuse by challenging faulty thinking patterns and challenging the religious distortions that continue to foster dysfunctional, maladjusted, and irrational beliefs and behavior.

In addition, it has been pointed out that treatment for alcoholism, for example, utilizes cognitive restructuring. The cognitive model helps the alcoholic work interactively with the counselor to "explore and reframe" the old faulty alcoholic assumptions, beliefs, perpetual filters, internal dialogue, and coconscious patterns of processing information. This is a process of cognitive restructuring that challenges dysfunctional thought patterns which lead to dysfunctional behaviors.

This cognitive restructuring is accomplished in AA and 12-step programs by:

- *Reprogramming.* The 12-step group encourages and supports alcoholics to explore, own, and confront selfish, self-seeking, and self-centered thinking.
- *Attendance.* Meetings provide alcoholics with emotional awareness, hope, and dependence on others for sobriety.
- *Messages.* Numerous slogans are used as messages of cognitive restructuring. These messages underscore issues of control, power, and distorted thinking. These messages help recovering alcoholics resist old dysfunctional ways of thinking.
- *Sponsorship.* Sponsors in AA can serve as role models, mentors, and teachers and assist in reinforcing new thought patterns.

Overall, the primary focus and purpose of AA and 12-step programs is to identify, challenge and change faulty beliefs, maladaptive cognitions, and dysfunctional thought patterns that lead to relapse and interfere with sobriety. Figure 5 presents a visual representation of the relation between the 12 steps and cognitive restructuring.

Step 1: We admitted we were powerless over alcohol—that our lives had become unmanageable.

Distortions:

a. Core belief of power over self
b. Control of drinking
c. Empowered by alcohol

Step 2: Came to believe that a power greater than ourselves could restore us to sanity.

Distortions:

a. Omnipotence
b. Grandiosity
c. Defiance

Step 3: Made a decision to turn our will and lives over to the care of God as we understand Him.

Distortions:

a. Inflated self-will
b. Egocentricity
c. Narcissism

Step 4: Made a searching and moral inventory of ourselves.

Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Step 6: Were entirely ready to have God remove all these defects of character.

Step 7: Humbly asked Him to remove our shortcomings.

Step 8: Made a list of all persons we had harmed, and became willing to make amends to them all.

Step 9: Made direct amends to such people whenever possible, except when to do so would injure them or others.

Distortions:

a. Defenses
b. Projections
c. Dishonesty
d. Weak introspection

Step 10: Continued to take personal inventory; and when we were wrong, promptly admitted it.

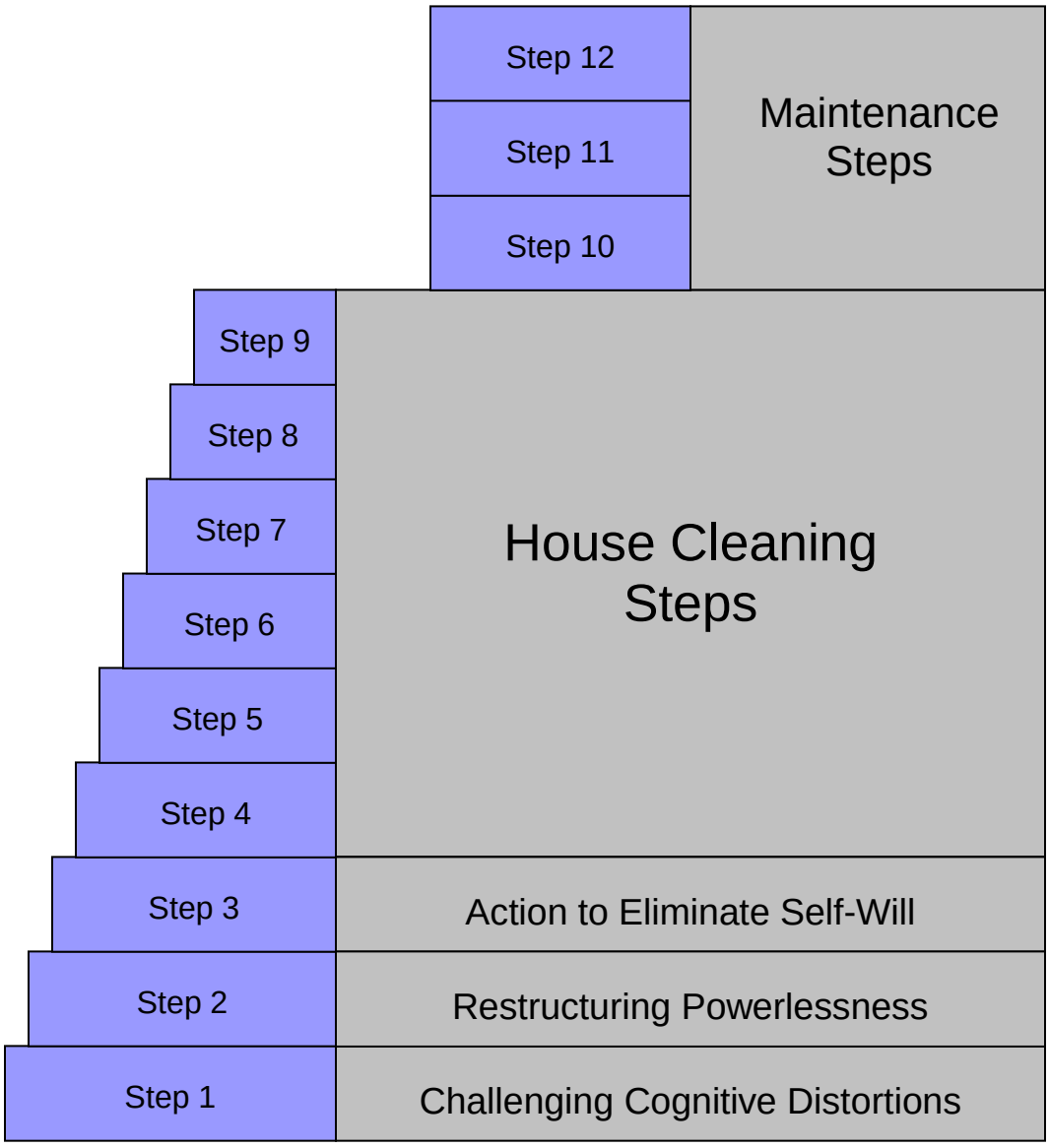
Step 11: Sought through prayer and meditation to improve our conscious contact with God, as we understand Him, praying only for knowledge of His will for us and the power to carry that out.

Step 12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all of our affairs.

Distortions:

a. Lack of vigilance
b. Stagnant development
c. Turning away from God
d. Dishonesty
e. Arrogance
f. Irresponsibility

Figure 5
AA and Cognitive Restructuring



Faith-based substance abuse treatment programs tend to rely heavily on AA, NA, and on 12-step programs along with professional treatment on occasion. These faith-based programs can work together to provide effective establishment and maintenance of abstinence. Working the 12 steps can provide a mechanism through which substance abusers learn new thought patterns of recovery that can be complemented, reinforced, and supported in counseling.

Finally, in a survey of 232 prison chaplains, over half in a particular state reported that they employed reality therapy, group counseling, and client-centered counseling. While the chaplains reported that they utilize established, secular methods of counseling, they place a great deal of emphasis on religion. Most believe that offenders change due to religious transformation. These findings further support the notion that certain counseling styles that might be viewed as secular can be blended with a religious worldview. Thus, these findings suggest that faith-based substance abuse treatment programs can combine secular and religious or spiritual content.

Skills, Knowledge, and Attitudes for Working in Faith-Based Substance Abuse Programs

It is not readily apparent what skills, knowledge, and attitudes are needed for working in faith-based substance abuse programs. What is clear is that most individuals working in faith-based substance abuse treatment are not professionally trained to work with alcohol and drug dependence. Furthermore, professional training, while not guaranteeing competency in working in these areas, provides a level of assurance that professionals have skill, knowledge, and attitude competency.

Fortunately for counselors in faith-based substance abuse treatment programs, the Center for Substance Abuse Treatment has identified the core competencies for clergy and other ministers for working with individuals and family members who are confronted with alcohol and drug problems. Although these core competencies are not a perfect match, they should be of serious benefit to counselors in faith-based programs who have not had specific training in working with substance abusing clients. The competencies provide a general framework with application to diverse faith-based situations.

These core competencies address four major concentrations:

- Knowledge
    1. Be aware of the:
        a. Generally accepted definition of alcohol and drug dependence
        b. Societal stigma attached to alcohol and drug dependence
    2. Be knowledgeable about the:
        a. Signs of alcohol and drug dependence

b. Characteristics of withdrawal
c. Effects on the individual and family
d. Characteristics of the stages of recovery

3. Be aware that possible indicators of the disease may include, among others: Marital conflict, family violence (physical, emotional, and verbal), suicide, hospitalization, or encounters with the criminal justice system.
4. Understand that addiction erodes and blocks religious and spiritual development; and be able to effectively communicate the importance of spirituality and the practice of religion in recovery, using the scripture, traditions, and rituals of the faith community.

- Intervention
  5. Be aware of the potential benefits of early intervention to the:
     a. Addicted person
     b. Family system
     c. Affected children
  6. Be aware of appropriate pastoral interactions with the:
     a. Addicted person
     b. Family system
     c. Affected children
  7. Be able to communicate and sustain:
     a. An appropriate level of concern
     b. Messages of hope and caring
- Referral
  8. Be familiar with and utilize available community resources to ensure a continuum of care for the:
     a. Addicted person
     b. Family system
     c. Affected children
  9. Have a general knowledge of and, where possible, exposure to:
     a. The 12-step programs- AA, NA, Al-Anon, Knar-Anon, Alateen, A.C.O.A., etc.
     b. Other groups
- Self and Others
  10. Be able to acknowledge and address values, issues, and attitudes regarding alcohol and drug use and dependence in:
      a. Oneself
      b. One's own family
  11. Be able to shape, form, and educate a caring congregation that welcomes and supports persons and families affected by alcohol and drug dependence.
  12. Be aware of how prevention strategies can benefit the larger community.

Individuals working in faith-based programs are not typically experts in addiction treatment. However, individuals working in community or institutional treatment programs should definitely be expected to know the basic facts about alcohol and drug dependence, and have a solid understanding of how these problems affect the individual, family members, and the faith community. They should also be cognizant of available resources for treatment, both professional and faith based, in the community. They should be able to connect people with needed services and treatment resources. These core competencies provide a guideline for the skills, knowledge, and attitudes for working in faith-based substance abuse treatment programs.

Faith-Based Program Theories and Research

The relationship between religion and deviant behavior has been debated for almost a century. The primary social control theorist, Travis Hirschi, dismissed religion as important to understanding deviant behavior. Hirschi's social bond theory was the leading theory of deviant behavior at the time. Hirschi's research with data on high school students in the Pacific Northwest found that church attendance is essentially unrelated to delinquency. Students who attend church every week are as likely to have committed delinquent acts as students who attend church only rarely or not at all. Failure to find significant effects of religiosity on crime has resulted in a tireless effort by sociologists and criminologists to either refute or qualify this non-relationship. What has emerged is a body of work that utilizes various approaches to reformulate a theory of religion and crime. These approaches take into consideration a large number of variables and utilize new data and methods to make theoretical advances. This section reviews these approaches, summarizing the empirical literature.

Hellfire Theory, Social Bonding, and Social Control

Travis Hirschi, a well known criminologist, published an article "Hellfire and Delinquency" which questioned the link between "hellfire" and crime. Hellfire theory states that religion deters individual-level criminal behavior through the threat of supernatural sanctions and promotes normative behavior through the promise of supernatural rewards. Hellfire theory measures the extent to which individuals who condemn an act on religiously based moral grounds are unlikely to contemplate engaging in delinquent behavior. Belief in hellfire is typically measured using one or more of a number of indicators: By beliefs regarding whether or not a certain act is a sin or considered morally wrong, by the frequency of church attendance, and by religious salience (i.e., how important religion is in an individual's daily life).

Within criminology, hellfire theory falls under the domain of social control theories. Social control theories assert that the impetus toward crime is uniform or evenly distributed across society. Individuals will break rules unless

controlled. With regard to religion, social control theories assert that religious doctrine and participation reinforce and strengthen internalization of moral beliefs that help regulate behavior and reduce the likelihood that one will turn to criminal behavior.

Parents, adults, school, teachers, and peers control an individual's behavior in the direction of conformity. With regard to religion, bonding theorists purported that religious institutions, like other institutions of social control (e.g., family, school) instill normative beliefs and foster individual attachment, commitment and involvement with the larger society. Religious institutions should deter criminal behavior by strengthening an individual's bond to society. Commitment is generally measured by an individual's membership in a particular religion, whereas participation is generally measured by examining how frequently an individual attends weekly church or religious meetings, or how often an individual participates in church activities (such as activities outside of weekly meetings, time in prayer, study of the bible, etc). Religious attachment has been termed "salience" and is generally measured by an assessment of the importance or practical influences of religion in daily life. Beliefs are often measured, for instance, by asking respondents about their belief in God, the afterlife, and opinions on what types of behavior are sinful.

Since these provocative studies, the majority of studies re-examining religion and crime within a bonding framework have found that religion impacts crime—that there is an inverse relationship between criminal involvement and religiosity. A number of studies have also hypothesized that parental bonds and parental involvement in an adolescent's life would be particularly important components of bonding when analyzing religion's impact on delinquency. One study measured parental religious involvement, as it related to marijuana and alcohol use, by asking high school seniors to place their parents in one of three categories: "Regular" participants, included families in which one or both parents attend church every week. "Occasional" participants included families in which one or both parents attend church at least once a month but neither attends regularly; and "Never," which includes those in which neither parent attends church or if one does, he/she attends only once or twice a year. Respondents were then asked about their religious participation. The study found no support for the hypotheses that parental bonds are an important component of religiosity and delinquency.

In a similar study, researchers examined a juvenile's attachment to their parents as a factor when examining the impact of religiosity on adolescent involvement in drugs and alcohol as well as property, person, and status offenses. Attachment to parents was measured by asking respondents four questions: How much do you like to be with your mother (stepmother or female guardian)?; How much do you want to be like your mother (same as above)?; How close do you feel to your mother (same as above)?; and How much do you

enjoy spending time with you mother (same as above)? The same items were used for father, stepfather, or male guardian. Religiosity was measured by asking respondent about eight religious expressions, including church attendance; time in prayer; study the bible; activity in church; financial contribution; share joys and problems of religious life; talk about religions with family and friends; and try to convert someone. The study found that parental bonds had no effect on delinquent behavior.

In contrast, a later study found that parents' religiosity was important to delinquency. As parents' religiosity rose, child delinquency fell. Similarly it was hypothesized that parental religiosity, not parental bonding, was an important component in explaining the influence of adolescent religiosity on crime. Utilizing two waves of data from the National Longitudinal Study of Adolescent Health, another study set out to test the timing and context for parental religious influence on their adolescent children's delinquent behavior. Parents' religiosity was measured as religious participation, religious salience, and private religious behavior. Religiosity for children included the same measures for adults and added a fourth measure, asking respondent to indicate attendance at church youth activities such as Bible studies or choir. The findings revealed that religious traits of both parent and child curb more serious forms of delinquency than just drinking and smoking. The findings showed that parental religiosity was directly linked to greater delinquency in boys, whereas conservative Protestantism served as a protective factor against the delinquency of boys. With regard to girls, both religiosity and Protestant affiliation offered protection against delinquency. The author argued that "persistent intensive religiosity in parents, while initially serving to foster the same in their children, may, among some, provoke a rejection of the parents' values at some point during adolescence."

As studies examining the effect of religious bonding on crime and delinquency proliferated, many of these studies began to elucidate a number of contextual elements that were important for understanding the relationship between religion and crime. These elements include type of offense, community context, and type of religious denomination.

Religion and Crime: Important Elements of the Relationship

Variation by Type of Offense

In the early 1970s, researchers began to question earlier findings, asserting that earlier studies assumed that all delinquent acts were equally frowned upon by society, without considering how religious teachings differ from secular norms and how those differences may affect criminality. Later it was hypothesized that religiosity would be relevant to delinquency only with respect to those acts that are condemned by churches but publicly condoned by secular

organizations. To test the hypotheses, researchers examined how religiosity (as measured by frequency of church attendance), morality, and supernatural beliefs affected adolescents' involvement in delinquency (larceny, vandalism, and assault) as well as alcohol and marijuana use. The findings showed that religiosity was not significantly related to alcohol and marijuana use. It was concluded that their findings supported their hypotheses—that religiosity influences "victimless" crime, particularly those crimes that are not publicly condoned by secular society.

A few years later, researchers evaluated how religiosity (as measured by religious participation and religious attitudes), and peer and family relationships affected Mormon (members of The Church of Jesus Christ of Latter-Day Saints) juveniles' participation in violent and non-violent crime. Results showed that religious variables had a greater impact on non-violent than violent crime. As other studies began to draw similar conclusions, the literature began to distinguish the behaviors influenced by religion as *ascetic behaviors* (versus *non-ascetic* or *secular behaviors*). Ascetic behaviors include alcohol and drug use, and status offenses. Secular deviance refers to behaviors that are condemned by both religious and secular organizations.

Another study set out to directly test the hypotheses that the impact of religiosity on deviance varies by type of deviance. The author's study was the first to examine a large range of crimes with the intent to inform the ascetic-anti-ascetic debate by understanding the range of deviant behaviors impacted by religion. Deviance was measured by fifteen self-report indicators including: use of beer, wine, liquor, marijuana, stimulants, depressants, psychedelics, and/or narcotics; engaging in premarital sexual intercourse; vandalism; motor vehicle theft; assault; the use or threat to use a weapon; theft of items worth $50 or less; and theft of items worth more than $50. Religiosity was measured by examining salience (*what is the importance to you of the church activities you participate in?)* and religiousness (*how religious of a person are you?*). The findings show that the probability of involvement in deviant behavior is less for the strongly religious than for the weakly religious, but the effect of religious commitment is only slightly stronger for ascetic than secular deviance. It was concluded that the findings offered only minimal support for the anti-ascetic behavior hypotheses. However, it did add that the inhibitory effect of religion on delinquent behavior is more generalized than analysis predicted.

A more recent study of testing the anti-ascetic behavior hypothesis also found no support for a relationship between religiosity and ascetic behaviors. Measures of crime included property, person, and status offenses, as well as measures of alcohol and hard drug use. Religiosity was measured by asking respondents about eight religious expressions, including church attendance; time in prayer; study of the bible; activity in church; financial contribution; share joys and problems of religious life; talk about religions with family and friends; and try

to convert someone. However, in a later study the findings yielded mixed support for the hypotheses. It was found that religion has an inverse relationship with alcohol use and criminal behavior but found no relationship for drug use.

Researchers argue that empirical research generally has failed to make the claim that religion has special effects on a unique type of offense. They assert that research has not empirically grounded and validated the ascetic crime conception that clearly establishes it as a distinct type of crime. To test the ascetic crime hypothesis, a study examined self-report responses from a mail survey answered by 477 white respondents. Respondents were asked about 43 possible criminal acts, including workplace crime and white-collar crime. Religion measures included religiosity, denominational conservatism, and interpersonal religious networks. Religiosity was measured as a multiple-dimension scale that included religious activity (involvement), religious salience (attachment), and hellfire beliefs. An important component of the study was inclusion of measures of *secular constraints* and measures of the *socio-ecological neighborhood context*. Some studies have concluded that secular sources of morality weaken the religion-delinquency relationship. These social constraints and legal deterrents included measures of expressions of respect for father and mother, quality of relationships with parents, the probability that friends would intervene to keep one from breaking the law, and fear of detection of illegal behavior, apprehension, and sanctioning by the law.

Measures of the socio-ecological context included both measures of individual perceptions of the social integration of their neighborhood, and aggregate census measures of the neighborhoods that were attributed to individuals. Aggregate measures included proportion of rental housing and percentage of female-headed households. It has been found that religiosity impacted all forms of adult crime, rendering no support for the antiascetic behavior hypothesis. With regard to type of religiosity, only one subdimension of general religiosity—*participation* in religious activities—had direct personal effects on adult criminality. This relationship remained significant even when secular controls, religious networks, and social ecology were taken into account. Hellfire beliefs and salience had no significant effects on general crime when all controls were taken into account.

The findings from this study, as well as later studies, have led to the general conclusion that it is behavior, not beliefs, that are important in inhibiting criminal involvement. It suggests that those that are active in church-sponsored events are subjected to religious-group controls. Participation in religious activities requires immersion of church networks.

Variation by Religious and Social Contest: Moral Communities

New research findings in 1982 led researchers to begin to assert that the effect of religion on delinquency is ecological in nature. Measuring religiosity by evaluating religious values, religious salience, and religious participation; it was found that in communities where religious commitment is the norm, the more religious an individual, the less likely he or she will be delinquent. However, in highly secularized communities, even the most devout teenagers are no less delinquent than the more irreligious. Note the statement:

So long as we restrict ourselves to thinking that religious beliefs concerning the punishment of sin function exclusively as elements within the individual psychic economy, causing guilt and fear in the face of temptations to deviate from the norms, we may or may not find confirmatory evidence. However, if we take a more social view of human affairs, it becomes plausible to argue that religion only serves to bind people to the moral order if religious influences permeate the culture and the social interactions of the individuals in question.

The purported link between community context and religion's influence on deviance and crime has become known as the *moral communities hypothesis*. This hypothesis specifies that it is neither the degree of personal religiosity, nor the type of offense, nor even individual-level religious affiliation or denomination that matters with regard to criminal behavior; but that community-level religiosity provides a moral climate that becomes embedded in the culture of the community.

However, other empirical research evaluating the moral communities hypothesis has produced mixed results. Researchers examined self-reported data on projected deviance from a sample of adults located in Iowa, New Jersey, and Oregon in order to determine the link between contextual variables (such as normative dissensus, social integration, perceived conformity, aggregate religiosity, and status inequality) and deviance. Religiosity was measured by frequency of church attendance. Results showed that under some conditions religious participation inhibited deviance. Religiosity had its greatest effect on locations where "secular social disorganization" was predominant or where "the larger environment lacks the mechanisms that normally curtail deviance." Specifically, the religiosity-deviance relationship can be predicted across socio-demographic contexts. Individual religiosity was the most effective in restricting deviant behavior in areas distinguished by general normative ambiguity, low social integration, generalized perceptions of low peer conformity, and a high proportion of religious non-affiliates. Further, religious participation inhibits deviance when conformity-inducing mechanisms typical of religious communities are not replicated in the larger community. The study concluded that the impact of religious constraints is amplified when secular controls are not present.

Using a unified ecological data set from 75 American metropolitan cities, researchers tested the deterrent effect of religion on crime, suicide, cultism, and homosexuality. The results showed that many forms of crime and cultism were deterred by religion, while the influence of religion upon suicide and homosexuality was indirect. It was concluded that the effect of religion changes with social context, and social conditions may vary drastically over time and space.

Religion, Crime, Violence, and Terrorism

In a time of international terrorism, we have seen the connection between religion, crime, and violence. This is obviously not a new connection. Almost two hundred years ago the fanatical preacher John Brown was executed for treason (terrorist acts). It is well known his violence was being supported and funded by abolitionists and anti-slavery churches in New England. He became a hero in the abolitionist North and a hated man in the pro-slavery South.

Today we see the connections between religion, drugs, and violence in both domestic and international terrorist activities.

- Religious groups fund, support, and train individuals for violence in terrorist camps and on the internet.
- Many terrorist activities are supported by money from the illicit drug trade.
- There are indications that terrorist groups are recruiting followers in non-traditional faith groups in American correctional institutions. Although most of the prisoner conversions to non-traditional religions exert a positive influence on inmate attitudes and behaviors, some carry the potential for ideologically inspired criminal attitudes and behaviors. Consequently, a small group of adherents to Islam or white supremacy religions could instigate terrorist acts upon their release from custody.

The risks are great and the connections between religion, crime, violence, and drugs are very complex and dangerous. We have to insure that there are not unintended consequences of faith-based treatment programs in American correctional institutions.

Motivation for Participation in Faith-Based Programs

The question inevitably arises as to why offenders become involved in religious and faith-based programs in correctional institutions. Sometimes offenders are sincere or genuine in their religious belief and practice. In contrast, other offenders were more likely to be involved in faith-based and religious programs for insincere purposes. They are involved for manipulative purposes

even though they might claim to be religious. Some of the important sincere and insincere reasons are:

Sincere-

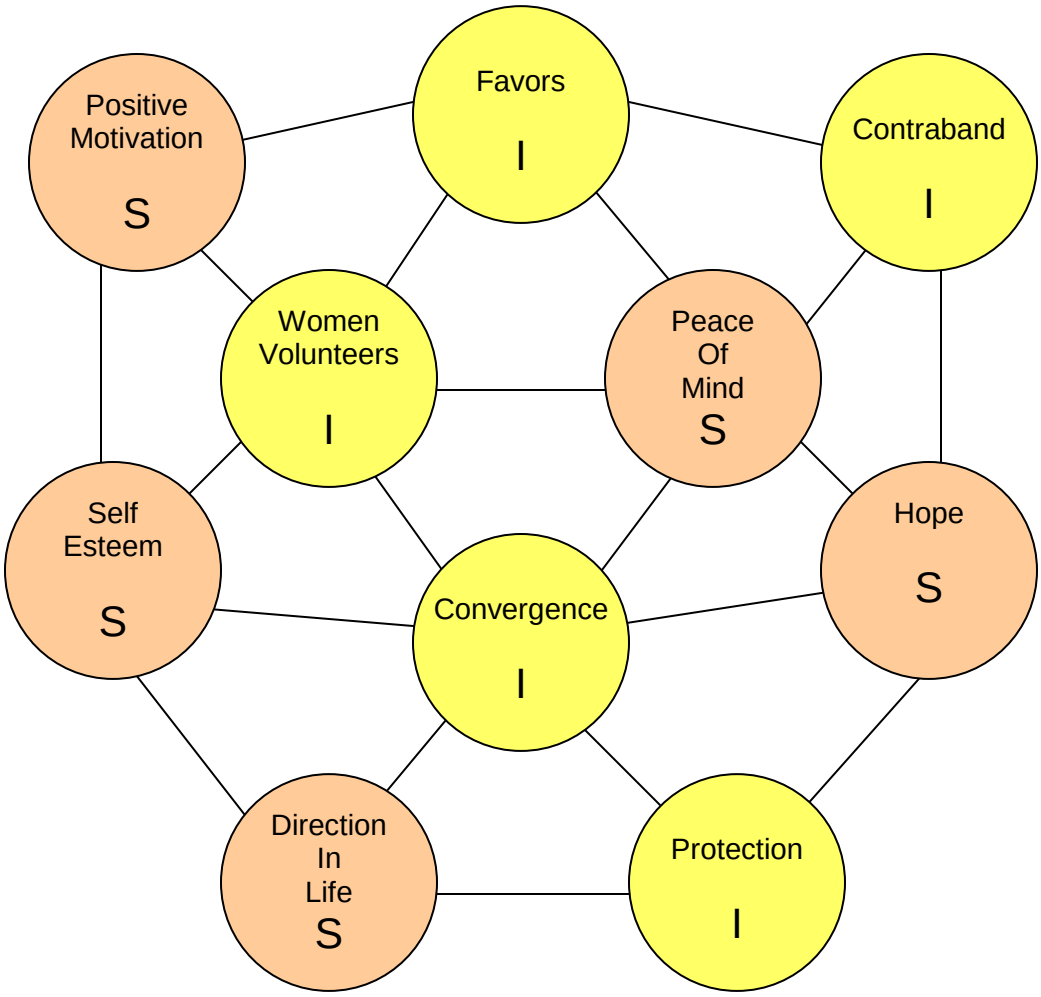
- Motivation. Religion gives offenders direction and meaning to life. Religion gives them a way to search for a life that is better than their present life condition.
- Hope. Faith-based programs give offenders hope to keep them optimistic about the future, and that they will be reformed from a life of drugs and crime after they are released.
- Peace of mind. Offenders participate in religious and faith-based programs to achieve an inner peace to deal with the intense feelings of guilt, fear, rejection, and personal failure.
- Self-esteem. Offenders also participate in religious programs to improve their self-concept and self-esteem.
- Self-control. Many offenders become involved in faith-based programs to develop self-control to assist them in:
  1. Complying with institutional rules and regulations.
  2. Avoiding risky behavior such as drug dealing and foul language.

Insincere-

- Protection. One of the most significant reasons why offenders in institutions become involved in religion is for protection. Faith-based programs served as a means of protection and was related to:
  1. Race. In many correctional institutions, being Muslim provides an offender with protection.
  2. Past criminality. If an offender was incarcerated for child molestation or sexual assault of a child, for example, religious involvement would allow some protection from attack from other offenders.
  3. Sexual preference. Many offenders who practice homosexuality attend religious services for protection.
- Social networking. Faith-based programs allow offenders to converge and socially interact with other offenders. This interaction provided two opportunities:
  1. Socialization with friends
  2. Passing contraband
- Women. Faith-based and religious programs allow male offenders the opportunity to interact with women staff members and volunteers.
- Program resources. Finally, an insincere reason for faith-based and religious program involvement was to exploit resources.
  1. Free food and other special occasion items.
  2. Music and musical instruments.
  3. Opportunity to obtain favors from the program staff.

In conclusion, there are many reasons for the involvement in faith-based and religious programs. What is not clear is the degree to which offenders participate in these programs to obtain early *parole*. It is a common belief that offenders attend these programs which the hope that authorities will think they have become rehabilitated and ready for release. It is not clear whether this belief is true. Figure 6 provides a visual representation of these sincere and insincere motivation factors.

Figure 6
Motivation for Offenders to Participate in
Faith-Based Programs: Sincere (S), Insincere (I)



Critical Issues in Faith-Based Substance Abuse Treatment

Even though religious organizations are doing excellent work in treating substance abuse and significant contributions are being made to this nation by people and organizations of faith, several critical issues have arisen in the faith-based treatment of substance abuse.

- *Selection Bias*. Typically participants who volunteer for faith-based programs are more motivated to make changes in their lives. Consequently, unless the program selection process accounts for pre-existing differences between the treatment and non-treatment groups, there is no way to determine whether differences between program participants are due to actual program effects. Selection bias can go two ways:
    1. Religiously devout offenders are the ones most likely to volunteer for treatment programs based on faith.
    2. Hard core offenders are likely to volunteer to impress prison personnel as well as the parole board

  In any case, *motivation* for participation is always the weak point in any comparison group design when the effectiveness of faith-based substance abuse programs is being studied.

- *Effectiveness.* Another major issue is what measures are used to evaluate the effectiveness of faith-based treatment programs. Which of the following would be most appropriate:
    1. Arrest?
    2. Incarceration?
    3. Relapse?

  Measuring all of these criteria for effectiveness is a difficult, if not elusive task.

- *Autonomy vs. equal employment*. If autonomy is maintained in the faith-based substance abuse treatment program, what should be done about a system that takes money from taxpayers and gives it to religiously affiliated programs, which are allowed to deny staff or volunteer positions to applicants based on their religious preference? There are obviously serious questions in the provision of federal funds to religious organizations that proselytize to state-incarcerated citizens and simultaneously deny employment to members of other faiths.

- *Program selectivity*. There are potential problems associated with government selectivity in determining the recipients of direct funding. This selectivity becomes a strong issue when there is extreme diversity in religions:
    1. Inter-religious diversity. The rising number of non-Christian groups can contribute to the problem. Should funding for faith-based

substance abuse treatment programs include Hare Krishnas, Scientologists, The Nation of Islam, Wiccans, Santerias, and native American Churches?

2. Intra-religious. Within the Christian groups there is a strongly felt division between fundamentalists and mainline denominations. This diversity is even more pronounced if groups like Deliverance and healing Ministries are included in the pool of potential funding possibilities.

The issue is created by the prospect that a particular religious group may be eligible to receive aid and some may not, or received by some government agencies but not by others.

- *Professional Standards*. States are accountable for the quality of the services they provide and have a legal obligation to evaluate the standards of service providers at the highest level. Consequently, the clinical competency of the treatment provider is the most important issue. Faith-based organizations tend to insist that evidence of clinical competency is discriminatory, whereas professional drug and alcohol counseling organizations believe that failure to require evidence of competency constitutes malpractice.

- *Rehabilitation vs*. *Redemption*. In faith-based substance abuse treatment programs, a critical issue concerns the goals of the program. This issue is an almost insurmountable constitutional barrier to direct funding because faith-based programs readily state that the only way to help drug addicts is through religious conversion. They feel that offenders do not simply need rehabilitation. They require regeneration of a sinful heart. Thus crime and substance abuse are seen as a fundamental moral and spiritual problem. Tax funding for programs having a religious transformation as their goal implicates core constitutional concerns because the government is, in fact, setting up a church with public tax money.

- *Oversight*. In addition, there is the issue of supervisory oversight and program monitoring. Most states have extensive organizational structures to oversee professional substance abuse counseling programs. In the case of faith-based programs, who is going to oversee and monitor programmatic content for constitutional compliance and legal/ethical risk violations?

- *Secular alternatives*. Also, there is the issue of the requirement that secular alternatives be provided for program participants who do not want to be in a faith-based substance abuse treatment program. Many programs are located in rural areas where alternative programs are not convenient or available. In addition, the community where the treatment

program is located may not be diverse and few alternatives are available. Some of the secular programs available are:

1. *Secular Organization for Sobriety (SOS).* SOS is an abstinence-based self-help program that believes that sobriety should be the highest priority for recovering alcoholics.
2. *Women For Sobriety (WFS).* This is an abstinence-based self-help group that emerged from the realization that female alcoholics differ from their male counterparts in a number of important ways. They drink for different reasons and have different reactions to alcohol.
3. *SMART Recovery.* Self Management and Recovery Training (SMART) is an abstinence-based self-help program that utilizes cognitive behavioral techniques to train members in changing self-defeating thinking.
4. *Rational Recovery (RR).* This is an abstinence-based self-help program that focuses on self-empowerment using Rational Emotive Therapy (RET).
5. *Moderation Management (MM).* This is the only self-help group that supports problem drinkers who wish to moderate their alcohol consumption rather than abstain.

Most of these secular programs exist because some individuals have found that religious or spiritual programs were not suited for their needs and one program type does not fit all individuals.

- *Feminist Therapy*. Alcoholics Anonymous and 12-step programs have gained acceptance as an important, if not necessary, adjunct to professional counseling and a primary element of faith-based substance abuse treatment programs. Yet feminists take issue with the core belief of the 12-steps: "I am powerless over alcohol". Powerless is viewed as the source of women's oppression within a patriarchal society. It has been suggested that many women abuse chemicals *because* they feel powerless in their lives. Thus, many women prefer to affirm that they have the power to *choose* not to use chemicals or have dependent relationships. The central issue in faith-based substance abuse treatment programs is the degree to which the program can address feminist issues.

- *Multiculturalism/Diversity*. America is rapidly becoming multicultural, multiethnic, multireligious and multidenominational. This issue concerns the degree to which a traditional and primarily white Christian based treatment approach to substance abuse can be adapted to the diverse characteristics of a rapidly emerging nation of individuals with vastly different beliefs and religious traditions. For example, diverse characteristics can encompass gender, ethnic, and religious differences. To support this diversity are the findings that there are stark contrasts between the religious practices of incarcerated African American men and women. Male inmates tend to convert to Islam at a much higher degree

than African American female inmates. If religion and faith-based programs are going to continue as a means of rehabilitation, then striking differences in cultural, gender, and religious preferences will have to be considered in faith-based substance abuse treatment programming.

- *Screening/Assessment*. Faith-based substance abuse treatment programs do not typically screen or assess participants the way that professional treatment programs do. This lack of screening and assessment could lead to several types of participants who would not be appropriate candidates for treatment:
  1. Intellectually challenged clients/offenders who could have difficulty understanding abstract religious and spiritual concepts.
  2. Antisocial/psychopathic clients/offenders who are likely to be very disruptive in any treatment program.
  3. Sex offenders who may be covering a less socially acceptable with a more socially acceptable classification.
  4. High or low risk offenders who may not be matched to the appropriate level of program intensity.

- *Deterioration of Effect*. A critical issue for any treatment program is the degree of (and time for) treatment effect to "wash out" and deteriorate once the participant has left the program. This issue is important for faith-based programs. Folklore among correctional personnel alludes to the volume of religious books and reading materials thrown in the trash receptacles as the newly released offender is leaving the institution. The issue concerns the degree to which offenders "get religion" in faith-based programs that is conscious or unconscious role playing with little, if any, permanency or long-term effect.

- *Court-ordered Treatment.* There has been a widespread practice in operation at the local, state, and national levels where offenders are ordered to enter treatment programs that are primarily faith-based or attend community out-patient faith-based programs for substance abuse problems. The practice of court-ordered treatment creates serious legal, ethical, practical, and theoretical concerns, not the least of which is a faith-based program becoming a form of punishment.

Spirituality and Substance Abuse Counseling Orientations

Now that you have completed most of this course of faith-based substance abuse counseling, you may find it interesting to turn to the *appendix* and complete the *Comprehensive Substance Abuse Counseling Orientation Inventory (CSACOI).* Regardless of whether you are a faith-based or professional counselor, the CSACOI will give you an indication of

how much you endorse spirituality in substance abuse counseling or other orientations.

The CSACOI is self administered, so you need only to respond to the 15 items on the *answer sheet* and then score each of the three components by adding the number of items marked “agree”. Then, compare your score with some of the scores provided.

Legal Issues Associated with Faith-Based Treatments

Legal developments pertaining to service partnerships between government and faith-based organizations (FBOs) typically involve matters of both substance and process. The following summary is a presentation of the administrative, judicial, and procedural outcomes of litigation by December 2006.

Problems of Guidance

Current establishment clause law generally prohibits the use of direct public funds for religious activity, including social services that have significant religious content. The constitutionality of a program of direct public aid depends significantly on the extent to which the program can ensure that public funds are not used for religious activities. A constitutionally sound program must therefore provide public officials and grantees with adequate guidance about limits on the use of public funds and on necessary mechanisms for monitoring and auditing grantees’ expenditures. As we have noted in prior reports, the guidance provided under the Faith Based and Community Initiative (FBCI) remains a matter of some concern.

A. Report of the U.S. Government Accountability Office, Faith-Based and Community Initiative: Improvements in Monitoring Grantees and Measuring Performance Could Enhance Accountability (June, 2006).

In June of 2006, the Government Accountability Office (GAO) released a study on the FBCI that focused on a number of aspects of the Initiative, including the extent to which federal and state agencies provide grantees with adequate information about the regulations that govern aid to FBOs. The report identified a number of successes within the FBCI, but also raised questions about faith-based grantees’ understanding of restrictions that are especially relevant for FBOs, including limits on their use of public funds. In addition, GAO identified weaknesses in agencies’ ability to monitor the compliance of FBOs with regulations on the use of government funds.

B. ACLU of Massachusetts v. Michael O. Leavitt, Secretary of Health and Human Services (U.S. District Court for the District of Massachusetts, settled February 22, 2006).

On February 22, 2006, the Department of Health and Human Services (HHS) and the American Civil Liberties Union (ACLU) of Massachusetts reached a settlement in a lawsuit that challenged the constitutionality of HHS grants to the Silver Ring Thing (SRT), a faith-based sexual abstinence education program. The settlement agreement is highly significant because it incorporates a set of safeguards that HHS agreed to impose on SRT should the program again receive government aid. The safeguards document, which was prepared by HHS, represents the clearest and most complete legal guidance for faith-based grantees that has thus far been produced under the FBCI.

- **GRANTS FOR CAPACITY-BUILDING**

Barry Christianson v. Michael O. Leavitt, Secretary of Health and Human Services (U.S. District Court for the Western District of Washington, filed September 12, 2006).

On September 12, 2006, Americans United for Separation of Church and State filed suit against the Department of Health and Human Services (HHS), alleging that the Department violated the Establishment Clause by awarding grants under the Compassion Capital Fund (CCF) to a marriage counseling organization that provides exclusively religious counseling programs. The lawsuit is of great significance for the FBCI because it represents the first direct challenge to a grant for capacity building. Such grants are at the heart of the FBCI's project of Legal Developments Affecting Government Partnerships with Faith-Based Organizations helping smaller religious and community-based entities improve their ability to deliver social welfare services. But the lawsuit raises serious questions about the constitutionality of capacity building grants for organizations that only provide explicitly religious social welfare services.

- **FAITH-BASED PROGRAMS IN PRISON**

A. Americans United for Separation of Church and State v. Prison Fellowship Ministries (U.S. District Court for the Southern District of Iowa, decided June 2, 2006).

In June of 2006, a federal district court in the Southern District of Iowa issued a long-awaited ruling in a case involving a challenge by Americans United to a faith-based rehabilitation program in the Newton Correction facility in Iowa. The ruling represents a significant victory for Americans United.

Chief Judge Pratt's opinion describes a state-financed program of prisoner rehabilitation that is suffused with evangelical Christianity, and that involves substantial efforts to transform the religious identity of prison inmates. The state has sponsored no comparable secular program, nor any comparable program involving any other faith tradition. Moreover, the program offers valuable material privileges to its participants, and thereby induces religious participation. The judge declared the program to be a violation of the Establishment Clause, ordered the cessation of the program, and ordered Prison Fellowship Ministries, the program grantee, to return $1.5 million to the State of Iowa. The case is now on appeal.

B. Freedom From Religion Foundation v. Alberto R. Gonzales (U.S. District Court, Western District of Wisconsin, filed May 4, 2006).

Shortly before the Iowa decision involving Prison Fellowship Ministries, Freedom From Religion Foundation filed suit against the federal Bureau of Prisons with respect to the Bureau's "Life Connections" program. The program's first phase, Life Connections 1, involves a multi-faith approach to prisoner reentry and rehabilitation, all under the supervision of prison chaplains. By contrast, a new phase of the program, Life Connections 2, was described in the Bureau's initial request for proposals as a single-faith, residential program for prisoners. Several weeks after the lawsuit was filed, the federal Bureau of Prisons suspended plans for the Life Connection 2 program, and has recently cancelled it. Adjudication of the validity of the Life Connections 2 program is thus moot, but the case may nevertheless proceed with respect to the Life Connection 1 program.

- **GOVERNMENT CHAPLAINCIES – AND THEIR LIMITS**

A. Freedom From Religion Foundation v. R. James Nicholson, Secretary of Veterans Affairs (U.S. District Court for the Western District of Wisconsin, filed April 18, 2006, motion to dismiss denied September 5, 2006).

On April 18, 2006, FFRF filed suit against the Department of Veterans Affairs (VA), alleging that the chaplaincy program of the Veterans Health Administration violates the Establishment Clause because it integrates spirituality into all aspects of its healthcare. FFRF does not claim that the chaplaincy itself is unconstitutional, but rather that the VA's chaplaincy program exceeds the constitutionally limited warrant for government-financed chaplaincy.

The lawsuit will be an important test of the scope and limitations of government chaplaincies, which fall within a poorly developed area of Establishment Clause law. Because the practices of VA chaplains that are challenged in this lawsuit seem very similar to those of chaplains at other government-funded healthcare facilities, this lawsuit could have an impact far beyond the VA program.

The district court recently denied the VA's motion to dismiss the lawsuit. The parties will now proceed to develop the factual record that will be necessary to resolve the litigation.

B. GAO Report, Faith-Based and Community Initiative: Improvements in Monitoring Grantees and Measuring Performance Could Enhance Accountability (June 2006).

In its June, 2006 Report on the FBCI, GAO raised concerns about the interpretation of "chaplaincy" used in Department of Justice (DOJ) grants. Specifically, GAO questioned the claim apparently made by DOJ officials that restrictions on the use of direct government aid for religious activities do not apply in the context of community corrections centers. GAO's concerns highlight the need for greater clarity about limitations on the government's role in supporting religious activities for individuals who are under government care or control.

- **STRUCTURAL, PROCEDURAL, AND REMEDIAL CONCERNS**

Increasingly, litigation under the Establishment Clause is shaped by concerns of structure, procedure, and remedy. In particular, questions of the identity of the parties, the timing of the suit, and remedial options available to the courts, all have significant impact on the litigation and the challenged programs. Two recent decisions by the U.S. Court of Appeals for the 7th Circuit have highlighted these concerns. The Supreme Court has been asked to review both of them.

A. Freedom From Religion Foundation v. Dennis Grace, Acting Director of WHOFBCI (U.S. Court of Appeals, 7th Circuit, decided January 2006, rehearing denied May 2006, petition for certiorari filed August 2006).

This case is a broad-based, constitutional challenge to the promotion of the FBCI by the White House Office of Faith-Based and Community Initiatives, and by various Cabinet-level agencies. The district court (Western District of Wisconsin) dismissed the suit on the ground that the named taxpayer-plaintiffs did not have legal standing to challenge this promotional conduct by the Executive Branch. In January, 2006, a panel of the Court of Appeals reinstated the lawsuit in an opinion that supported a very broad view of taxpayer standing. Several months later, the full court of appeals denied rehearing in the case. The denial was accompanied by opinions from several of the 7th Circuit judges explicitly calling for Supreme Court reconsideration of the law of taxpayer standing in Establishment Clause cases. The United States has asked the Supreme Court to review the 7th Circuit's decision. As of this writing, the Supreme Court had not yet decided whether or not to grant review in the case.

B. Laskowski v. Spellings (U.S. Court of Appeals, 7th Circuit, decided May 2006, rehearing denied July 2006, petition for certiorari filed October 2006).

This case involves a challenge to an earmarked appropriation that led to a grant from the U.S. Department of Education, to the University of Notre Dame, for a program entitled Alliance for Catholic Education. The program trains teachers, a number of whom participate in the Americorps program for placing teachers in schools in poor areas. Notre Dame redistributed much of the grant to other Catholic colleges that engage in this teacher training, and the suit alleges that subgrantees impermissibly spent grant funds on instruction to teachers on how to live and work within the Catholic faith. The district court dismissed the suit as moot, because the money had already been spent and the grant was non-recurring. On appeal, the 7th Circuit reinstated the case. Judge Posner's opinion argued that the case was not moot, because the district court might still order Notre Dame to repay any amount that had been spent in violation of the Establishment Clause. The obligation to repay, Judge Posner concluded, should turn on whether or not Notre Dame reasonably believed its expenditures to be lawful. The case raises very important questions about the potential impact on FBOs if they receive and spend government funds in ways that the Constitution forbids. In late October, Notre Dame filed a petition for certiorari with the Supreme Court, seeking review of the Seventh Circuit's decision. As of this writing, the Court had not yet acted on that petition.

- **STATE CONSTITUTIONAL LAW**

A. Bush v. Holmes (Florida Supreme Court, decided January 5, 2006)

In early January, 2006, the Supreme Court of Florida affirmed (by a vote of 5-2) a decision of an intermediate state court that Florida's school voucher program violated the state's constitution. Unlike the lower court, however, the state Supreme Court did not rely in this decision on the state's "Blaine Amendment," which prohibits financial assistance "directly or indirectly in aid of any church, sect, or religious denomination or in aid of any sectarian institution." Instead, the Supreme Court relied on a separate provision of the state constitution, which obliges the state to provide "by law for a uniform, efficient, safe, secure, and high quality system of free public schools that allows students to obtain a high quality education." As a result of this decision, the OSP will now terminate at the end of the 2005-06 school year. The full impact of Florida's Blaine Amendment on any other state policies of financial support for faith-based organizations remains highly uncertain.

B. Taetle v. Atlanta Independent School System (Georgia Supreme Court, decided January 17, 2006)

On January 17, 2006, the Georgia Supreme Court held that the Atlanta school system did not run afoul of Georgia's "Blaine Amendment" by leasing classroom space from a Baptist Church for a kindergarten annex that would be operated by the public school system. The Court reasoned that the transaction between the City and the church was entirely commercial, involved payment at ordinary market value, and did not include the provision of any educational or social services by the church itself. The arrangement thus did not involve the state in assisting the church, nor in supporting social or educational services offered by the church. The impact of Georgia's Blaine Amendment on government-financed social services by religious entities thus remains a highly controversial question in both the law and the politics of Georgia.

Appendix

REFERENCES

American Prison System. Criminal Justice Policy Review. 16(2), 164-189. McLoy, L.K., Hermos, J.A., Bokhoor, B.G. & Frayne, S.M. (2004). Conceptual Bases of Christian, Faith-Based Substance Abuse Rehabilitation Programs: Qualitative Analysis of Staff Interviews. Substance Abuse, 25(3), 1-11. McMinn, M.R. (Ed) & Dominquez, A.W. (Ed.) (2005). Psychology and the Church. Hauppauge, NY: NOVA Science Publishers

Aromin, R.A., Galanter, M., Solhkhaha, R., Dermatis, H. & Bunt, G. (2006). Preference for Spirituality and Twelve-Step-Oriented Approaches Among Adolescents in a Residential Therapeutic Community. Journal of Addictive Diseases. 25(2), 89-96

Bell, J., Islam, M., Bobak, T., Ferrari, J. R., & Jason, L. A. (2023). Spiritual awakening in 12-step recovery: Impact among residential aftercare residents. Spirituality in Clinical Practice, 10(4), 337-349. https://doi.org/10.1037/scp0000296

Berenson, D. (1991). Powerlessness—Liberating or Enslaving? Responding to t Feminist Critique of the Twelve Steps. In C. Bepko (Ed). Feminism and Addiction. (67-84). New York: The Haworth Press

Branham, L.S. (2004). "Go and Sin no More". The Constitutionality of Governmentally Funded Faith-Based Prison Units. University of Michigan Journal of Law Reform, University of Michigan Law School

Brown, D.R., Scott, W., Lacey, K., Blount, J., Roman, D. & Brown, D. (2006). Black Churches in Substance Use and Abuse Prevention efforts, Journal of Alcohol and Drug Education, 50(2), 43-65

Buddie, A.M. (2004). Alternatives to Twelve-Step Programs. Journal of Forensic

Burnside, J. Loucks, N., Adler, J.R. and Rose, G. (2005). My Brother's Keeper: Faith Based Units in Prisons. Portland, OR: William Publishing

Camp, S.P., Klein-Saffran, J., Okyun, K., Daggett, D.M. & Joseph, V. (2006). An Exploration into Participation In a Faith-Based Prison Program. Criminology and Public Policy, 5(3), 529-550

Clinical Psychology. 62(6), 735-750. National Crime Prevention Council (2003). Philanthropy and Faith: An Introduction. Washington, DC: NCPC. National Institute on Drug Abuse (2009). Principles of Drug Addiction Treatment: A Research Based Guide (second edition). National Institute of Health, Bethesda, Md

Cloud, R.N., Ziegler, C.H. & Blondell, R.D. (2004). What is Alcoholics Anonymous Affiliation? Substance Use & Misuse. 39(7), 1117-1136. Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members DHH Pub. No. (2004). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

Common Ground. Working Group on Human Needs and Faith-Based and Community Initiatives (2002). Finding Common Ground: 29 Recommendations of the Working Group on Human Needs and Faith-Based Community Initiatives. Washington, DC: Search for Common Ground. Faith-Based Substance Abuse Treatment Working Group on Human Needs and Faith-Based and Community Initiatives (2003). Harnessing Civic and Faith-Based Power to Fight Poverty. Washington, DC: Search for Common Ground

Coyle, C., Crum, R.M., & Ford, D.E. (2006). Associations Between Spirituality and Substance Abuse Symptoms in the Baltimore Epidemiologic Catchment Area Follow-Up, 1993-1996. Journal of Addictive Diseases. 25(4), 125-132

Daggett, D.M., Camp, S.D., Kwon, O., Rosenmerkel, S.P. and Klein-Saffran, J. (2008). Faith-Based Correctional

Programming in Federal Prisons: Factors

Dammer, H.R. (2002). The Reasons for Religious Involvement in the Correctional Environment. Journal of Offender Rehabilitation. 35 (3/4), 35-58

Dermatis, H., Guschman, M.T., Galanter, M. & Bunt, G. (2004). Orientation Toward Spirituality and Self-Help Approaches in The Therapeutic Community. Journal of Addictive Diseases. 23(1), 39-54

Dix-Richardson, F. (2002). Resistance to Conversion to Islam Among African

Dooley, T. P., MeGahee, J., & MeGahee, M. (2026). Retrospective cohort study of The Lovelady Center: A large faith-based residential recovery program for women with substance use disorders in the USA. Journal of Religion and Health. https://doi.org/10.1007/s10943-026-02659-6

Duvall, J.L., Staton-Tindall, M., Oser, C.B., and Leukefeld, C.G. (2008). Persistence in Turning to Faith as a Predictor of Drug Use and Criminality Among

Ebaugh, H.R., Chafetz, J.S. & Pipes, P.F. (2006). Where's the Faith in FaithBased Organizations? Measures and Correlates of Religiosity in Faith-Based

Edwards, A. (2006). Cognitive and Cognitive-Behavioral Therapy with Religiously Oriented Clients: Two Case Studies. Social Work and Christianity, 33(1), 36-57

Fiorentine, R. & Hillhouse, M.P. (2003). Why Extensive Participation in Treatment and Twelve-Step Programs Is Associated with Cessation of Addictive Behaviors: An Application of the Addicted-Self Model of Recovery. Journal of Addictive Diseases, 22(1), 35-55

Gallanter, M. (2006). Spirituality and Addiction: A Research and Clinical Addiction: A Research and Clinical Perspective. The American Journal on Addictions. 15(4), 286-292

Geter, L. (2009). Faith-Based Initiative—A Brief Perspective. Retrieved from: http://EzineArticles.com/?expert=Leon_Geter

Governmental Research. The National Center on Addiction and Substance Abuse At Columbia University (2001). So Help Me God: Substance Abuse, Religion and Spirituality

Griffin v. Coughlin, 88 N.Y.2d 674 (1996).

Hai, A. H., Franklin, C., Park, S., DiNitto, D. M., & Aurelio, N. (2019). The efficacy of spiritual/religious interventions for substance use problems: A systematic review and meta-analysis of randomized controlled trials. Drug and Alcohol Dependence, 202, 134-148. https://doi.org/10.1016/j.drugalcdep.2019.04.045 (PMID: 31349206)

Hall, S.T. (2003). Faith-Based Cognitive Programs in Corrections. Corrections Today, 65(7), 108-113, 120-137

Hamm, M.S. (2007). Terrorist Recruitment in American Correctional Institutions: An Exploratory Study of Non-Traditional Faith Groups Final Report. Retrieved from: http://www.ncjrs.gov/app/publications/abstract.aspx?ID=242801

Harden, M.G. (2006). Towards a Faith-Based Program Theory: A Reconceptualization of Program Theory. Evaluation Review, 30(4), 481-504

Harris, A.H.S., Thoresen, C.E. & Lopez, S.J. (2007). Integrating Positive Psychology Into Counseling: Why and (When Appropriate) How. Journal of Counseling and Development. 85, 3-13

Hercik, J. (2004). Development of a Guide to Resources on Faith-Based Organizations in Criminal Justice. U.S.

Department of Justice, Office of Justice Programs, National Institute of Justice

Inouye v. Kemna, 504 F.3d 705 (9th Cir. 2007).

Johnson, B.R. & Larson, D.B. (2003). The Inner Change Freedom Initiative: A Preliminary Evaluation of a Faith-Based Prison Program. University of Pennsylvania: Center for Research on Religion and Urban Civil Society (CRRVCS)

Kelly, J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics Anonymous and other 12-step programs for alcohol use disorder. Cochrane Database of Systematic Reviews, 2020(3), CD012880. https://doi.org/10.1002/14651858.CD012880.pub2 (PMID: 32159228)

Kennedy, S.S. (2003). Redemption or Rehabilitation? Charitable Choice and

Kerley, K.R., Matthews, T.L. & Blanchard, T.C. (2005). Religiosity, Religious Participation, and Negative Prison Behaviors. Journal for The Scientific Study of Religion. 44(4), 443-457

Kerley, K.R., Matthews, T.L. & Shulz, J.T. (2005). Participation in Operation Starting Line, Experience of Negative Emotions, and Incidence of Negative Behavior. International Journal of Offender Therapy and Comparative Criminology, 49(4), 410-426

Kerr v. Farrey, 95 F.3d 472 (7th Cir. 1996).

Koh, H. K., Frederick, D. E., Balboni, T. A., O'Reilly, S. M., Kelly, J. F., Humphreys, K., Botticelli, M., Mathur, M. B., Psimopoulos, C. S., Long, K. N. G., & VanderWeele, T. J. (2026). Spirituality and harmful or hazardous alcohol and other drug use: A meta-analysis of longitudinal studies. JAMA Psychiatry, 83(4), 363-378. https://doi.org/10.1001/jamapsychiatry.2025.4816 (PMID: 41706493)

Kownacki, R.J. & Shadish, W.R. (1999). Does Alcoholics Anonymous Work? The Results From a Meta-Analysis of Controlled Experiments. Substance Use & Misuse. 34(13), 1897-1916

Krepper, P. (2003). Faith, Public Policy, and The Limits of Social Science. Criminology and Public Policy, 2(2), 331-352

Lupu, I.C. & Tuttle, R.W. (2006). The State of the Law 2006: Legal Developments Affecting Government Partnerships with Faith-Based Organizations. George Washington University: The Roundtable on Religion and

Mallow, A.J. (1998). Self-Disclosure: Reconciling Psychoanalytic Psychotherapy and Alcoholics Anonymous Philosophy. Journal of Substance Abuse Treatment. 15(6), 493-498. Faith-Based Substance Abuse Treatment McDaniel, C., Davis, D.H. & Neff, S.A. (2005). Charitable Choice and Prison Ministries: Constitutional and Institutional Challenges to Rehabilitating the

Manzler, C. A., Lewis, B., Teitelbaum, S., & Schlauch, R. C. (2026). Investigation into the psychometric properties of the Brief Religious Coping Scale (Brief RCOPE) in adults with substance use disorder. Addictive Behaviors, 174, 108584. https://doi.org/10.1016/j.addbeh.2025.108584

Mears, D.P., Roman, C.G., Wolff, A. & Buck, J. (2006). Faith-Based Efforts to Improve Prisoner Reentry: Assessing the Logic and Evidence. Journal of Criminal Justice, 34, 351-367

Meissner, C. M. (2006). Prayer or prison: The unconstitutionality of mandatory faith-based substance abuse treatment [Note]. Cleveland State Law Review, 54(4).

Moos, R.H. & Moos, B.S. (2006). Participation in Treatment and Alcoholics Anonymous: A 16-Year Follow-Up

of Initially Untreated Individuals. Journal of

Neff, J.A. & MacMaster, S.S. (2005). Spiritual Mechanisms Underlying Substance Abuse Behavior Change in Faith-Based Substance Abuse Treatment. Journal of Social Work Practice in the Addictions. 5(3), 33-54

Neff, J.A. (2006). Exploring the Dimensionality of "Religiosity" and "Spirituality" in the Fetzer Multidimensional Measure. Journal for the Scientific Study of Religion, 45(3), 449-459

Neff, J.A., Shorkey, C.T. & Windsor, L.C. (2006). Contrasting Faith-Based and

Ofuchi, T., Shimane, T., & Matsumoto, T. (2025). Spirituality and continued abstinence among methamphetamine users in a 12-step program in Japan: Data from a cohort study of residential substance use treatment. Neuropsychopharmacology Reports, 45(3), e70032. https://doi.org/10.1002/npr2.70032

Rabinowitz, J. A., Masyn, K., Thomas, N., Kahn, G., Grimm, K. J., Ellis, J., Hochheimer, M., Strickland, J. C., Ramdin, C., Piccirillo, M. L., & Huhn, A. S. (2026). Associations of spirituality and craving among individuals in substance use disorder treatment: A latent change score modeling approach. Drug and Alcohol Dependence, 283, 113116. https://doi.org/10.1016/j.drugalcdep.2026.113116

Saucier, G. & Skrzypinska, K. (2006). Spiritual But Not Religious? Evidence for TwoIndependent Dispositions. Journal of Personality, 74(5), 1257-1292

Seesink, H. J., Vrijmoeth, C., Ostafin, B. D., Schaap-Jonker, H., & Wiers, R. W. (2026). A one-year longitudinal study on Surrender to God assessed during addiction treatment. Addiction Behavior Reports, 23, 100693. https://doi.org/10.1016/j.abrep.2026.100693

Solhkhah, R., Galanter, M., Dermatis, H., Daly, J. and Bunt, G. (2009). Spirituality Orientation Among Adolescents in a Drug-free Therapeutic Community. Substance Abuse. 18 (1), 57-71

Steigerwald, F. & Stone, D. (1999). Cognitive Restructuring and The 12-Step Program of Alcoholics Anonymous. Journal of Substance Abuse Treatment. 16(4), 321-327

Steiner Pappalardo, N.L., & Luka, M. (2005). Faith-Based Substance Abuse Treatment Programs, In Psychology and the Church, McMinn, M.R. (Ed) &

Suire, J.G. & Bothwell, R.K. (2006). The Psychosocial Benefits of Alcoholics Anonymous. The American Journal on Addictions. 15(3), 252-255

Sundt, J.L., Dammer, H.R., and Cullen, F.T. (2002). The Role of The Prison Chaplin in Rehabilitation. Journal of Offender Rehabilitation. 35 (3/4), 59-86

Thanner, M.H., Yancey, C. & Taxman, F.S. (2004). Understanding Spirituality in Community Programming: Final Report. College Park, MD: Bureau of

Traditional Substance Abuse Treatment Programs. Journal of Substance Abuse Treatment. 30, 49-61. O'Connor, T.P. (2002). Introduction: Religion-Offenders-Rehabilitation: Questioning the Relationship. In Religion, The Community, and the Rehabilitation of Criminal Offenders, T.D. O'Connor (Editor). The Haworth Press. O'Connor, T.P. (2004). What Works, Religion as a Correctional Intervention: Part 1. Journal of Community Corrections. 14(1), 4-22, 27. O'Connor, T.P. (2004-2005). What Works, Religion as a Correctional Intervention: Part II. Journal of Community Corrections, 14(2), 4-6, 20-26

Trusty, B. & Eisenberg, M. (2003). Initial Process and Outcome Evaluation of the Inner Change Freedom Initiative: The Faith-Based Prison Program in TDCJ. Austin, TX: Texas Criminal Justice Policy Council

Vaillant, G.E. (2005). Alcoholics Anonymous: Cult or Cure? Australian and New Zealand Journal of Psychiatry. 39, 431-436. Working Group on Human Needs and Faith-Based and Community Initiatives (2003). Agreed Statement of Current Law on Employment Practices, FaithBased Organizations, and Government Funding. Washington, D.C: Search for

Warner v. Orange County Department of Probation, 115 F.3d 1068 (2d Cir. 1997).

Zemore, S. E., Lui, C., Mericle, A., Hemberg, J., & Kaskutas, L. A. (2018). A longitudinal study of the comparative efficacy of Women for Sobriety, LifeRing, SMART Recovery, and 12-step groups for those with AUD. Journal of Substance Abuse Treatment, 88, 18-26. https://doi.org/10.1016/j.jsat.2018.02.004 (PMID: 29606223)

Zimmer, B. (2005). Effect of Faith-Based Programs in Reducing Recidivism Substance Abuse of Ex-Offenders. Journal of Community Corrections. 14(1), 7 19

Appendix A

Introduction

In the counseling field, previous efforts have been made to measure counselor orientations. Anderson (1987) developed the *Style-Shift Indicator* (SSI) to assess therapeutic-counseling style. The purpose of the instrument was to increase awareness of one's personal choices and styles in counseling and therapy. The SSI is a tool designed to increase awareness of counselors in training so that they can apply theoretical orientations to clients at varying levels of readiness. Apparently, the SSI was not used as a research instrument to measure orientations.

Corey (1996) developed an instrument to measure counseling orientations. *The Survey of Attitudes and Values Related to Counseling and Psychotherapy: A Self-Inventory and Pre-Test* is also an instrument that assists students in counselor training or education in quantifying or exploring their counseling orientation. Again, this was not a research instrument.

Substance Abuse

The field of substance abuse counseling seems to have generated more curiosity about counseling orientations. Miller and Moyers (1993) developed the *Understanding Alcoholism Scale* (UAS). The UAS is a 70-item scale that uses a "strongly disagree" to "strongly agree" format. The research with the UAS revealed three factors concerning beliefs about alcoholism: Disease Model, Psychosocial Model, and Client Heterogeneity Model. The UAS was developed to assist in better matching clients and counselors. They do not report any normative data or reliability studies.

Grosenick and Hatmaker (2000) studied the perceptions of staff attributes in substance abuse treatment. They identified four critical variables that were perceived as influential in chemically dependent women's treatment success: Knowledge and experience, supportiveness, non-threatening behaviors, and availability. These critical variables were not theoretically based, but were perceived in relation to client's achievement of goals.

Shearer and King (2001) developed *The Powerless-Empowerment Scale* (P-E Scale) in an attempt to quantify endorsement of substance abuse counseling orientations. The P-E Scale is an 18-item scale consisting of 6 empowerment items, 6 powerless items, and 6 buffer items that use a simple agree-disagree format. The P-E Scale produced acceptable reliability and validity indicators, but the scale was not a factor analyzed to determine if the rationality determined factors were statistically valid.

Forman, Bovasso, and Woody (2001) surveyed a diverse group of staff members in a variety of addiction treatment programs concerning their beliefs about addictions. In their study, they found strong endorsement of the items in

the survey instrument making up the innovation, 12-steop traditional treatment, and spirituality factors. More than 75% of staff endorsed support for each of these items. Specifically, over 80% of the respondents agreed with the increased use of research findings and new approaches in addiction treatment. The study was questioned because of the inclusion of clerical and support staff in the survey.

Ball, Backrach, DeCarlo, Farentinos, Keen, McSherry, Polcin, Snead, Sockriter, Wrigley, Zammarelli and Carrol (2002) surveyed community clinicians about their characteristics, beliefs and practices. The clinicians they surveyed reported using techniques from a range of theoretical orientations. In order of magnitude from the most used to the least used, clinicians rated the following orientations: Relapse prevention, cognitive-behavioral, 12-step, disease, Rogerian, cognitive-behavioral, reality therapy, motivational interviewing, psychodynamic, interpersonal, gestalt, experimental. Relatively few clinicians reported reliance on one dominant theoretical orientation. In relation to the present study, it is worth pointing out that the Ball et. al. study was not in a correctional setting, and half of the sample had a master's degree.

Finally, Mulvey, Hubbard, and Hayashi (2003) surveyed the substance abuse treatment workforce in the United States. They found that most treatment professional are white, middle-aged, and slightly more are female than male. Treatment professionals tend to enter the field licensed or certified, and treat clients from different racial and ethnic backgrounds than themselves. Their study was also not conducted exclusively in corrections, and it did not involve an attempt to survey orientations or beliefs about substance abuse treatment.

The CSAOI is a fifteen item self-administered instrument that measures three substance abuse counseling orientations: Spirituality, Identification, and Self-efficacy. Table 1 presents the basic comparison statistics for 323 substance abuse counselors in a correctional system in the southwestern United States. The results of this study provide several counseling orientation trends.

- Strong endorsement of the disease model of addiction emerged according to age, length of service, gender, and type of employment. The older the counselor and the longer their length of service, the more they endorsed the *spirituality* and *identification* with former abusers as an important counseling orientation.
- This was also true for gender. Female counselors endorsed the disease model less than male counselors.
- The most strongly endorsed substance abuse counseling orientation for the total sample has self-efficacy.

Reliability and Validity

1. All three scale score means were significantly different (N=66) at the .01 level of confidence. This means that the three scales are very likely to be measuring different orientations.
2. The *identification Scale* was significantly correlated to drug addiction familiarity (r=.30). This means that the more familiar the respondents were with drug addiction, the more they endorsed the need for individuals with substance abuse problems to identify with others who had experienced a similar problem. It also means that those with less familiarity tend not to endorse the *Identification Scale.*
3. The alpha coefficient of internal reliability was .11 for the total CSACOI and .77 or the *Spirituality Scale*, .59 for the *Identification Scale,* and .14 for the *self-efficacy scale.* The CSACOI does not consist of a practical total score, but rather consists of separate scales as indicated by the results reported in number 1 above.
4. Table 1 presents initial normative data for sixty-six male and female university students and 323 substance abuse counselors.

CSACOI-M

(This is a tool for the student to utilize; it is not the course exam.)

Directions: The following is a series of attitude statements. Each represents a commonly held opinion and there are no right or wrong answers. You will probably disagree with some items and agree with others. We are interested in which you agree or disagree with in such matters of opinion.

Read each statement carefully. Then indicate whether you agree or disagree by placing a check (✓) in the appropriate space on the answer sheet. Give your opinion on each statement.

If you are not sure, answer the closest to the way you feel. Also keep in mind the statements primarily are referring to heavy use of substances, addictions, and dependence, not occasional, non-problematic substance use.

1. Substance abuse should be treated through a spiritual program that directs the abuser toward the ultimate truth.
2. Addicts need to let go of their old way of coping and let God control their life.
3. It is very important that substance abusers identify with others with similar problems.
4. A person who has never experienced the cravings and power of addiction would have a difficult time counseling substance abusers.
5. Refusal skills should be an important element of substance abuse counseling.
6. Substance abusers need to find someone else who can manage their lives.
7. It is important that substance abuse be met strongly with meditation (prayer) to improve the abusers contact with God.
8. If substance abusers follow their Higher Power, they would never be lost in drugs again.
9. The last group of people alcoholics should associate with is recovering alcoholics.
10. Recovering substance abusers are the true experts on addictions.
11. Substance abusers can take control and make positive choices in their lives.
12. Substance abusers are powerless over alcohol and drugs.
13. Alcoholics need to follow God's plan.
14. Without others who have kicked drug addictions, a substance abuser would be isolated.
15. It is very difficult for counselors to put themselves in the place of an alcoholic if they haven't been an alcoholic.

CSACOI

ANSWER SHEET

Agree-	Disagree		Agree-	Disagree		Agree-	Disagree	
_____	_____	1	_____	_____	6	_____	_____	11
_____	_____	2	_____	_____	7	_____	_____	12
_____	_____	3	_____	_____	8	_____	_____	13
_____	_____	4	_____	_____	9	_____	_____	14
_____	_____	5	_____	_____	10	_____	_____	15

_____ Sp _____ Id _____ SE _____ TOTAL

CSACOI-M

Scoring Key-Loadings

Component 1: Spirituality

Items: 1, 2, 7, 8, 13

Component 2: Identification

Items: 3, 4, 10, 14, 15

Component 3: Self-Efficacy

Items: 5 , 6R , 9, 11, 12R

Scoring Instructions

Add the items marked *agree* to obtain a total score for each component (range 0-5) according to the above key. For example, to obtain the *spirituality* score, add the number of *agree* on items 1, 2, 7, 8, and 13. If all five of these items are marked *agree,* the score for *spirituality* is "5". If none are marked *agree*, then the score is "0", and so on. Note that item 6 and 12 on the *self-efficacy* component are reverse scored or counted when *disagree* is marked. After scoring the CSACOI, you can compare your scores on *spirituality, identification*, and self-efficacy to the undergraduate university students or the substance abuse counselors in Table 1.

NOTE; Item loadings can range from +1.00 to -1.00. A +1.00 loading indicates that the item (statement) is exactly consistent with the component and a -1.00 loading is exactly the reverse of the component and would obviously not be included as part of the scale unless it is reverse scored (R). Consequently, loadings of .66 to .80 and above are considered to be quite acceptable when considering the various ways people in the original research group could have interpreted the statements. The loadings were statistically derived (factor analysis), and the components were rationally determined.

Table 1

Average scores for university students and substance abuse counselors on the *CSACOI* (Range 0-5)

Subscale	Group	Mean
CSACOI		
Spirituality	Male Counselors	2.49
	Female Counselors	2.10
	Male Students	1.46
	Female Students	2.03
Identification	Male Counselors	2.45
	Female Counselors	2.03
	Male Students	3.37
	Female Students	2.94
Self-Efficacy	Male Counselors	2.97
	Female Counselors	2.85
	Male Students	3.75
	Female Students	3.67

CSACOI References

Anderson, T.D. (1987). *Style Shift Indicator for Therapist and Counselors.* North Amherst, MA: Microtraining Associates.

Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., Sockriter, R., Wrigley, P., Zammarelli, L. & Carroll, K. (2002). Characteristics, Beliefs, and Practices of Community Clinicians Trained to Provide Manual-Guided Therapy for Substance Abusers, *Journal of Substance Abuse Treatment*, 23, 309-318.

Corey, G.D., & Buelow, S.A. (1998) *Psychotherapy in Chemical Dependence Treatment.* Pacific Grove, CA: Brooks-Cole.

Forman, R.F., Bovasso, G. & Woody, G. (2001) Staff Beliefs About Addiction Treatment, *Journal of Substance Abuse Treatment,* 21, 1-9.

Grosenick, J.K. & Hatmaker, C.M. (2000). Perceptions of Staff Attributes on Substance Abuse Treatment, *Journal of Substance Abuse Treatment.* 19, 273-284.

Luke, D.A., Ribisl, K.M., Nalton, M.A., & Davidson, W.S. (2002). Assessing the Diversity of Personal Beliefs About Addiction: Development of the Addiction Belief Inventory. *Substance Use and Misuse,* 37 (1), 89-120.

Miller, W.R. & Moyers, T.B. (1993). Therapist Conceptualization of Alcoholism: Measurement and Implications for Treatment Decisions, *Psychology of Addictive Behavior,* 1, 238-245.

Mulvey, K.P., Hubbard, S. & Hayashi, S. (2003) A National Study of the Substance Abuse Treatment Workforce, *Journal of Substance Abuse Treatment*, 24, 51-57.

Shearer, R.A. (2002). *The Comprehensive Substance Abuse Counseling Orientation Inventory Administrators Manual,* College of Criminal Justice, Sam Houston State University.

Shearer, R.A. & Roberts, E (2003). *Offender Counseling Inventory*, College of Criminal Justice, Sam Houston State University.

Shearer, R.A. & King, P.A. (2001). The Powerless-Empowerment Scale: Measurement of Substance Abuse Counseling Orientation, *Journal of Addictions and Offender Counseling*, 21 (2), 68-75.

Spiritual Transformation Self-Inventory (STS)

(This is a tool for the student to utilize; it is not the course exam.)

For each of the following statements, indicate whether you *agree* or *disagree* with the statement:

1. Because of this program, I'm not who I used to be.
   Agree_____ Disagree_____

2. Before this program, I had a bad attitude and a hard time getting along with people.
   Agree_____ Disagree_____

3. This program has made me feel like I am somebody and that I have potential.
   Agree_____ Disagree_____

4. Because of this program, I'm now trying to turn spiritual knowledge into wisdom.
   Agree_____ Disagree_____

5. I've grown spiritually in this program.
   Agree_____ Disagree_____

6. I'm becoming stronger in the word of God.
   Agree_____ Disagree_____

7. I didn't trust anyone before I came here.
   Agree_____ Disagree_____

8. For me, faith and spirituality now are more important than the prison code.
   Agree_____ Disagree_____

9. Because of this program, I now have a more positive outlook on life.
   Agree_____ Disagree_____

10. I have gained a peace of mind in this program that I never had in the free world.
    Agree_____ Disagree_____

11. Because of this program, I feel a need to give something back to society.
    Agree_____ Disagree_____

12. I now feel a desire to make a positive contribution to the community.
Agree_____ Disagree_____

13. My thinking and feeling is different from when I got to this program.
Agree_____ Disagree_____

14. Helping others in this program find purpose in their life through faith has been a real blessing for me.
Agree_____ Disagree_____

15. This program has started me on a very profound spiritual journey.
Agree_____ Disagree_____

16. Before this program, I didn't think anyone cared—now I see they really do.
Agree_____ Disagree_____

17. Because of this program, I feel a deep inner peace.
Agree_____ Disagree_____

18. I now consider myself a very religious person.
Agree_____ Disagree_____

19. Instead of drugs, I look to God for strength, support, and guidance.
Agree_____ Disagree_____

20. I now find my strength and comfort in religion and not drugs or alcohol.
Agree_____ Disagree_____

Spiritual Transformation Self-Inventory (STS)

Scoring Instructions

Add the items marked *agree* to obtain a total score (range 0-20).

In general, the degree of spiritual transformation indicated by the scoring of the items marked *agree* is:

0 – 7	Low spiritual transformation
8 – 13	Intermediate spiritual transformation
14 – 20	Strong spiritual transformation

Appendix B: Post Test and Evaluation for the Faith Based Substance Abuse Treatment

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

1. Religious or spiritual content can range from faith _____ to faith-secular partnerships.
    a. selective
    b. delineated
    c. saturated
    d. attenuated
    e. satiated

2. One definition of “faith-based” is the presence of explicit or implicit _____.
    a. rules
    b. structure
    c. laws
    d. mores
    e. content

3. Another definition of faith-based includes the presence of a particular:
    a. ideology
    b. administrator
    c. social control mechanism
    d. mysticism
    e. minister

4. Recovery programs endorsing 12-step philosophy typically emphasize spiritual _____.
    a. transactions
    b. transfer
    c. transtheoretical approaches
    d. revelation
    e. transformation

5. In faith-based programs, professional credentials and licensing may not be required.
    a. True
    b. False

6. Which of the following is not a degree of importance in defining faith-based substance abuse treatment programs?
   a. SA
   b. PT
   c. SS
   d. SE
   e. MM

7. Group activities and cohesion is referred to as:
   a. synopsis (SP)
   b. synergy (SN)
   c. factorial cohesion (FC)
   d. structural cohesion (SC)
   e. syntactic energy (SG)

8. FBP's tend to be divided in how many main types?
   a. six
   b. ten
   c. thirteen
   d. four
   e. three

9. Empirical studies of religiosity and spirituality suggest two _____ dispositions.
   a. inverse
   b. codependent
   c. interdependent
   d. correlated
   e. independent

10. Religiousness components include private religious practices, organized religiosity, and _____ religiosity.
   a. self-rated
   b. other-rated
   c. community rated
   d. self-affirmed
   e. significant other rated

11. Spirituality can include a search for a greater meaning for _____.
   a. society
   b. criminal behavior
   c. external morality
   d. experience
   e. existence

12. Spirituality can be associated with _____ experience.
    a. magical
    b. mystical
    c. myopic
    d. astrology
    e. psychokenisis

13. Which of the following is not a component of spirituality?
    a. daily spiritual experiences
    b. belief in a watchful God
    c. forgiveness
    d. paranormal experiences
    e. positive coping

14. Reincarnations, spells, and psychic powers are more closely associated with _____.
    a. mysticism
    b. religiosity
    c. exoteric spiritualism
    d. superstitiousness
    e. hyper mysticism

15. Exoteric Religiosity tends to emphasize _____.
    a. literalistic dogmas
    b. contemplation
    c. knowledge
    d. wisdom
    e. the metaphysical

16. Extrinsic Religiosity refers to people who:
    a. use religion as an end in itself
    b. have a high commitment to religious activities
    c. have a high commitment to religious beliefs
    d. don't equate religiosity with social status
    e. use religion as a means to an end

17. The relationship between religion and crime is:
    a. modest to large
    b. non-existent
    c. unknown
    d. modest to small
    e. strong

18. The direct crime-faith relationship suggests that faith may have a direct _____ effect.
    a. casual
    b. causal
    c. reverse
    d. retroactive
    e. reciprocal

19. The interactive equation is:
    a. faith-employment-law abiding
    b. employment-law abiding-faith
    c. active-interactive-indirect
    d. intrinsic-extrinsic-exoteric
    e. conditional-unconditional

20. The threshold relationship involves:
    a. dose response curve
    b. program dose
    c. dose-doe
    d. exoteric doses
    e. conditional doses

21. A sufficient faith dose of treatment would <u>not</u> include:
    a. consistent cohort
    b. attendance
    c. assessment
    d. program fidelity
    e. treatment manual

22. One of the critical questions about faith-based substance abuse programs involves:
    a. a risky shift
    b. fidelity drift
    c. assessment drift
    d. fidelity shift
    e. internal-external drift

23. Symmetry refers to a _____ relationship.
    a. casual
    b. causal
    c. drift
    d. nonlinear
    e. linear

24. When initial faith changes are easier and more likely than later faith changes, it is termed _____.

a. program dose symmetry
b. inconsistent
c. non symmetric
d. linear
e. nonlinear

25. Which of the following is not a typology of faith-based organizations?

a. faith-saturated
b. faith-secular
c. faith-background
d. faith-infused
e. faith-related

26. Which of the spirituality and substance abuse models is consistent with the stages of change model?

a. external model
b. compatibility
c. addicted self model
d. internal model
e. incompatibility

27. There is a distinct difference between correlation and:

a. compatibility
b. criminogenic
c. intercorrelation
d. relationship
e. causation

28. The group who were less likely to prefer spiritually based programs in a TC were:

a. women
b. adults
c. adolescents
d. alcoholics
e. meth users

29. One of the techniques that can be blended with religious ideas is:

a. SOS
b. MM
c. REBT
d. Gestalt Therapy
e. Cognitive Therapy

30. In the content of substance abuse treatment, clients can exhibit:
    a. distorted religious views
    b. deeply ingrained thinking patterns
    c. faulty thinking patterns
    d. difficulty in changing thinking patterns
    e. all of the above

31. Clients who categorize people as good or bad exhibit the thinking error of:
    a. rationalization
    b. dichotomous thinking
    c. overgeneralization
    d. selective thinking
    e. interpersonal rigidity

32. Cognitive restructuring is *not* accomplished in AA and 12-step programs by:
    a. insight
    b. attendance
    c. messages
    d. reprogramming
    e. sponsorship

33. There are how many areas of concentration for core competencies for working in faith-based programs?
    a. two
    b. six
    c. ten
    d. four
    e. five

34. The theory that states that religion deters individual-level criminal behavior is:
    a. socio-ecological theory
    b. moral communities theory
    c. hellfire theory
    d. acetic theory
    e. non-ascetic theory

35. Non-ascetic behaviors are also known as:
    a. secular behaviors
    b. semi-ascetic behaviors
    c. quasi-ascetic behaviors
    d. orthodox behaviors
    e. none of the above

36. Results testing the moral communities hypothesis are:
    a. strong
    b. non-existent
    c. mixed
    d. confusing
    e. statistically weak

37. The weak point for any comparison group design when the effectiveness of faith-based substance abuse programs is being studied is:
    a. criminal history
    b. traits
    c. personality
    d. motivation
    e. intelligence

38. The measures that are typically used to measure effectiveness are:
    a. arrest
    b. incarceration
    c. relapse
    d. all of the above
    e. none of the above

39. Which of the following is *not* a secular program alternative?
    a. SOS
    b. WW
    c. MM
    d. RR
    e. SMART

