Physicians' Beliefs About Faith-Based Treatments for Alcoholism

Ryan E. Lawrence, M.D., M.Div.
Kenneth A. Rasinski, Ph.D.
John D. Yoon, M.D.
Harold G. Koenig, M.D., M.H.Sc.
Keith G. Meador, M.D., Th.M.
Farr A. Curlin, M.D.

Objective: **The study examined physicians' beliefs about faith-based alcohol treatments vis-à-vis Alcoholics Anonymous, pharmacologic treatment, and residential treatment.** ***Methods:*** **A survey was mailed to a national sample of U.S. primary care physicians and psychiatrists. It included a brief vignette of a nominally religious 47-year-old man hospitalized for acute alcohol poisoning who requested addiction treatment. Physicians rated the likely effectiveness of three treatment methods: Alcoholics Anonymous, pharmacological therapy by an addiction specialist, and a residential program. Physicians were asked whether they would refer the patient to a faith-based program (beyond Alcoholics Anonymous) and whether an emphasis on spirituality is critical to 12-step program success.** ***Results:*** **The response rate was 896 of 1,427 (63%) for primary care physicians and 312 of 487 (64%) for psychiatrists. Psychiatrists were more likely to rate Alcoholics Anonymous as very effective (64% versus 57% of primary care physicians), more likely to rate residential treatment as very effective (47% versus 38% of primary care physicians), and more likely to rate pharmacologic therapy as very effective (31% versus 22% of primary care physicians). Psychiatrists and primary care physicians were equally likely to consider referring the patient to a faith-based program (71% and 79%) and equally likely to believe that "an emphasis on spirituality is critical to the success of 12-step programs" (81% and 85%).** ***Conclusions:*** **Psychiatrists were more optimistic than primary care physicians about all three treatments. Physicians in both specialties would refer even nominally religious patients to explicitly faith-based programs (beyond Alcoholics Anonymous). Physicians' enthusiasm for faith-based treatments highlights the need for scientific study of these treatments to determine which elements are most helpful for patients seeking recovery. (*Psychiatric Services* 63:597–604, 2012; doi: 10.1176/appi.ps.201100315)**

Faith-based organizations have long provided treatment programs for individuals struggling with addiction. Although many persons have been greatly helped by these programs, physicians may not be entirely comfortable referring patients to faith-based organizations. Concerns that such referrals will be perceived as proselytizing are less problematic for Alcoholics Anonymous, where the faith component is vague by design, but more significant for programs like Teen Challenge, with an explicit mission to provide a "Christian faith-based solution to life-controlling drug and alcohol problems" (www.teenchallengeusa.com/about).

Other concerns that might make physicians less likely to refer individuals to faith-based programs include whether the programs are as effective as traditional (secular) programs (1,2), whether they provide staff with training and qualifications comparable with what is offered in traditional programs (1,2), whether faith-based programs treat all faiths equitably (1,2), and whether they are appropriate for patients who may not endorse the program's spiritual or religious teachings (1,3,4). If physicians have a low referral rate to faith-based organizations, many patients may not access a treatment that is widely available (Teen Challenge has more than 200 locations, in 49 states; www.teenchallengeusa.com/locations), potentially as effective as traditional programs, and by some accounts less expensive (1,5–7). Little

Dr. Lawrence is affiliated with the Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Dr., Box 103, New York, NY 10032 (e-mail: rlawrence@uchicago.edu). Dr. Rasinski, Dr. Yoon, and Dr. Curlin are with the Department of Medicine, University of Chicago Medical Center, Chicago. Dr. Koenig is with the Department of Psychiatry, Duke University Medical Center, Durham, North Carolina. Dr. Meador is with the Department of Psychiatry, Vanderbilt University Medical Center, Nashville, Tennessee.

is known about how physicians navigate these concerns.

This article describes a survey of primary care physicians and psychiatrists that included a vignette of a patient with an alcohol problem. The survey asked about the likely effectiveness of Alcoholics Anonymous (a faith-based program by some accounts) (8–10) as well as the likely effectiveness of pharmacologic therapy with a specialist and residential rehabilitation. It also asked about faith-based programs more explicitly: whether the physician knew of any nearby programs, whether he or she would refer patients there, and whether he or she considered spirituality to be critical to the success of 12-step programs. The primary hypotheses were that beliefs would differ between primary care physicians and psychiatrists and between religious and nonreligious physicians.

Methods

Survey

Between September 2009 and June 2010, we mailed a confidential self-administered questionnaire to a stratified random sample consisting of 1,504 U.S. primary care physicians and 512 U.S. psychiatrists age 65 or younger. The sample was generated from the American Medical Association Physician Masterfile, a database intended to include all practicing U.S. physicians. To increase minority religious group representation in the primary care sample, we used validated surname lists to create four strata and oversampled from these strata (11–13). We sampled 121 primary care physicians with typical south Asian surnames, 171 primary care physicians with typical Arabic surnames, 86 primary care physicians with typical Jewish surnames, and 1,126 additional primary care physicians (from all those whose surnames were not on one of these ethnic lists). The psychiatrist sample was not sufficiently large to warrant oversampling by ethnic surname. Physicians received up to three separate mailings of the questionnaire. The first mailing included a twenty-dollar bill, and the third offered an additional $30 for participation. Data were double-keyed, cross-compared, and corrected against the original questionnaires. The study was approved by the University of Chicago Institutional Review Board.

We presented the following vignette in the survey materials: "A 47-year-old man is admitted to the hospital with acute alcohol poisoning. After a medical detox, the patient says he has been drinking heavily for years and wants to get help. He has never been hospitalized or gone through rehabilitation before." The survey included a split-ballot experiment that varied whether the vignette concluded with "He identifies himself as a Christian but says he has not been to church in months" or with "He identifies himself as a Christian but has never been a church-goer." Each potential respondent was randomly chosen to receive one of these two versions. Identifying the vignette patient as Christian allowed more direct comparison with other literature that focuses on Christian faith-based organizations (4,5).

Physicians were asked about the likely effectiveness of three treatments: participation in a local chapter of Alcoholics Anonymous, pharmacological therapy by a physician who specializes in the treatment of addiction, and completion of a residential rehabilitation program. Response options included very effective, somewhat effective, not very effective, and not at all effective (these responses were dichotomized for multivariable analyses as very effective or less effective).

Physicians were then asked, "To the best of your knowledge, are there any explicitly faith-based alcoholism treatment programs (not including AA) in your area to which you could potentially refer this patient?" Response options were yes or no. If respondents answered yes, they were asked, "How likely would you be to refer this patient to one of those programs?" If respondents answered no (they do not know of a faith-based program nearby), the follow-up question was, "Assuming there were, how likely would you be to refer this patient to one of those programs?" The four response options were very, somewhat, not very, and not at all likely, which were dichotomized as very likely or less likely. Finally, we asked, "To what extent do you agree with the following statement: 'An emphasis on spirituality is critical to the success of 12-step programs.' " Responses were dichotomized as agree or disagree.

Primary predictors were physicians' clinical specialty (primary care versus psychiatry) and their religious characteristics. Religious affiliation was categorized by self-report as non-Evangelical Protestant, Evangelical Protestant, Catholic (Roman Catholic and Eastern Orthodox), Muslim, Jewish, Hindu, other religion (including 24 Buddhists), and none or no religious affiliation. The importance of religion was assessed by asking, "How important would you say your religion is in your own life?" Response options were dichotomized as "not very important in my life/fairly important" or "very important/the most important part of my life."

Statistical analysis

Stratum weights for the primary care physician sample were calculated to account for oversampling from the ethnic surname strata (the design weight). We also created a poststratification adjustment weight to correct for higher response rates among U.S. medical school graduates (versus international medical school graduates) and among physicians whose roles are primarily teaching or "other" (versus office-based, hospital-based, research, or administrative roles or roles identified as unclassified because of missing data). Weights were the inverse probability that a person with the relevant characteristic would be in the final data set. The final weight for each case or respondent was the product of the design weight and the poststratification adjustment weight. This method of weighting—widely used in population-based research (14)—enabled us to adjust for sample stratification and variable response rates in order to generate estimates for the population of U.S. primary care physicians. Weights were not calculated for the psychiatrist sample because no disproportionate sampling by name strata was performed and because re-

sponse rates by background variables available from the Masterfile did not differ significantly.

We used the chi square test to see if the experimental variable—whether the patient in the vignette had ever been a church-goer—was associated with any of the primary care physicians' or psychiatrists' responses. We then pooled data from both experimental arms and generated population estimates for psychiatrists' and primary care physicians' responses to each survey item measure. Next, we used multivariable logistic regression to test the primary hypotheses. Model 1 examined the effect of physician specialty, after adjustment for religious affiliation, importance of religion, sex, race, age, and region. Model 2 examined the effect of religion (affiliation or importance) after adjustment for sex, race, age, and region (primary care physicians and psychiatrists were analyzed separately). All analyses were conducted with the survey-design–adjusted commands of Stata SE statistical software, version 11.0.

Results

The response rate was 63% (896 of 1,427) for primary care physicians and 64% (312 of 487) for psychiatrists, after excluding 77 primary care physicians and 25 psychiatrists who had invalid addresses or were no longer practicing. The response rate for primary care physicians varied by stratum (p=.006): it was 53% (85 of 162) among those with Arabic surnames, 56% (63 of 112) among those with South Asian surnames, 70% (59 of 84) among those with Jewish surnames, and 64% (689 of 1,069) among the remaining physicians. In the primary care sample, graduates of U.S. medical schools were more likely than international medical school graduates to respond (65% versus 56%, p=.002). Primary care physicians whose practices were primarily teaching or "other" responded at a higher rate (75%, 103 of 138) than physicians whose roles were primarily office based, hospital based, research, administrative, or unclassified (62%, 793 of 1,288; p=.004). Response rates did not differ by age, gender, region, or board certification (Table 1).

Table 1

Demographic characteristics of primary care physicians and psychiatrists surveyed about treatments for alcoholism[a]

Characteristic	Primary care physicians (N=896)		Psychiatrists (N=312)		p
	N	%	N	%	
Sex					.042
Female	324	36	133	43	
Male	572	64	179	57	
Race					.25
White	625	71	198	64	
Black	53	6	23	7	
Asian	142	16	64	21	
Hispanic or Latino	41	5	17	5	
Other	22	2	8	3	
Age[b]					<.001
25–36	226	25	80	26	
37–44	224	25	42	13	
45–53	225	25	92	29	
54–65	221	25	98	31	
Region					.003
South	295	33	89	29	
Northeast	198	22	102	33	
Midwest	216	24	61	20	
West	187	21	60	19	
Immigration history					.34
U.S. born	637	72	214	69	
Immigrated to U.S.	249	28	96	31	
Education					.072
U.S. medical school graduate	678	76	220	71	
Foreign medical school graduate	218	24	92	29	
Board certified					<.001
Yes	639	71	187	60	
No	257	29	125	40	
Religious affiliation					<.001
Non-Evangelical Protestant	227	26	71	23	
Evangelical Protestant	95	11	20	7	
Catholic or Orthodox	212	24	68	22	
Muslim	60	7	8	3	
Jewish	97	11	41	13	
Hindu	42	5	24	8	
Other	39	4	27	9	
No affiliation	96	11	48	16	
Importance of religion					.004
Not important/not applicable	215	25	100	32	
Fairly important	283	32	104	34	
Very important	251	29	80	26	
Most important thing	127	15	25	8	
Attendance at religious services					.022
Never	118	14	53	17	
Once a month or less	413	48	162	52	
Twice a month or more	338	39	94	30	

[a] Results are not adjusted for survey design and reflect the percentages in our sample.
[b] Mean±SD age 45±10.4

In the chi square analysis, the experimental variable—whether the patient had ever been a church-goer—was not associated with any of the primary care physicians' or psychiatrists' responses to the vignette (p≥.09 for all analyses).

Participation in Alcoholics Anonymous

More psychiatrists (64%) than primary care physicians (57%) thought the vignette patient's participation in Alcoholics Anonymous would be very effective (Table 2) (odds ratio [OR]=1.2, 95% confidence interval

Table 2

Primary care physicians' and psychiatrists' beliefs about treatments for alcoholism[a]

Item and response[b]	Primary care physicians (N=896) N	%	Psychiatrists (N=312) N	%	p
Participation in a local chapter of Alcoholics Anonymous (AA)					.054
Very effective	497	57	199	64	
Somewhat effective	372	42	110	35	
Not very effective	15	2	2	1	
Not at all effective	0	—	0	—	
Pharmacological therapy by a physician who specializes in the treatment of addiction					.021
Very effective	197	22	95	31	
Somewhat effective	541	62	163	53	
Not very effective	137	15	47	15	
Not at all effective	8	1	3	1	
Completion of a residential rehabilitation program					.005
Very effective	332	38	144	47	
Somewhat effective	489	55	155	50	
Not very effective	64	7	10	3	
Not at all effective	0	—	0	—	
To the best of your knowledge, are there any explicitly faith-based alcoholism treatment programs (not including AA) in your area to which you could potentially refer this patient?					.002
Yes	262	29	121	40	
No	611	71	184	60	
Assuming there were, how likely would you be to refer this patient to one of those programs?					.008
Very likely	308	40	87	29	
Somewhat likely	303	39	124	42	
Not very likely	151	17	64	22	
Not at all likely	40	4	22	7	
To what extent do you agree with the statement: "An emphasis on spirituality is critical to the success of 12-step programs"?					.069
Agree strongly	344	39	137	44	
Agree somewhat	392	46	114	37	
Disagree somewhat	109	11	44	14	
Disagree strongly	33	4	13	4	

[a] Results are adjusted for survey design. Percentages reflect estimates for the population of U.S. primary care physicians and psychiatrists.

[b] The survey instructed respondents to "Please indicate how effective you think each of the following alcoholism treatment plans would be for this patient."

[CI]=1.1–1.4, model 1). Primary care physicians' beliefs did not vary with religious affiliation or the importance of religion (Table 3; model 2). Psychiatrists' beliefs showed some variation by religious affiliation. Whereas 76% of non-Evangelical Protestants (referent) believed that participation in Alcoholics Anonymous would be very effective, this belief was less common among Jewish psychiatrists (44%; OR=.3) and Catholic psychiatrists (57%; OR=.4) (Table 4; model 2).

Pharmacological therapy

Psychiatrists (31%) were more likely than primary care physicians (22%) to believe that pharmacological therapy by an addiction specialist would be very effective (Table 2) (OR=1.3, CI=1.1–1.6; model 1). Primary care physicians' beliefs varied with religious affiliation. Although 16% of non-Evangelical Protestants (referent) thought pharmacological therapy with a specialist would be very effective, the belief was more common among Catholics (23%, OR=1.9, CI=1.1–3.3), Muslims (44%, OR=4.6, CI=1.8–11.7), and those practicing some "other" religion (32%, OR=2.7, CI=1.2–6.5) (model 2). Psychiatrists were not analyzed by religious affiliation because of low cell counts. Their beliefs about pharmacological therapy did not vary with the importance of religion (model 2).

Completion of a residential rehabilitation program

More psychiatrists (47%) than primary care physicians (38%) believed that a residential rehabilitation program would be very effective (Table 2) (OR=1.2, CI=1.1–1.4; model 1). Primary care physicians' and psychiatrists' beliefs about residential rehabilitation did not vary with religious affiliation or the importance of religion.

Awareness of local faith-based programs

More psychiatrists (40%) than primary care physicians (29%) were aware of faith-based treatment programs nearby (Table 2) (OR=1.4, CI=1.2–1.6; model 1). Among primary care physicians, Evangelical Protestants were significantly more likely than non-Evangelical Protestants to know of a faith-based treatment program in their area (50% and

Table 3

The association of primary care physicians' religious characteristics with four indicators of their beliefs and practices related to alcohol abuse[a]

Characteristic	Total N	Believes Alcoholics Anonymous would be "very effective" for patient					Knows of local faith-based treatment programs to which patient could be referred					Would be "very likely" to refer patient to faith-based program					Agrees emphasis on spirituality is critical to success of 12-step programs				
		N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI
Religious affiliation				.07					.003					<.001					<.001		
Non-Evangelical Protestant[c]	223	121	53		1.0		69	31		1.0		82	40		1.0		200	90		1.0	
Evangelical Protestant	95	55	58		1.3	.8–2.2	47	50		2.3*	1.3–3.9	68	76		5.1*	2.6–9.8	92	97		3.4	.9–12
Catholic	210	127	59		1.3	.8–2.0	61	29		1.0	.6–1.6	82	46		1.4	.9–2.3	191	91		1.3	.6–2.5
Muslim	58	35	68		2.3	.95–5.7	12	22		.7	.3–1.9	16	35		.6	.2–1.6	51	92		1.3	.4–4.2
Jewish	96	49	48		.9	.5–1.5	26	28		1.1	.6–1.9	15	16		.4*	.2–.8	71	73		.4*	.2–.7
Hindu	42	32	74		2.7	.97–7.4	9	22		1.0	.4–3.1	12	33		.5	.2–1.4	32	84		.5	.1–2.2
Other	39	19	55		1.1	.5–2.4	11	26		1.0	.4–2.3	9	33		.7	.3–1.8	30	80		.5	.2–1.3
None	95	46	48		.9	.5–1.5	18	19		.6	.3–1.1	17	20		.4*	.2–.7	50	57		.1*	.1–.3
Importance of religion				.12					.03					<.001					<.001		
Not important or fairly important[c,d]	493	267	54		1.0		130	26		1.0		119	28		1.0		370	78		1.0	
Very important or the most important	373	218	60		1.1	.96–1.3	125	34		1.2	.99–1.4	182	55		1.8*	1.5–2.1	352	95		2.3*	1.7–3.0

[a] Odds ratios and confidence intervals are from multivariable logistic regression models, which included physician sex, race, age, and region. Percentages are weighted to adjust for survey design and variable response rates, and percentages reflect estimates for the population of U.S. primary care physicians.

[b] Bivariate

[c] Referent

[d] "Not important" includes responses of "not applicable" and "I have no religion."

*p<.05 (multivariable)

31%, respectively; OR=2.3; Table 3, model 2). Among psychiatrists, more Evangelical Protestants than non-Evangelical Protestants knew of a faith-based treatment program in their area (70% versus 39%, respectively; OR=4.1; Table 4, model 2).

Willingness to refer

Psychiatrists (29% very likely) and primary care physicians (40% very likely) did not significantly differ in their likelihood of referring individuals to faith-based programs (Table 2) (OR=.9, CI=.8–1.1; model 1). Among primary care physicians, 40% of non-Evangelical Protestants were very likely to refer the vignette patient to a faith-based program (referent). Significantly more Evangelical Protestants were very likely to refer the vignette patient (76%, OR=5.1), whereas smaller proportions of Jewish physicians (16%, OR=.4) and unaffiliated physicians (20%, OR=.4) were very likely to refer (Table 3, model 2).

Among psychiatrists, 35% of non-Evangelical Protestants were very likely to refer patients to a faith-based program. However, a smaller proportion of psychiatrists with no religious affiliation were very likely to refer patients to such programs (16%, OR=.3; Table 4, model 2).

The importance of religion also played a role. Compared with physicians who consider religion unimportant or not very important, more physicians who considered religion very important or the most important part of their lives were very likely to refer the patient to a faith-based program. This pattern was observed for primary care physicians (55% versus 28%, OR=1.8; Table 3) and psychiatrists (48% versus 19%, OR=1.9; Table 4, model 2).

Of note, physicians who knew of a faith-based program nearby were more likely than physicians who did not know of any nearby program to refer the patient to a faith-based program. This was true for primary care physicians (55% versus 32% very likely, OR=2.1, CI=1.4–3.1) and psychiatrists (41% versus 21% very likely, OR=2.9, CI=1.5–5.4) and was significant after adjustment for religious affiliation, importance of religion, sex, race, age, and region.

Spirituality as critical

Most respondents agreed somewhat or strongly that an emphasis on spirituality is critical to the success of 12-step programs (85% of primary care physicians and 81% of psychiatrists) (Table 2, model 1). Among primary care physicians, 90% of non-Evangelical Protestants (referent) believed spirituality is critical. However, a smaller proportion of Jews (73%, OR=.4) and of physicians with no religious affiliation (57%, OR=.1) agreed (model 2).

Table 4

Association of psychiatrists' religious characteristics with four indicators of their beliefs and practices related to alcohol abuse[a]

Characteristic	Total N	Believes Alcoholics Anonymous would be "very effective" for patient					Knows of local faith-based treatment programs to which patient could be referred					Would be "very likely" to refer patient to faith-based program					Agrees emphasis on spirituality is critical to success of 12-step programs				
		N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI	N	%	p[b]	OR	95% CI
Religious affiliation				.02					.3					<.001					.3		
Non-Evangelical Protestant[c]	71	54	76		1.0		27	39		1.0		25	35		1.0		56	79		1.0	
Evangelical Protestant	20	13	65		.5	.1–1.7	14	70		4.1*	1.3–13.4	13	68		3.6	.9–14.3	17	89		2.4	.5–12.3
Catholic	68	39	57		.4*	.2–.8	25	37		1.0	.5–2.1	17	27		.5	.2–1.1	60	90		2.5	.9–7.0
Muslim	8	5	63		.3	.1–1.3	3	38		.9	.2–4.3	2	29		.3	.04–2.2	6	75		.6	.1–3.5
Jewish	41	18	44		.3*	.1–.7	17	41		1.2	.5–2.8	6	16		.4	.1–1.2	34	83		1.6	.5–4.9
Hindu	24	17	71		.3	.1–1.3	8	35		1.4	.4–5.1	10	42		.3	.1–1.0	20	87		1.8	.4–7.8
Other	27	22	81		1.0	.3–3.4	9	36		1.0	.4–2.6	5	19		.2*	.1–.6	21	78		1.0	.3–3.4
None	48	31	65		.6	.3–1.4	16	35		.8	.4–1.8	7	16		.3*	.1–.8	34	71		.7	.3–1.6
Importance of religion				.6					.3					<.001					<.001		
Not important or fairly important[c,d]	204	129	63		1.0		75	38		1.0		38	19		1.0		153	75		1.0	
Very important or the most important	105	70	67		1.0	.7–1.3	45	44		1.1	.9–1.5	48	48		1.9*	1.4–2.5	97	94		2.3*	1.4–3.7

[a] Odds ratios and confidence intervals are from multivariable logistic regression models, which included psychiatrist sex, race, age, and region. Percentages reflect estimates for the population of U.S. psychiatrists.

[b] Bivariate

[c] Referent

[d] "Not important" includes responses of "not applicable" and "I have no religion."

*p<.05 (multivariable)

Compared with those who considered religion unimportant or fairly important, physicians who considered it very important or the most important part of their lives were more likely to consider spirituality critical to 12-step program success; this was true for primary care physicians (95% versus 78%, OR=2.3; Table 3, model 2) and psychiatrists (94% versus 75%, OR=2.3; Table 4, model 2).

Discussion

In this national survey, psychiatrists appeared more optimistic than primary care physicians about the effectiveness of Alcoholics Anonymous, pharmacological treatment, and residential rehabilitation to treat alcoholism. Some of this difference is likely attributable to psychiatrists' receipt of special training in addiction medicine during residency and through continuing education. Beyond this, though, opinions could be shaped by psychiatrists' and primary care physicians' seeing slightly different patient populations (for example, primary care offices may have more patients who are resistant to psychiatric treatment, often an important component of recovery from addiction). Alternatively, primary care physicians and psychiatrists may have different thresholds for calling a treatment effective.

Physicians' enthusiasm for Alcoholics Anonymous has been noted before (15) and is in line with evidence showing that more frequent attendance at meetings is associated with less drinking (16). Perhaps more surprising, however, is that so many physicians believed that the spiritual component is critical to the success of 12-step programs—an important consideration since Laudet (17) reported that 61% of clients (N=101) believe "the religious aspect of 12-step groups is an obstacle for many." The centrality of spirituality was a prominent theme among early theorists (9) and is still commonly encountered (5,18), but recent literature has also emphasized the social changes that occur in Alcoholics Anonymous (19–22), the value of finding (or becoming) a sponsor (18,19), and the acquisition of life skills for staying sober (5,9,18).

To date, empirical research on spirituality and addiction has been mixed. A 1995 survey of residents of Oxford House (a self-governed communal living environment for recovering alcoholics) found that 43% had no spirituality before joining the program and only 11% noted an increase in their spirituality from their experiences with the program (22). However, Kelly and colleagues (19), who conducted a lagged mediational analysis, found that Alcoholics Anonymous attendance was associated with increases in spirituality or religiosity (especially among those with low initial spirituality or religiosity) and that the effect of Alcoholics Anonymous attendance on drinking outcomes was partially explained by its effect on increasing spirituality or religiosity.

In our survey, 79% of primary care physicians and 71% of psychiatrists were at least somewhat likely to refer the patient to a faith-based program. These numbers are comparable with the number of patients who are referred to Alcoholics Anonymous (79.4% in a survey of substance abuse program directors in the Department of Veterans Affairs [23]). However, in our study, referrals varied dramatically with the physician's own religiosity and with knowledge of a local faith-based program to which to refer the patient. This finding suggests that physicians who were more familiar with local faith-based programs (perhaps through religious or professional ties) felt more comfortable referring patients there.

In this vignette experiment the patient was nominally religious, but this did not dissuade most physicians from referring him to a faith-based program or from anticipating that Alcoholics Anonymous would be very effective. Moreover, varying the patient's church background did not affect physicians' willingness to refer the patient to a faith-based treatment program or their confidence in Alcoholics Anonymous. Whether to refer nonspiritual patients to spiritually oriented programs has been a controversial topic for some time (16). The 1995 American Psychiatric Association practice guidelines recommended nonspiritual self-help groups (such as Rational Recovery) for patients not comfortable with the spiritual focus of Alcoholics Anonymous (24). Likewise, Galanter and colleagues (3) proposed that patients with low spirituality might find it easier to accept programs not oriented toward the 12-step model. Tonigan and colleagues (21) observed that patients who were atheists were more likely (65.4%, N=17) than religious patients (28.7%, N=87) or spiritual patients (35.2%, N=242) never to attend Alcoholics Anonymous. However, Tonigan and colleagues concluded that although atheists were less likely to attend Alcoholics Anonymous, those who did increased their abstinence.

The study has limitations. Survey results may differ from clinical experiences, and nonresponders may differ from responders. Surveys can assess tendencies, but treatment plans are multidimensional and are negotiated amidst dialogue that a survey cannot replicate. The views observed in this survey may not be representative of addiction specialists (including addiction psychiatrists or chronic pain specialists). Faith-based programs are highly variable, making assessment of the group as a whole difficult. Religion, spirituality, and faith were not sharply differentiated because they are such closely related terms. Future studies might examine whether beliefs differ when programs are described as religious, spiritual, or faith based. We did not observe an effect of manipulating the patient's religious characteristics. Future surveys might increase the degree of religious separation in order to find where opinions start to diverge. Many physicians were unaware of local faith-based programs, but the survey did not differentiate whether this was because physicians were unaware or because no programs exist in that location. The survey did not directly measure the availability of faith-based programs.

Conclusions

In conclusion, this survey indicated that it is not entirely the case that in the treatment of alcohol abuse, "clergy and physicians, religion and science, are ships passing in the night" (25). Physicians—especially religious ones—were supportive of Alcoholics Anonymous, with its spiritual component. Many physicians also would refer patients to other faith-based programs for alcohol treatment. Important limiting factors were that physicians may not have been located near faith-based organizations or may not have been aware of them. Future research could examine whether increasing physician awareness of local programs would increase referrals and whether this would increase participation or decrease costs. Overall, physicians' enthusiasm for faith-based treatments highlights the need for scientific study of these treatments to determine which elements are most helpful for patients seeking recovery.

Acknowledgments and disclosures

This study was supported by grants from the Greenwall Foundation and the John Templeton Foundation and by grant 1 K23 AT002749 from the National Center for Complementary and Alternative Medicine. Funding agencies did not participate in study design, data acquisition, analysis, interpretation, writing, or submission of the manuscript.

Dr. Curlin served as an advisor to Boehringer Ingelheim Pharmaceuticals, Inc. The other authors report no competing interests.

References

1. Langrod JG, Muffler J, Abel J, et al: Faith-based approaches; in Substance Abuse: A Comprehensive Textbook, 4th ed. Edited by Lowinson JH, Ruiz P, Millman RB, et al. Philadelphia, Lippincott, Williams and Wilkins, 2005
2. Committee on Government Reform: Effective Faith-Based Treatment Programs. HRG-2001-HGR-0045. Washington DC, Hearing before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources, US House of Representatives, 107th Congress, first session, May 23, 2001
3. Galanter M, Dermatis H, Bunt G, et al: Assessment of spirituality and its relevance to addiction treatment. Journal of Substance Abuse Treatment 33:257–264, 2007
4. Adkins J, Occhipinti L, Hefferan T: Not by Faith Alone: Social Services, Social Justice, and Faith-Based Organizations in the United States. New York, Lexington Books, 2010
5. McCoy LK, Hermos JA, Bokhour BG, et al: Conceptual bases of Christian, faith-based substance abuse rehabilitation programs: qualitative analysis of staff interviews. Substance Abuse 25:1–11, 2004
6. Humphreys K, Moos R: Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. Alcoholism, Clinical and Experimental Research 25:711–716, 2001
7. Humphreys K, Moos RH: Reduced substance-abuse–related health care costs among voluntary participants in Alcoholics Anonymous. Psychiatric Services 47:709–713, 1996
8. Cohen LM, Collins FL, Young AM, et al: Pharmacology and Treatment of Substance Abuse: Evidence- and Outcome-Based Perspectives. New York, Routledge, 2009
9. Tiebout HM: Therapeutic mechanisms of Alcoholics Anonymous. American Journal of Psychiatry 100:468–473, 1944
10. Yancey P: Lessons from rock bottom. Christianity Today, July 11, 2000. Available at www.christianitytoday.com/ct/2000/july10/33.72.html
11. Lauderdale DS, Kestenbaum B: Asian American ethnic identification by surname. Population Research and Policy Review 19:283–300, 2000
12. Lauderdale DS: Birth outcomes for Arabic-named women in California before and

after September 11. Demography 43:185–201, 2006

13. Sheskin IM: A methodology for examining the changing size and spatial distribution of a Jewish population: a Miami case study. Shofar 17:97–114, 1998

14. Groves RM, Fowler FJ, Couper MP, et al: Survey Methodology. Hoboken, NJ, Wiley, 2004

15. Chang G, Astrachan BM, Bryant KJ: Emergency physicians' ratings of alcoholism treaters. Journal of Substance Abuse Treatment 11:131–135, 1994

16. Winzelberg A, Humphreys K: Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. Journal of Consulting and Clinical Psychology 67:790–794, 1999

17. Laudet AB: Attitudes and beliefs about 12-step groups among addiction treatment clients and clinicians: toward identifying obstacles to participation. Substance Use and Misuse 38:2017–2047, 2003

18. Vaillant GE: Alcoholics Anonymous: cult or cure? Australian and New Zealand Journal of Psychiatry 39:431–436, 2005

19. Kelly JF, Stout RL, Magill M, et al: Spirituality in recovery: a lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. Alcoholism, Clinical and Experimental Research 35:1–10, 2011

20. Kaskutas LA, Bond J, Humphreys K: Social networks as mediators of the effect of Alcoholics Anonymous. Addiction 97:891–900, 2002

21. Tonigan JS, Miller WR, Schermer C: Atheists, agnostics and Alcoholics Anonymous. Journal of Studies on Alcohol 63:534–541, 2002

22. Nealon-Woods MA, Ferrari JR, Jason LA: Twelve-step program use among Oxford House residents: spirituality or social support in sobriety? Journal of Substance Abuse 7:311–318, 1995

23. Humphreys K: Clinicians' referral and matching of substance abuse patients to self-help groups after treatment. Psychiatric Services 48:1445–1449, 1997

24. Practice guidelines for the treatment of patients with substance use disorders: alcohol, cocaine, opioids. American Journal of Psychiatry 152:5–59, 1995

25. So Help Me God: Substance Abuse, Religion and Spirituality. New York City, Columbia University, National Center of Addiction and Substance Abuse, Nov 2001

Submissions for Datapoints Column Invited

Submissions to the journal's Datapoints column are invited. Datapoints encourages the rapid dissemination of relevant and timely findings related to clinical and policy issues in psychiatry. National data are preferred. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. The analyses should be straightforward, so that the figure or figures tell the story. The text should follow the standard research format to include a brief introduction, description of the methods and data set, description of the results, and comments on the implications or meanings of the findings.

Datapoints columns, which have a one-page format, are typically 350 to 400 words of text with one or two figures. Because of space constraints, submissions with multiple authors are discouraged; submissions with more than four authors should include justification for additional authors.

Inquiries or submissions should be directed to column editors Amy M. Kilbourne, Ph.D., M.P.H. (amy.kilbourne@va.gov), or Tami L. Mark, Ph.D. (tami.mark@thomsonreuters.com).