THE AMERICAN JOURNAL ON ADDICTIONS

The American Journal on Addictions, 19: 345–351, 2010
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ISSN: 1055-0496 print / 1521-0391 online
DOI: 10.1111/j.1521-0391.2010.00050.x

Use of Clergy Services among Individuals Seeking Treatment for Alcohol Use Problems

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This study examined the prevalence and characteristics of adults with an alcohol use-related problem who receive clergy services. Data come from the National Epidemiologic Survey on Alcohol and Related Conditions. Among persons who sought any services for alcohol-related problems (n = 1,910), 14.7% reported using clergy services. In a multivariable logistic regression model, factors associated with increased likelihood of service use included being Black, aged 35–54 years, a lifetime history of alcohol dependence, major depressive disorder, and personality disorder. Clergy may benefit from training to identify alcohol use problems and serve an important role in making treatment referrals. (Am J Addict 2010;19:345–351)

BACKGROUND

Problematic alcohol use includes patterns of excessive use, such as heavy drinking[1] and binge drinking,[2] as well as psychological conditions, operationalized in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as alcohol use disorders (AUDs).[3] Collectively, these patterns of alcohol misuse and psychological conditions due to alcohol misuse have been linked to a wide variety of negative social and health outcomes.[4–11] Effective treatments for alcohol misuse exist.[12,13] However, among adults with an AUD, only one quarter receive treatment.[13] The average time between onset of an alcohol use disorder and subsequent treatment is typically more than 10 years.[14]

A variety of factors contribute to the low rates of treatment and long delays among adults with problematic alcohol use. Treatment-related barriers include concerns about cost, lack of insurance, and difficulty accessing treatment.[15] In addition, social and psychological barriers to alcohol treatment include denial, stigma, guilt, and ignorance about treatment options.[16] Reducing these barriers is critical. Making initial contact with a treatment provider is an essential first step toward recovery. Individuals with an AUD who receive treatment are often referred from other treatment settings, including primary care providers and mental health providers. Others enter treatment through coercion by the criminal justice system or pressures from family members. Understanding the correlates of AUD treatment is essential to understanding how to reduce barriers to care.

One type of service or support that may hold potential for reducing barriers and increasing engagement in the treatment process for persons with AUDs is churches and other religious community organizations.[17] In many communities, churches are important sources of social support by virtue of their involvement in activities as varied as economic and community development, political and civic issues, education, and social networks.[18,19] This appears to be particularly true in African American communities; approximately 90% of African Americans report that churches fulfill a wide variety of social roles in the community, and that churches have a positive influence in their lives.[20]

While social networks within churches are a valuable resource for congregants, clergy are often the most visible and trusted source of support within churches.[21] With

Received August 19, 2009; revised September 12, 2009; accepted October 29, 2009.
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more than 400,000 ministers, priests, and rabbis actively serving in the United States, clergy represent a large body of professionals. They are involved in their communities, know their congregants well, and see them on a regular basis. Thus clergy are in a unique position to notice changes in behavior over time. Their roles as senior leaders of churches, their embodiment of important tenants of their faiths, and their formal roles as caregivers of their congregations also lend clergy considerable credibility, particularly within African American communities. Clergy are often seen as being deeply committed to their congregants and willing to honor desires for confidentiality. They typically receive some training in pastoral counseling methods.[21] In addition, clergy do not typically charge fees for pastoral counseling services, require insurance, or have extensive paperwork requirements.[18] Clergy represent an important front line resource for those seeking mental health or social services; for many adults who seek help with a mental illness, substance use problems, or personal issues, the first professional contacted is clergy, rather than mental health specialists.[22,23]

It is widely known that many people rely on clergy for various problems in their lives, but rates and correlates of use of clergy for alcohol problems remain unclear. While clergy are positioned to be an easily accessible source of support and services for alcohol misuse, qualitative research suggests that some individuals do not feel comfortable with taking issues related to alcohol misuse to their clergy.[24] Reasons for not using clergy counseling services include shame, perceived lack of knowledge or skill on the part of the clergyperson, and availability of clergy time.[24] To date there has been little population-level quantitative study of the use, or lack of use, of clergy services for individuals with alcohol-related problems.

To help improve the overall system of care for persons with alcohol-related problems, it is important to understand both specialty and nonspecialty service use. As nonspecialty service use is understudied, we sought to examine the prevalence of use of clergy services among those adults who received help for an alcohol use problem in the United States, as well as characteristics and correlates of individuals with alcohol-related problems who used clergy services compared to individuals who used other types of services. We also examined the degree to which individuals who receive help from the clergy receive other types of services as well. The results will contribute to a better understanding of the overall system of care for persons with alcohol problems and inform strategies for increasing service use.

MATERIALS AND METHODS

Study Design

This study used data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationally representative survey of 43,093 noninstitutionalized U.S. residents aged 18 years and older. Descriptions of the NESARC survey and sampling protocol are described in detail elsewhere.[25,26] The NESARC was based on multistage sampling design, oversampling young adults, Hispanics, and Blacks to obtain reliable statistical estimation in these subpopulations, and to ensure appropriate representation of racial/ethnic groups. A sample of households and group living facilities was drawn based on U.S. census data, and one person was selected at random from the roster of eligible individuals living at each selected household. The overall response rate was 81%, and all participants provided informed consent. Data were weighted at the individual and household levels and to adjust for oversampling and nonresponse on select demographic variables and adjusted to be representative of the U.S. population assessed during the 2000 census.

In the administration of this survey, U.S. Census Bureau workers, trained by National Institute on Alcohol Abuse and Alcoholism (NIAAA) staff, administered the Alcohol Use Disorders and Associated Disabilities Interview Schedule DSM-IV version (AUDADIS-IV).[27] AUDADIS-IV is a structured interview designed for administration by trained lay interviewers. AUDADIS assesses 10 DSM-IV substance use disorders and has evidenced good-to-excellent reliability for the assessment of substance use disorders.[27]

Measurement

A series of questions on treatment utilization measured use of clergy services for alcohol use problems. The sample for the present analyses was restricted to those individuals who endorsed the question "Have you ever gone anywhere or seen anyone for a reason that was related in any way to your drinking—a physician, counselor, alcoholics anonymous, or any other community agency or professional?" ($n = 1,910$). Respondents who endorsed this question were then asked about lifetime use of services for alcohol-related problems, including Alcoholics Anonymous/Narcotics Anonymous, inpatient wards, private physicians, and human service professionals (ie, psychiatrists, psychologists, and social workers), outpatient clinics, family or social services, detoxification, rehabilitation, emergency departments, halfway houses, employee assistance programs, crisis centers, and clergy (ie, clergyman, priest, or rabbi). The outcome of the current study was receiving clergy services for reasons related to drinking.

Several sociodemographic variables were assessed in this study. These included racial/ethnic groups (including non-Hispanic White, Black, and Hispanic), gender (male and female), living area (urban/rural), marital status (married, separated/divorced/widowed, and never married), personal income (in dollars), age (in years), and employment status (employed, unemployed). Insurance status referred to current (at the time of taking the survey) private or public insurance (eg, medicare, medicaid, CHAMPUS, CHAMPVA, VA, or other military healthcare). It should

be noted that data regarding insurance status at time of diagnosis and/or treatment are not available in the NESARC data set.

Several DSM-IV concordant clinical characteristics were also included in the current study. The AUDADIS instrument study queries respondents on the symptoms of AUDs (abuse and dependence) and other disorders described in the DSM-IV. The data from this symptom inventory were coded by NESARC study staff to indicate if respondents met criteria for alcohol abuse and/or alcohol dependence, according to the criteria set forth in the DSM-IV. For the purposes of the present study, we created a variable for alcohol-related problems with three mutually exclusive categories, indicating which individuals had a lifetime diagnosis of alcohol abuse (without history of dependence), had a lifetime alcohol dependence (with or without abuse), or had no lifetime alcohol use disorder (this group likely including individuals with heavy or binge drinking, but without the negative consequences and psychological symptoms associated with AUDs). As prior research shows that psychiatric comorbidities are associated with higher rates of service utilization, the following DSM-IV-defined psychiatric conditions were included in the analysis: major depressive disorder, anxiety disorders (ie, generalized anxiety disorder, social phobia, panic disorders, agoraphobia, and specific phobia), an Axis II personality disorder (ie, antisocial, avoidant, dependent, obsessive compulsive, paranoid, schizoid, and histrionic), and any non-nicotine lifetime drug use disorder (ie, marijuana, cocaine or crack, tranquilizers, stimulants, painkillers, other prescription drugs, heroin, inhalants or solvents, hallucinogens, and sedatives).

Analysis

Analyses were computed using SUDAAN Version 9.0 (RTI International, Research Triangle Park, North Carolina) in order to obtain properly adjusted standard errors based on the complex survey weights. This system implements a Taylor series linearization to adjust standard errors of estimates for complex survey sampling design effects including clustered data. Chi-square tests and simple logistic regressions were used to examine bivariate associations. Multivariable logistic regression analyses were used to identify factors associated with use of clergy services, while adjusting for other sociodemographic and clinical variables.

RESULTS

Of the 1,910 individuals who reported seeking treatment for alcohol use-related problems, 14.7% (95% CI 12.8–16.8) reported using clergy services. The majority of those who used services from clergy also used professional services at some point; only .5% used clergy services exclusively for their alcohol use-related problem. Chi-square tests (reported in Table 1) revealed a higher prevalence of clergy service use among individuals with alcohol dependence, an anxiety disorder, major depressive disorder, personality disorder, or other drug use disorder than among individuals without these diagnoses (all $p \leq .001$).

Similar trends emerged in multivariable logistic regression modeling (Table 2). Individuals who met criteria for major depressive and personality disorders were significantly more likely to report use of clergy services (adjusted odds ratio [AOR] = 1.78 and 1.73, respectively), though the relations between anxiety disorders and drug use disorders with use of clergy services attenuated after adjustment for demographic characteristics and the other mental health conditions (AOR = .98 and 1.31, respectively). Persons with lifetime alcohol dependence (with or without abuse) were 4.83 times more likely to seek clergy services than those without an AUD. No statistically significant differences were observed between those without an AUD and a lifetime history of alcohol abuse (without dependence). Subsequent post hoc comparisons showed that individuals who met criteria for alcohol dependence (with or without abuse) were significantly more likely to report use of clergy services compared to individuals with lifetime alcohol abuse (without dependence; AOR = 2.70, 95% CI = 1.76–4.46).

Among the sociodemographic characteristics examined, we found that Black respondents had 68% greater odds of using clergy services for alcohol-related problems than White respondents, and individuals aged 35–54 had 62% greater odds of using clergy services than individuals aged 18–34.

DISCUSSION

The majority of addiction services research focuses on specialty service but little is known about the nonspecialty sector of care, particularly clergy services. This study represents the most detailed study to date of clergy service use for alcohol-related problems. Notable strengths of this study include using a nationally representative community-based sample, DSM-IV concordant diagnoses, and adjustments for other sociodemographic and clinical characteristics. Overall, we found that approximately 14.7% of service users for alcohol problems met with clergy. Although professional services are used more commonly, these findings show that clergy services are an important part of the overall system of care for persons with alcohol problems. Because the vast majority (96.7%) of individuals who used clergy services also reported lifetime use of professional services, it is important that professional service providers and clergy effectively coordinate and integrate their support services. The system of care has the possibility of being enhanced when specialty and nonspecialty providers can make cross-sector referrals. However, previous research has shown that few clergy refer their clients to professional services.[20]

TABLE 1. Bivariate comparisons of individuals who used minister, clergy, or rabbi services and individuals who did not among those seeking treatment for alcohol use problems in the NESARC

Characteristic	Overall sample ($n = 1{,}910$) %	Clergy services ($n = 273$) %	No clergy services ($n = 1{,}637$) %	Chi-square test, p-value
Sex: Female	26.9	30.6	26.2	1.62, .21
Race				
White	80.7	79.9	80.8	.84, .44
Black	9.7	12.0	9.3	
Hispanic	9.6	8.1	9.9	
Living area: Urban	30.8	31.4	30.7	.04, .84
Marital status				.74, .48
Married	51.2	53.5	50.8	
Separated/widowed/divorced	26.4	27.3	26.3	
Never married	22.4	19.2	22.9	
Income				1.83, .15
$70,000 or more	18.3	21.0	17.9	
$35,000–69,999	30.5	29.4	30.7	
$20,000–34,999	23.1	17.3	24.1	
$0–19,999	28.1	32.4	27.4	
Age				3.55, .03
55 and over	19.4	17.5	19.8	
35–54	54.0	62.3	52.5	
18–34	26.6	20.2	27.7	
Any insurance	25.6	28.3	25.1	.79, .38
Lifetime anxiety disorder	29.4	41.7	27.3	11.57, .001
Lifetime personality disorder	34.8	51.9	31.9	20.85, <.001
Lifetime major depressive disorder	37.1	55.1	33.9	26.32, < .001
Lifetime drug use disorder	47.9	60.3	45.9	15.00, <.001
Lifetime alcohol use disorder diagnosis				21.42, <.001
None	2.9	.7	3.3	
Abuse (only)	29.1	12.6	32.0	
Dependence (with or without abuse)	68.0	86.7	64.8	

Note: All percentages are weighted column percentages.

Black adults are more likely to use clergy services for alcohol use-related problems. This finding is consistent with previous research which indicates the centrality of religion and churches in Black American life[20] and the significantly higher levels of religious service attendance among Black adults.[28] Clergy may be an entryway for Blacks to engage in alcohol-related treatment. This is particularly important for Black Americans because of their overall underutilization of professional services.

Individuals who met criteria for alcohol dependence were more likely to have used clergy services for alcohol use-related problems than individuals who never met criteria or who only met criteria for alcohol abuse. This may in part reflect the fact that individuals who meet criteria for alcohol abuse by definition have experienced legal, occupational, and/or social problems due to their alcohol consumption, and may be more likely to enter treatment through the legal system, employee assistance programs, or social services. We also found that individuals with more psychopathology were more likely to have used clergy services for alcohol problems. Specifically, individuals with DSM-IV-defined major depressive disorder and individuals with a personality disorder were more likely to have sought the services of a clergy member. This suggests the importance of providing clergy with increased educational opportunities to understand these clinical disorders. Professional service providers can also benefit from a greater understanding of the spiritual needs of their clients and the types of resources that would be most beneficial.

Limitations

There are several limitations to this study. The analysis is cross-sectional, and based on lifetime measurements of mental health and substance use-related conditions. We

TABLE 2. Weighted logistic regression of correlates of use of minister, clergy, or rabbi services among individuals seeking treatment for alcohol use problems in the NESARC ($N = 1{,}910$)

Factors	Unadjusted odds ratio (95% CI)	Adjusted odds ratio (95% CI)
Sociodemographic characteristics		
Sex		
Males	1.00	1.00
Female	1.24 (.90, 1.71)	1.03 (.71, 1.50)
Race		
White	1.00	1.00
Black	1.30 (.82, 2.06)	**1.68 (1.01, 2.79)**
Hispanic	.84 (.48, 1.44)	1.07 (.60, 1.92)
Urbanicity		
Rural	1.00	1.00
Urban	1.03 (.74, 1.44)	1.09 (.76, 1.56)
Marital status		
Never married	1.00	1.00
Married	1.26 (.84, 1.88)	1.16 (.75, 1.79)
Separated/divorced/widowed	1.24 (.81, 1.88)	.88 (.55, 1.41)
Income		
$70,000 or more	1.00	1.00
$35,000–69,999	.81 (.50, 1.34)	.88 (.52, 1.48)
$20,000–34,999	.61 (.35, 1.05)	.62 (.36, 1.06)
$0–19,999	1.01 (.63, 1.60)	.85 (.50, 1.45)
Insurance		
None	1.00	1.00
Any	1.18 (.83, 1.67)	1.07 (.66, 1.74)
Age		
18–34	1.00	1.00
35–54	**1.62 (1.09, 2.43)**	**1.62 (1.05, 2.51)**
55 and over	1.21 (.74, 1.99)	1.59 (.85, 2.97)
Clinical characteristics		
Lifetime alcohol use disorder diagnosis		
None	1.00	1.00
Abuse (only)	2.00 (.60, 6.67)	1.79 (.48, 6.61)
Dependence (with or without abuse)	**6.78 (1.94, 23.74)**	**4.83 (1.25, 18.72)**
Lifetime major depressive disorder		
No	1.00	1.00
Yes	**2.49 (1.81, 3.42)**	**1.78 (1.22, 2.61)**
Lifetime personality disorder		
No	1.00	1.00
Yes	**2.30 (1.68, 3.17)**	**1.73 (1.19, 2.50)**
Lifetime drug use disorder		
No	1.00	1.00
Yes	**1.83 (1.36, 2.47)**	1.31 (.93, 1.85)
Lifetime anxiety disorder		
No	1.00	1.00
Yes	**1.90 (1.37, 2.64)**	.98 (.65, 1.47)

Note: CI stands for Confidence Interval. Values in bold are statistically significant based on a 95% CI that does not bound the value 1.0.

did not have data on the temporal ordering of service use to help determine what types of services were used first. While individuals who had met criteria for alcohol dependence were more likely to report use of clergy services, it is also unknown if they sought this service during the same period that they met criteria. In addition to using lifetime measurements, we have used DSM-IV criteria to determine the presence of mental health and substance use-related conditions. While this method has the advantage of relying on well accepted, reliable, and clinically valid measurement

tools, the study was not able to examine less severe mental health issues and conditions that may also be improved through treatment. A measure of religious beliefs was not available in the present dataset. Future research should explore religious beliefs as a mediator of the association of demographic characteristics with clergy service use. In particular, differences in religious beliefs and affiliation may explain the race group differences observed in this study given the higher rates of church attendance among Black Americans.[28] Despite these limitations, the present findings are important because this is one of very few studies to examine correlates of clergy service use for alcohol-related problems.

Implications and Future Research

This study revealed that approximately one in seven persons in the United States who used services for alcohol problems met with a member of the clergy. Further research on patient preferences for treatment, particularly including spiritual needs, can help us understand the overall potential role of clergy within the system of care for alcohol-related problems. Additional research is also needed to better understand the extent to which clergy are meeting the complex needs of this population.

This study revealed that those with alcohol dependence are more likely to meet with clergy than those without. Religious leaders may benefit from training on identifying signs of problem drinking among parishioners, intervening with individuals exhibiting signs of problem drinking, and reducing stigma and other barriers to professional care. Training for clergy may be particularly helpful for determining when a congregant should be referred for professional services and what type of referral is required (eg, detoxification for physical dependence to alcohol, emergency services for suicidal behaviors, or violent tendencies toward others). Professional service providers may also consider collaboration with clergy around problems that involve issues that call into question basic life beliefs[24,29] (eg, death, illness, and disability) and may also exacerbate alcohol abuse. Future research is needed to explore the feasibility and effectiveness of such outreach and collaborative efforts.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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