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Contrasting faith-based and traditional substance abuse treatment programs

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Abstract

This article (a) discusses the definition of faith-based substance abuse treatment programs, (b) juxtaposes Durkheim's theory regarding religion with Simpson's (2004) treatment process model to highlight key dimensions of faith-based and traditional programs, and (c) presents results from a study of seven programs to identify key program dimensions and to identify differences/similarities between program types. Focus group/Concept Mapping techniques yielded a clear "spiritual activities, beliefs, and rituals" dimension, rated as significantly more important to faith-based programs. Faith-based program staff also rated "structure and discipline" as more important and "work readiness" as less important. No differences were found for "group activities/cohesion" and "role modeling/mentoring," "safe, supportive environment," and "traditional treatment modalities." Programs showed substantial similarities with regard to core social processes of treatment such as mentoring, role modeling, and social cohesion. Implications are considered for further research on treatment engagement, retention, and other outcomes.

Keywords: Substance abuse treatment; Faith-based treatment; Health disparities; Concept Mapping

1. Introduction

"Faith-based" initiatives in areas of welfare-to-work, child care, and substance abuse treatment have recently received an increasing amount of public attention, both positive and negative (Johnson, 2002; Sider & Unruh, 1999). Growing interest in faith-based approaches coincides with increasing attention directed to conceptual and methodological issues surrounding spirituality, religiosity, and their implications for health and well-being (Fetzer Institute, 1999).

Unfortunately, systematic empirical research regarding the efficacy of faith-based interventions (i.e., those rooted in some spiritual or religious content) for alcohol or substance abuse is sparse. Although general evidence regarding the efficacy of faith-based interventions is reviewed elsewhere (Johnson, 2002), we emphasize that efforts to understand the effectiveness of faith-based programs presumes an understanding of (at the very least) what faith-based programs are and what they do. There is a growing literature on the definition of faith-based organizations involved in the provision of social services (Vidal, 2001), although we will argue that faith-based substance abuse treatment may occupy a unique niche and must be understood in relation to traditional substance abuse treatment programs—particularly in light of the preeminence of 12-step philosophy (Roman & Blum, 1999) and emphasis upon spirituality in the recovery process (Albers, 1997; White, 1998).

The literature regarding religion and spirituality dimensions in relation to substance abuse and substance abuse treatment has been aptly reviewed by Gorsuch (1995) and

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Miller (1997). The interested reader is referred to those sources for background information. The present exploratory analysis focuses upon substance abuse treatment, presenting an empirically grounded, qualitative and quantitative study of a range of treatment programs to identify differences and similarities between faith-based and more "traditional" substance abuse treatment programs. Our hope is that identification of unique (and common) elements will demystify the notion of "faith-based" treatment, while highlighting more fundamental dimensions common to treatment programs in general.

To clarify the nature and diversity of faith-based substance abuse treatment programs, the present article will (a) discuss the definition of faith-based organizations, specifically as they relate to substance abuse treatment programs, (b) contrast classical theory regarding the structure and functions of religious organizations with contemporary middle-range theory of substance abuse treatment process to highlight key dimensions of faith-based and traditional treatment programs, and (c) present results from an exploratory qualitative/quantitative study of a range of substance abuse treatment programs seeking to identify key dimensions of such programs and to identify sources of variation between program types.

Specifically, seven programs are studied, ranging from "traditional" treatment programs employing licensed professional staff to more clearly "faith-based" programs employing largely lay staff and endorsing more explicitly Christian philosophies. Focus group and Concept Mapping (Trochim, 1993a) methodologies are used to identify key program dimensions of these programs and to see if traditional and faith-based programs can be differentiated based on these dimensions. Ultimately, the goals of our research program are to clarify the nature of faith-based treatment, to assess the extent to which these programs differ (or are similar to) "traditional" treatment programs, and to develop hypotheses regarding possible implications of differences for treatment outcomes of these programs.

1.1. The definition of faith-based organizations

A critical starting point for this discussion is the definition of "faith-based" programs, as extant definitions appear many and varied. Castelli and McCarthy (1997) define faith-based organizations to include congregations, national networks (such as Catholic Charities or YMCA), freestanding religious organizations, or other urban or social ministries providing some community service (Vidal, 2001). A White House White Paper (2001, p. 3) takes a broader view, including both religious and secular organizations, referring to "faith-based grassroots groups. . .[involving networks]. . .of local congregations. . .small nonprofit organizations (both religious and secular). . .and neighborhood groups that spring up to respond to a crisis. . .." In contrast, Scott (2003) emphasizes (a) the linkage of faith-based organizations to an organized faith community, (b) the presence of a particular religious ideology, and (c) staff and volunteers drawn from a particular religious group.

In considering the differing emphases of such definitions, we argue that an appreciation of the diversity of faith-based groups requires a broad, inclusive approach allowing for both secular and religious organizations. Thus, Sider and Unruh (1999) posit four types of faith-based providers: (a) secular providers who make no explicit to reference to God or any ultimate values, (b) religiously affiliated providers who use standard nonreligious techniques and approaches without religious content, (c) exclusively faith-based providers who rely on religious content and technologies to the exclusion of traditional nonreligious approaches, and (d) holistic faith-based providers who combine religious and nonreligious content and approaches. Sider and Unruh emphasize a combination of religious affiliation and religious content similar to the Working Group on Human Needs and Faith-Based and Community Initiatives (2002), who emphasize the degree to which a program is imbued with religious and/or spiritual content (e.g., a continuum ranging from "faith-saturated" to "faith-secular partnership").

We argue that a broad definition is a necessity, in particular, in examining faith-based providers of substance abuse treatment. With regard to the definition of faith-based substance abuse treatment programs, we downplay the importance of the religious or congregational affiliation of the program itself. Rather, for purposes of this article, we define "faith-based" programs broadly in terms of the presence of implicit or explicit religious and/or spiritual content underlying program activities. This follows from the fact that many programs, although not associated with any organized religion, may endorse 12-step conceptions of spirituality and the existence of a "higher power." Thus, although they may not constitute a religion per se, 12-step programs do promote practices such as prayer, meditation, confession, and penance (White, 1998) and as well involve elements of ideology and recruitment of volunteers and "staff" from existing 12-step members proposed as characteristics of faith-based organizations (Scott, 2003). In this sense, even a secular treatment program may have "faith-based" elements.

The line between secular and faith-based programs becomes further blurred in that recovery programs endorsing 12-step philosophy typically emphasize "spiritual transformation" (Albers, 1997; Alcoholics Anonymous [AA], 1995) as fundamental to the recovery process. In this regard, an approach emphasizing the degree to which a program is imbued with religious and/or spiritual content (Sider & Unruh, 1999) becomes critical with regard to examining substance abuse treatment programs where even a traditional program (emphasizing conventional medical and psychosocial treatments) may incorporate the 12-step philosophy or other spiritual content to some extent.

A final definitional issue involves the credentials of program staff. That is, as noted, 12-step-oriented treatment programs often recruit staff members who are in recovery. Although this is common and although faith-based pro-

grams may recruit their "graduates" as well, an important distinction lies in the degree of training of staff in more traditional versus faith-based programs. That is, we suggest that traditional treatment programs that emphasize conventional medical and psychosocial treatment modalities will generally be more likely to have professional, licensed staff (in part a function of licensing requirements) than less formal faith-based programs who may be more likely to hire unlicensed nonprofessional staff.

1.2. Theoretical foundations for approaching "faith-based" and traditional treatment

Although the emphasis of the current study is primarily empirical—to contrast "faith-based" and traditional substance abuse treatment programs—it may be useful to briefly examine these programs from a broader theoretical perspective. Specifically, it is noted that much of the extant conceptual work on faith-based organization is typological rather than explanatory in nature. As such, we might look conceptually beyond the structure of faith-based programs to consider what those structures accomplish for the individuals and groups involved. Additionally, it is relevant to ask whether faith-based programs would necessarily appear different conceptually and procedurally from traditional substance abuse treatment programs?

In thinking about faith-based programs, we start by considering Durkheim's (1948) classic structural–functional analysis of religious organization as an "integrated system of *beliefs* and *practices* relative to sacred things...which unite in one moral community...all those who adhere to it." Religion was thus viewed as fulfilling basic collective social functions (Alpert, 1961) including promoting self-discipline, social cohesion, "revitalizing" the social heritage of the group, and promoting well-being. In this sense, specifically religious practices (prayer, singing, testifying, etc.) reinforce the underlying belief system and promote integration of the individual into the collective.

Against the structural–functional background provided by Durkheim (1948), it may be instructive to juxtapose Simpson's (2004) heuristic, empirically supported, general model of the substance abuse treatment process. This model (Fig. 1) begins with inputs involving both patient attributes (treatment readiness, illness severity, and program attributes (resources, staff, organizational climate, and management information). These dimensions impact early engagement in the program (processes of program participation and development of a therapeutic relationship), which subsequently feed into the early recovery stage (behavioral and psychosocial changes) and the stabilized recovery stage (program retention), which ultimately leads to better or worse posttreatment outcomes (drug use, criminal activity, and social relations).

In considering possible points of conceptual convergence between Durkheim's and Simpson's models and their implications with regard to faith-based and traditional treatment, several points might be noted. First, Simpson's treatment process model does not mention concepts of "spirituality" or "spiritual/12-step" orientation. Although not mentioned, such elements, whether found in faith-based or traditional programs, might appropriately fall within the program attributes dimension (e.g., organizational climate) as might recruitment of staff in recovery as a structural characteristic of a treatment program.

Second, Simpson notes the importance of treatment readiness and motivation for change with regard to engagement, retention, and outcomes. As substance abuse is often associated with loss of social ties and a marginalized social status (Jellinek, 1960), substance abusers may be particularly likely to be disenfranchised from key societal institutions as well as from the church. Given low levels of treatment readiness, the critical question is how a treatment program

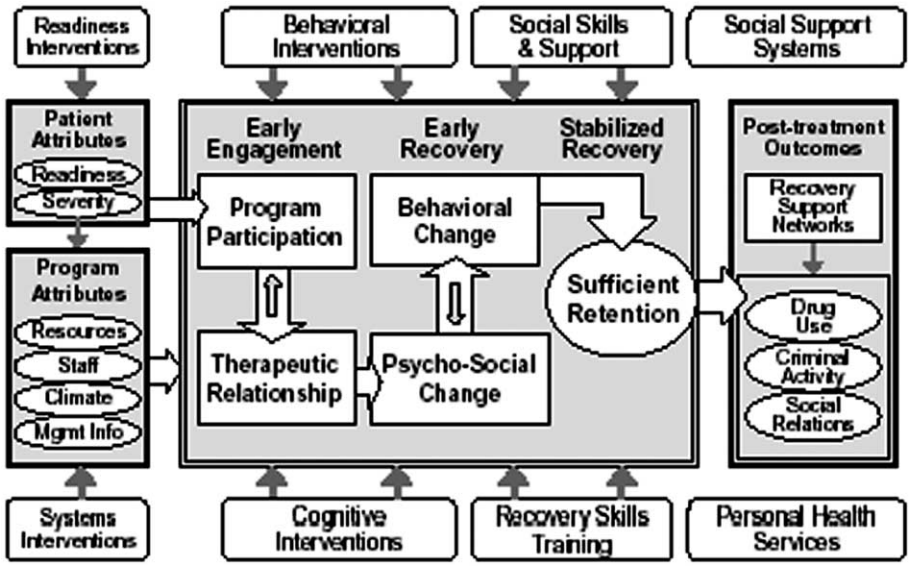

Fig. 1. Simpson's (2004) treatment process model.

(faith-based or traditional) can be structured or organized (i.e., program dimensions or elements) to engage and retain the individual in the program and in the recovery process?

Simpson (2004) notes that the least developed dimension of his model involves program attributes (and organizational climate dimensions). In this regard, Durkheim's (1948) conceptualization may be relevant in suggesting the importance of (a) structure and discipline and (b) engaging participants in rituals and activities that foster social integration and adoption of new norms, values, and behaviors. With regard first to structure and discipline, note that Simpson (2004) cites Moos, King, Burnett, and Andrassy (1997), who demonstrate the importance of "high expectations for patients, clear policies, structured programming, high proportion of staff in recovery, and emphasis upon psychosocial treatment" as predictors of treatment participation (engagement) and treatment outcomes. Thus, given the rather chaotic lifestyles experienced by many out-of-treatment substance abusers, such clear program structure might be hypothesized to be crucial to engagement and outcomes.

With regard to elements of organizational culture that promote social cohesion, Durkheim (1948) and Alpert (1961) might suggest the important functions of rituals and group activities. In a more faith-based setting, such activities may involve group Bible study; in a traditional treatment setting, this might involve 12-step study. White (1998) has extensively detailed the importance of rituals in 12-step culture such as prayer/meditation, testifying or witnessing regarding faith (or recovery), testimonials regarding individual salvation (or recovery), or simply group activities (such as recreational activities or even housecleaning). Such activities might be found in either faith-based or traditional treatment settings (at least in traditional programs with a 12-step emphasis).

Further, Simpson (2004) notes the potential usefulness of special "induction" efforts such as individual and group-based motivational interventions (Foote et al., 1999), to foster treatment readiness and program engagement. Among other elements contributing to the induction process, interpersonal skills and empathy (Miller, 2000) are cited as contributing to the development of productive therapeutic relationships—consistent with evidence from Miller, Taylor, and West (1980) regarding empathic, warm, accepting, and nurturing counseling style as characteristic of effective substance abuse counselors. To the extent that such empathic therapeutic relationships can be interpreted in terms of fundamental Christian tenets of agape as Miller (2000) suggests, then these may represent elements common to effective treatment approaches, whether faith-based or traditional.

Perhaps, a final convergence between Durkheim and Simpson, a critical psychosocial component (as in Moos et al., 1997) of either faith-based or traditional treatment programs that promote social cohesion and the engagement and recovery process would be activities that specifically provide mentoring or social support to the individual. This could involve the presence of formal or informal mentors (or sponsors) such as use of recovering program staff members (providing role models of successful recovery; cf. Moos et al, 1997), AA, or other 12-step meetings to provide support and social reinforcement, or more general emphasis upon the group as a source of support for recovery. All of these activities or elements would serve to reinforce a "recovery" belief system—whether explicitly faith-based or traditional.

The point of this brief conceptual overview is not to formally derive specific hypotheses, but rather to lay a foundation for interpreting what our empirical work may uncover. That is, the above review may suggest that more spiritually oriented programs might emphasize activities, beliefs, and rituals that promote social cohesion and integration, although such elements may be viewed as motivational induction mechanisms and elements of organizational climate that serve to increase engagement and retention. Core social processes such as role modeling and support may be common to both faith-based and traditional programs.

1.3. Overview of the research questions

Thus far, we have discussed definitional issues involving faith-based programs, noting that dimensions of spirituality may pervade both faith-based and traditional programs given the pervasiveness of 12-step philosophy. Further, we have examined both classic theory and Simpson's model of treatment process, suggesting that common features such as an empathic climate, elements to promote engagement and integration, and role modeling and support, may pervade both faith-based and traditional programs. These discussions provide a point of departure. We feel that an understanding of such programs must come from an empirical examination of a range of programs themselves. In this regard, following from our earlier discussion, we argue that faith-based programs can best be understood in comparison to more traditional programs so that similarities and differences can be examined. Thus, our guiding research question is whether and how traditional treatment programs differ from faith-based programs. That is, to the extent that social processes are essential to effective treatment, there may be more similarities between traditional and faith-based programs than differences. To that end, we present the results of an exploratory study, which provides qualitative and quantitative data on key program dimensions identified in a range of substance abuse treatment programs.

2. Materials and methods

2.1. Overview of participating treatment programs

To provide a range of variation in program structures and philosophies, seven Central Texas treatment programs

were studied. Names of these programs are not given here to maintain the confidentiality of the programs. Characteristics of these programs (based upon program literature and interviews with program leaders) are presented in Table 1.

All programs provide residential services, with the more faith-based programs offering longer term residential care. All of the programs incorporate some elements of spirituality, either in terms of 12-step philosophy or Christian tenets. As the table indicates, programs included two traditional treatment programs (Programs 1 and 2) involving licensed professional staff and medical/psychosocial treatment modalities. Both programs incorporate spiritual dimensions in terms of 12-step programming; Program 2 also incorporates specifically Christian elements. Toward the more traditional end of the continuum, Program 3 represents somewhat of a mix, with a combination of licensed professional and volunteer staff, with a philosophy that is Christian in orientation, emphasizing biblical teachings combined with more traditional counseling, 12-step programming, and work therapy.

At the less traditional end of the continuum are four more explicitly faith-based programs, characterized by unlicensed nonprofessional staff (often program graduates) and an emphasis upon biblical teachings, prayer, individual and group worship, and some emphasis upon supervised work experience. These faith-based programs do not necessarily endorse 12-step programming. Thus, for example, Program 4 (Garcia & Garcia, 1988) promotes "17 lessons for living" and Program 5 (Diez, 1991) emphasizes "4 pillars of evangelism, discipleship, social work, and individual faith" as alternatives to 12-step philosophy.

It is noted that no therapeutic communities (TCs) were included in the study. Although there was one TC in operation in the area, it was excluded from the study on the assumption that, as a prison-based program, it would not be comparable to the other programs. The implications of the exclusion of TCs from the study will be discussed in the Conclusions section of the article.

2.2. Concept Mapping methodology: Establishing treatment program dimensions

To help to understand the nature of faith-based and traditional treatment programs, the present study utilizes Concept Mapping (Trochim, 1993a) to (a) identify core dimensions of these treatment programs, defined through focus group methods conducted with program staff and residents, and (b) assess the utility of these dimensions to differentiate between traditional and faith-based programs. The goal here, simply put, is to examine the extent to which faith-based programs differ from more traditional treatment programs.

Concept Mapping methodology (Trochim, 1993a) has been described by Johnsen, Biegel, and Shafran (2000, p. 68) as a "process that involves a series of structured and discrete steps to arrive at a pictorial representation, in the form of a map, of the interrelationships among ideas." The process involves several stages. To generate the concepts, respondents in focus groups or individual interviews brainstorm in response to a focus question and generate a pool of statements or items that describe the concept. Later, the combined set of statements is sorted by respondents (same or different) into categories reflecting similarity of statements (i.e., statements reflecting a similar concept). This procedure yields a similarity matrix. Respondents also rate the importance of each statement to the focus question (e.g., how important they feel each statement/descriptor is to the concept, generally on a Likert scale).

After the similarity matrix is constructed, Concept Mapping software generates two sets of statistical analyses. First, a two-dimensional nonmetric multidimensional scaling of the group similarity matrix is applied to the table of similarities or distances that iteratively place points on a map so that the original table is as fairly represented as possible (Trochim, 1993a). This procedure produces a map of points that represent the set of statements. The distance between two points (statements) indicates the similarity. Second, a hierarchical cluster analysis is used to group individual statements on the map into clusters of statements that presumably reflect similar concepts (Trochim, 1993a). The analyses generate a point map and a cluster map. From the rating data obtained from group participants, average importance ratings across participants can be overlaid graphically on the maps to produce a point rating map and a cluster rating map.

Several different cluster maps can be generated to represent a range of cluster solutions. The default number of clusters generated by the Concept System software is equal to approximately 20% of the number of statements entered. The next step is to "name" the clusters, which can be done by the original focus groups, groups reflecting the same or similar populations (Trochim, 1993a), or by the research team or other experts (Johnsen et al., 2000).

A few statistical points regarding the Concept Mapping approach merit consideration. First, as a Concept Mapping can yield a number of "maps," the question of model fit to the data arises. Multidimensional scaling procedures provide a measure of goodness of fit of the obtained map (called a "stress value"), where smaller stress values indicate better model fit-expressed in terms of the goodness of fit of the map to the original dissimilarity map that served as input. Stress values more than 0.35 suggest that interpretation of the obtained map may be problematic (Trochim, 1993b) and values less than 0.25 indicate a reasonable solution. A second issue involves sample size. As Trochim (1993b) notes, Concept Mapping is designed for small samples of rater/sorters (rule of thumb of 15; Trochim, 1993b, p. 8), although he cites data to support a positive correlation between number of raters and various measures of reliability.

Table 1
Characteristics of participating programs

Characteristics	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6	Program 7
Type	Nonprofit	Nonprofit	Nonprofit	Nonprofit	Nonprofit	Nonprofit	Nonprofit
Established	1967	1970	1865	1972	1992	1995	1993
Denomination	None	None	None	None	None	None	None
Program	Residential/outpatient	Residential/outpatient/after-care	Residential	Residential	Residential	Residential	Residential/outpatient
Number of staff	124	28	10	2 Church leaders	10	4	6
Length of stay	28–90 days	Varies	6–12 months	3–6 months	6 months	9 months	3–6 months
Number of Clients	132	38	116	19 men, 2 youth	12–15	20	22
Clients per year	2700	143	600	300–400	820	350–400	300
Services provided	Assessment, medical detoxification, residential, outpatient, family, relapse prevention, aftercare, and alumni	Adult men and women, 24-hour supervision, 12-step, group/ individual counseling, Bible study, church services, alcohol/ drug education, assessment, and referral, GED, vocational planning, life skills, parenting, family counseling, mentoring	Vocational/group/individual counseling, group/personal worship, recreation, food, shelter, clothing, health concerns, lab tests, education, referrals	Chapel, Bible studies, discipleship, book reports	Spiritual guidance, meeting, Bible study, job training, counseling, and legal services	Room and board, Bible study, counseling, prayer, work opportunity	Classes, group therapy, worship services, 12-step program, job counseling, training, and placement
Costs	Free for the needy	Fee for service	Free	Free	Free	Free	Free
Funding	State, county, city, United Way, self-pay	United Way, individual/corporate donors, private pay, probation	Thrift store donations, vehicle auctions	Contributions	Grants, donations, services provided, thrift store	Community and individual contributions f	Private donations and client services
Staff qualifications	LCDC, MSSW, volunteers, RN, RLVN, MD	LCDC, BS, MS, PhD-level counselors	Volunteers, licensed professionals, unlicensed professionals	Lay, unlicensed disciples	Lay, unlicensed disciples	Lay, unlicensed disciples (12 months in program); program director has CPR and First Aid training	Paid/volunteers, lay, licensed pastor

3. Results

3.1. Concept Mapping implementation and results

All research activities were conducted under an approved Institutional Review Board protocol with a waiver of written informed consent to assure respondent anonymity. Our first step in applying the Concept Mapping method involved asking key informants (one or more program leaders) in each program to "list some elements of your program (or things that you do in your programs) that helping individuals to successfully recover from alcohol or drug abuse." Informants generated a list of 68 program activities or elements. Groups of staff (n = 29) and residents (n = 32) from each program then individually sorted statements into conceptual categories (i.e., into groups of statements reflecting "similar" types of program activities) and rated statements on "importance to their program" (a four-point Likert scale ranging from 4 = *very much like my program* to 1 = *not at all like my program*). In each program, an attempt was made to obtain sorting and rating data from a minimum or two staff and two residents. Where there were separate programs for men and women (Programs 1, 2, and 4), separate sorting/rating groups were conducted for men and women.

Overall, sorting/rating respondents were ethnically diverse (46% White, 30% African American, 21% Hispanic), 67% men, and 48% with a high school education or less. Raters were predominantly unmarried (42% single, 42% separated or divorced, 11.7% currently married). Resident raters were 34.8 years on average and had received previous treatment in an average of 1.2 treatment programs. Most common drugs of choice among residents included alcohol (64%), crack cocaine (45%), marijuana (43%), and heroin (26%). Polydrug use was the norm in the sample, with 51% of residents reporting use of two or more drugs (average of 2.85).

More detailed demographic data on sorter/raters, broken out by program and respondent type (staff vs. resident) are presented in Table 2 to provide a better sense of the heterogeneity of programs, both between and within traditional and nontraditional categories. Minority staff and residents were more common among the faith-based programs studied. The faith-based programs were more targeted to male residents (except for Program 4, which had a special women's program). Residents tended to be somewhat more likely to have education beyond the high school level in the traditional programs (Programs 1–3), which also served a higher proportion of White residents. Among staff, raters were consistently more likely to be licensed among traditional programs (ranging from 33% to 67%) compared with the faith-based programs, which had no licensed staff among the raters. It is notable that, in all

Table 2
Demographic characteristics of sorting/rating respondents by program and respondent type (staff vs. resident)

Program	White (%)	Black (%)	Hispanic (%)	Men (%)	Mean age (years)[a]	Higher than high school education (%)[a]	Licensed (%)[b]	Prior treatment (%)[b]
Program 1								
Staff (n = 16)	83	17	0	33	–	–	50	50
Resident (n = 6)	38	25	38	75	33	100	–	–
Program 2								
Staff (n = 6)	50	33	17	33	–	–	67	50
Resident (n = 6)	83	17	0	50	27.8	50	–	–
Program 3								
Staff (n = 3)	100	0	0	67	–	–	33	67
Resident (n = 3)	67	33	0	100	45.3	67	–	–
Program 4								
Staff (n = 8)	12	38	50	63	–	–	0	75
Resident (n = 8)	37	25	38	75	36.2	38	–	–
Program 5								
Staff (n = 2)	0	100	0	100	–	–	0	100
Resident (n = 3)	33	0	67	100	35.7	0	–	–
Program 6								
Staff (n = 2)	0	0	100	100	–	–	0	0
Resident (n = 2)	0	0	100	100	21.0	0	–	–
Program 7								
Staff (n = 2)	0	100	0	100	–	–	0	100
Resident (n = 5)	20	80	0	100	41.4	40	–	–
Total sample								
Staff (n = 29)	41	35	21	59	–	–	25	62
Resident (n = 32)	50	25	22	75	34.8	47	–	–
Total (n = 61)	46	30	21	67	–	–	–	–

Note. Education coding: 1 = high school education or less; 2 = high school/GED; 3 = high school or more; 4 = some college; 5 = college degree. - denotes data not available for staff (a) or resident (b) comparisons.

[a] Residents only.

[b] Staff only.

programs but Program 6, staff were likely to have had some history of substance abuse treatment, ranging from 50% to 67% among traditional programs to 75% to 100% among faith-based programs.

3.2. Concept Mapping solution and interpretation

Concept Mapping software was used to generate "maps" of key program dimensions for traditional (three programs; $n = 32$) and nontraditional (four programs; $n = 29$) programs. Because of our interest in faith-based programs, maps were first generated for those programs, and maps were then used as a reference to compare with traditional programs. Concept System software generated a seven-cluster solution (Fig. 2), which yielded an acceptable "stress value" of 0.249. Although several alternative solutions were generated, investigators felt that the seven-cluster solution appeared most reasonable. Cluster labels were developed by the investigators. A listing of statements in each cluster and their rated importance is available from the first author upon request.

Clusters generated by the Concept Mapping procedure (and sample statements in each) included spiritual activities, beliefs, and rituals (17 items: Bible as a guide for behavior, providing regular Bible study, encourages spiritual rather than material values, encourages public affirmations of faith, provides regular scripture readings), safe, supportive environment (five items: let residents know they are accepted, provide supportive environment, provides for basic needs, encourages role modeling of health recovery), structure and discipline (four items: penalties for rule violation, prohibits drug talk, prohibit cursing, emphasize respect for others), role modeling and mentoring (nine items: use recovering staff as models, use mentors to work with residents, emphasize importance of group as community, provides daily recreation), group activities and cohesion (seven items: emphasize group as family, regular group meetings, encourages group participation, regular activities such as singing/music/drama), work readiness and referrals (eight items: emphasize importance of work, provide job training, referrals to medical and legal services, referrals to job counseling and placement), and traditional alcohol and drug treatment modalities (eight items: group as source of support, detoxification services, drug and alcohol education, offers AA or Celebrate Recovery meetings).

The obtained concept map is of interest in that, to the extent that the mapping procedure places statements and clusters on the maps in terms of similarity and distance indices, the location of a cluster in the map may be viewed as providing information regarding the "centrality" of individual clusters in terms of meaning. Here, note that "work readiness" and "traditional treatment modalities" clusters appear on the periphery of the map. Interestingly, the "spiritual activities, beliefs, and rituals" cluster appears noncentral at the right lower corner of the map. However, "role modeling and mentoring" and "safe, supportive environment" appear in the map center. Thus, although the map was generated based on the sorting/rating data from the faith-based programs, explicitly spiritual dimensions did not emerge as central activities in the map.

3.3. Internal consistency reliability of observed cluster items

Trochim (1993b) has presented an elaborate analysis of issues related to estimating reliability of maps and sorting/rating results, finding that reliability generally increases with number of sorters, although adequate reliability is generally obtained with small samples, as discussed earlier. Although he suggests that similarity matrices and multidimensional scaling procedures do not lend themselves to traditional internal consistency reliability analyses (to establish the reliability of the "map" in terms of sorting or ratings), it may be useful to examine whether clusters

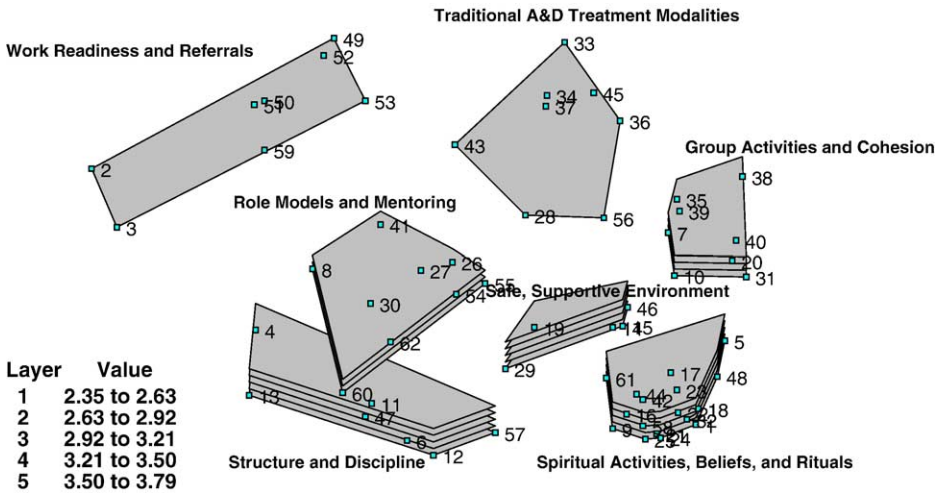

Fig. 2. Seven-cluster concept map of spiritual dimensions of treatment programs, based upon sorting/rating data from nontraditional programs as reference group.

Table 3
Mean cluster ratings for "importance to your program" by program type (traditional vs. nontraditional) and respondent type (staff vs. resident) (*SD* in parentheses)

	Staff		Residents	
Program attributes	Traditional (n = 13)	Nontraditional (n = 18)	Traditional (n = 15)	Nontraditional (n = 14)
Spiritual activities and beliefs	2.86* (0.99)	3.78 (0.40)	2.76* (0.95)	3.79 (0.42)
Structure and discipline	3.47* (0.72)	3.7 (0.49)	3.32 (0.69)	3.72 (0.49)
Supportive environment	3.52 (0.61)	3.68 (0.54)	3.53 (0.62)	3.64 (0.54)
Role modeling and mentoring	3.20 (0.82)	3.16 (0.89)	3.07 (0.89)	3.14 (0.77)
Group activities and cohesion	3.27 (0.75)	3.26 (0.85)	3.18 (0.85)	3.38 (0.75)
Work readiness and referrals	2.59* (0.90)	2.43 (1.04)	2.83 (0.89)	2.23 (1.00)
Traditional treatment modalities	3.00 (0.90)	2.64 (1.08)	2.94 (0.93)	2.48 (0.91)

Note. Scales are scored on a four-point Likert format (4 = *very important to my program*; 1 = *not at all important to my program*).
* Significant single degree of freedom contrast between traditional and faith-based program types within respondent type groups ($p < .05$) by one-tailed t test.

of items identified through the Concept Mapping procedure would also represent reasonable "scales" in terms of internal consistency reliability. To examine this question, Cronbach's alpha estimates computed for "importance ratings" of items in each cluster indicated adequate reliabilities for each dimension: spiritual activities (α = .95), structure and discipline (α = .71), safe, supportive environment (α = .78), role modeling and mentoring (α = .74), group activities and cohesion (α = .81), work readiness and referrals (α = .82), and traditional alcohol and drug treatment modalities (α = .67).

3.4. Pattern-matching analyses comparing mean cluster ratings for subgroups

Concept Mapping software was also used to examine mean cluster ratings of "importance to your program." Specifically, these pattern-matching analyses (Trochim, 1993a) can be used to compare mean cluster ratings for specific subgroups to identify differences in mean ratings. At least two comparisons are of interest here, both substantively and methodologically. First, comparisons between ratings of traditional and faith-based programs are clearly of substantive interest in terms of identifying differences in program emphases. Second, as both program staff and residents did the sorting/rating tasks, the consistency of their ratings is of interest—especially as staff might be expected to be more familiar with their programs than residents would. Both main effects of program type (faith-based vs. traditional) and respondent type (staff vs. resident) and possible Program × Respondent Type interactions were examined for each cluster rating domain using two-factor analysis of variance (Table 3).

Overall, it is notable that no significant main effects of respondent type or significant interaction effects were obtained. However, significant main effects of program type were observed with regard to "spiritual activities and beliefs," $F(1, 56) = 26.76$, $p < .001$, and "structure and discipline," $F(1, 56) = 4.22$, $p < .05$. To further explore the nature of program type differences, single degree of freedom contrasts (one sided tests; $p < .05$) were conducted within respondent type groups. The direction of mean differences was consistent for both staff and resident ratings on all dimensions. Differences were significant for both groups on "spiritual activities, beliefs, and rituals," with nontraditional programs (compared with traditional programs) reporting significantly higher importance ratings for that dimension. Other significant differences were specific to staff, with higher ratings for faith-based programs for "structure and discipline." At the same time, faith-based programs had significantly lower importance scores on "work readiness and referrals." No significant differences were found between traditional and nontraditional programs on ratings of the importance of "role modeling and mentoring," "group activities and cohesion," "safe, supportive environment," and "traditional treatment modalities."

4. Discussion

This article represents a preliminary empirical exploration of the structure of faith-based substance abuse treatment programs. Beginning with the premise that distinctions between "faith-based" and secular substance abuse treatment may be blurred given the preeminence of 12-step philosophy emphasizing spirituality and "higher power," the question of interest is how similar or different explicitly faith-based treatment programs are when compared with more traditional programs. Thus, we have examined traditional and faith-based programs from the standpoint of both staff and resident perspectives using focus group and Concept Mapping methodologies to identify key "dimensions" of programs and then to assess differences between traditional and nontraditional programs on these dimensions. It is acknowledged that the traditional versus faith-based distinction may be somewhat arbitrary, particularly as we have argued that both program types may have some spiritual elements. However, as the term "faith-based" may have political and other connotations, we would not go as far as to argue that all substance abuse treatment is faith-based. Rather, although somewhat awkward, we maintain a distinction between "traditional" and "faith-based" pro-

grams, while acknowledging that traditional programs may have spiritual elements. The degree to which program types differ on these dimensions is the empirical focus of the present investigation.

Our Concept Mapping study yielded a very clearly defined "spiritual activities, beliefs, and rituals" dimension, which clearly differentiated traditional from faith based programs. At the same time, other key dimensions identified reflected "structure and discipline," a "safe supportive environment," use of "role models and mentoring," "group activities and cohesion," as well as "work readiness/ referrals" and "traditional treatment modalities." Overall, faith-based programs rated "structure and discipline" as significantly more important than did traditional programs, although within-groups analyses indicated that these differences were specific to staff. Among staff also, faith-based programs rated "work readiness" as less important to their programs. In contrast to these differences, there were fundamental similarities between traditional and faith-based programs in terms of "group activities and cohesion" and "role modeling and mentoring," as well as "safe, supportive environment" and "traditional treatment modalities." Again, although differences emerged in the spiritual overlay of faith-based programs, fundamental similarities exist with regard to core dimensions of treatment.

Before interpreting the specific Concept Mapping results, a number of methodological points merit consideration. First, although the present study is limited to a relatively small number of programs (four faith-based and three traditional), it is emphasized that most extant studies have focused on a single program (e.g., Bicknese, 1999). From this standpoint, the present exploratory investigation provides a strong foundation for future research. Second, although the sample size in the present study (approximately 60) may not appear large by survey design standards, this represents a substantial sample in Concept Mapping terms, where maps are found to stabilize with samples of 15 raters. Given roughly 15 sorter/raters per subgroup in the present analyses, findings should be robust. Third, reliability analyses presented here support the internal consistency of the dimensions identified. Fourth, the general consistency of mean cluster ratings between staff and residents is reassuring, particularly with regard to highly significant differences obtained between faith-based and traditional programs on "spiritual activities, beliefs, and rituals."

In examining the concept maps, we acknowledge that this is a preliminary exploratory study, so our interpretations should be viewed as suggestive. However, one issue of interest in the observed maps involves the "centrality" of clusters. As noted earlier, given that the original maps were developed on the sorting and rating data of the faith-based programs, it might seem odd that the "spiritual activities, beliefs, and rituals" dimensions did not appear to be more central. More central in the map were "role modeling/ mentoring" and "safe, supportive environment" dimensions. Although these dimensions may not appear to be explicitly "spiritual" in focus, it is noted that the "safe, supportive environment" dimension includes not only provision of basic needs, but also (a) provision of a warm supportive environment, (b) letting residents know that they are accepted, (c) role modeling of spiritual recovery, and (d) provision of testimonials regarding spirituality.

Although both "mentoring" and "environment" dimensions emphasize fundamental social integration processes, the "safe, supportive environment" dimension clearly incorporates elements of warmth and acceptance that are fundamental to what Miller (1997, 2000) would call the central Christian tenet of agape. Thus, in his discussion of what "works" in brief motivational interventions, he emphasizes the importance of warm, nonjudgmental, accepting counseling styles, noting the Christian origins of the approach. From the point of view of "agape," elements of faith may well be central in the concept maps obtained here, although more fundamental values appear to be emphasized rather than specific biblical content.

This view of "safe, supportive environment" as a reflection of agape is consistent with observed differences between traditional and faith-based programs in ratings of the importance of specific cluster dimensions. Not surprisingly, faith-based programs rated "spiritual activities, beliefs, and rituals" as more important to their programs than did the traditional programs. However, faith-based program staff also placed significantly more importance upon "structure and discipline" than did traditional program staff. Although an emphasis upon "structure and discipline" might appear inconsistent with warmth and acceptance, this finding appears consistent with a growing body of literature arguing that more restrictive or "stricter" churches may be more successful at attracting and engaging members than less restrictive churches. This "strict church" thesis (Iannaccone, 1992; 1994) argues that highly conservative, strict churches may repel less committed individuals who seek to avoid the costs of joining, thus leaving more committed individuals who generate more collective benefits for the group. In terms of faith-based substance abuse treatment, this view would suggest that the more conservative, stricter programs may be more selective in terms of who they attract, although they may fare better than less restrictive programs in terms of retention. The suggestion is that the faith-based programs studied here may combine warmth and acceptance with structure and discipline, all informed by an emphasis upon faith and spirituality. Such a view would be consistent with the communal, familial, atmosphere promoted in these programs. This application of the "strict church" argument to this situation is, of course, highly speculative as the present study does not address retention or other outcomes. However, as a hypothesis for future research, it would be interesting to test whether program "structure and discipline" is positively or negatively related to engagement, retention, and outcomes.

Important similarities between traditional and faith-based programs were noted in terms of the rated

importance of "group activities/cohesion" and "role modeling/mentoring." "Role modeling and mentoring" occupied a central location in the map, consistent with the importance of social influence and social learning processes in substance abuse treatment. "Group activities and cohesion" included elements such as emphasizing the group as a family, group meetings, group rituals such as singing and prayer, in addition to counseling and assessment—all oriented toward promoting social integration and cohesion. Thus, both traditional and faith-based programs appear to share these common "social process" dimensions. Faith-based programs may add a layer of spiritual and/of biblical content, ritual, and structure and discipline. Again, the important question for future research involves the implications of these dimensions for treatment outcomes.

With regard to extending the present approach to the study of treatment outcomes, it is noted that fundamental differences existed between our traditional and faith-based programs—particularly in terms of length of stay—which could ultimately confound efforts to compare these types of programs with regard to treatment outcomes. Thus, it is acknowledged that our study focused upon residential programs. Specifically, not being funded by third-party payers, faith-based programs studied here had lengths of stay ranging anywhere from 2 to 9 months (and beyond in some cases). To the extent that length of treatment is a key predictor of successful outcomes (Simpson, Joe, & Brown, 1997), as third-party payers increasingly move toward shorter residential stays or use of intensive or other outpatient modalities, comparisons between shorter (28 days or less) residential programs and longer, and potentially open-ended, faith-based programs will become increasingly problematic. Indeed, an implication of this discussion (and a potential limitation of the study) is that a "traditional" residential treatment (i.e., 28 days) model may no longer be a standard referent.

An additional methodological point concerns selection bias. As Miller (1997) suggests, spiritually oriented programs may be effective, although only for those who are "spiritually inclined." Those not spiritually inclined or not willing to conform to strict discipline may either not enter faith-based programs or leave prematurely. Given these differences, it is difficult to envision a randomized trial comparing faith-based and traditional programs, although the present study clearly should not be taken to suggest that longer faith-based programs would necessarily yield more positive outcomes than shorter traditional programs. There are obviously a myriad of factors that would need to be taken into account in such comparisons, and the present study just begins to scratch the surface of what faith-based programs may look like and does not address outcomes.

Several limitations of the present study are acknowledged. As noted in describing the study methodology, a limitation of the current study is the lack of a TC among our programs studied. This omission was, in part, intentional, as the only available TC was prison-based and serious questions arose regarding the comparability of a mandated prison-based program to the generally more voluntary programs examined here. However, in principle, a TC model should offer a useful comparison to the faith-based programs examined here. Specifically, a TC approach may involve longer term residential care, characterized as "community as method," utilizing peer influence process and discipline to change negative patterns of thinking and behavior through individual and group therapy, group sessions with peers, community-based learning, confrontation, games, and role playing (National Institute on Drug Abuse, 2002; Yates, 2003). However, in contrast to our emphasis upon "warmth" and acceptance, the TC model has traditionally emphasized a confrontational "verbal-attack therapy" approach (Yablonsky, 1965). Although the benefits of confrontation in TC have recently been questioned (Polcin, 2003), TCs could well pose a thought-provoking comparison group to the traditional and faith-based programs studied here-particularly in terms of structure/discipline, supportive environment, and mentoring dimensions in the Concept Mapping analysis.

Another limitation is that although the present study has examined four faith-based programs, these can in no way be assumed to be representative of the universe of such programs. Indeed, three of the programs studied here are part of larger organizations having programs located across the country, which may vary in unknown ways from those studied here. An important next step in the present line of research would perhaps be to extend the current study to some of these multisite programs to examine variation in structure and organizational climate. As some of these larger programs such as Teen Challenge are well established, they might well serve as useful models of faith-based programs for future research. In addition, the present exploratory study is limited in focusing only upon structure and climate variables—and indeed, only perceived structure and climate. Clearly, further research is needed to extend the present line of research to measure these structural and climate dimensions more precisely and to examine the implications of the dimensions identified here for treatment outcomes. Indeed, it is acknowledged that measurement is crude in the present study. Both faith-based and traditional staff or residents may be involved in "individual counseling," for example, although the content may vary.

It is noted that our reference to the TCU treatment process model (Simpson, 2004) has not been accidental. As that model has an extensive history of application to traditional treatment programs and involves a well-validated set of treatment process measures (e.g., treatment readiness and engagement; Joe, Broome, Rowan-Szal, & Simpson, 2002), we suggest that a combination of the present approach to establishing dimensions of faith-based programs (particularly organizational climate dimensions) with

the TCU model and associated instrumentation might prove quite useful in further research in the area.

A final limitation to be considered before concluding involves our distinction between traditional licensed programs with professional staff and faith-based programs with nonprofessional staff. Although we are attempting to identify differences between program types, staff characteristics—beyond professional training—likely influence our findings in ways that we cannot assess in study. Thus, our traditional programs are generally state-licensed and are more likely to include staff such as nurses and credentialed substance abuse counselors. In contrast, our faith-based programs are generally not state-licensed and are more likely to have noncredentialed staff, often lay program graduates. However, the degree to which our apparent "program" differences on dimensions identified here are attributable to program-level differences or to differences in staff characteristics or orientations cannot be disentangled in the present data. For example, our findings suggest greater structure and discipline in nontraditional programs. Although we have suggested that this may result from the fundamentalist orientation of the faith-based programs studied (i.e., the strict church thesis), we do not have direct evidence of this. One potentially important variable that we do not have information on involves the recovery status of staff in both program types and, among those in recovery, whether they are involved in 12-step or other traditions. As our nontraditional programs generally eschewed 12-step philosophy and promoted their own approaches, we must be wary of attributing differences to "programs" per se. Further investigation of the role of staff backgrounds and orientations as an influence upon program orientation is needed.

5. Conclusion

Although complex issues remain in terms of studying the effectiveness of these programs, the present study has sought to provide an exploratory first look at the nature and structure of "faith-based" substance abuse treatment programs, utilizing both qualitative and quantitative methods. Although generalizations may be limited by the relatively small sample size and focus upon seven programs in the same state, the present study is unique in examining a range of programs, both traditional and faith-based. Thus, in contrast to studies of a single program (e.g., Teen Challenge; cf. Bicknese, 1999), a comparative focus is essential in highlighting both the unique and common elements of faith-based programs. The findings of our preliminary study suggest substantial similarities between traditional and faith-based programs, with differences on dimensions related to spiritual beliefs, activities, and content as well as in structure and discipline. Whether variation between programs on such dimensions will be associated with program retention and/or treatment outcomes is a crucial question to be pursued in future studies.

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