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The Religious and Spiritual Dimensions of Cutting Down and Stopping Cocaine Use: A Qualitative Exploration Among African Americans in the South

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Abstract

This study qualitatively examines the religious and spiritual dimensions of cutting down and stopping cocaine use among African Americans in rural and urban areas of Arkansas. The analyses compare and contrast the narrative data of 28 current cocaine users living in communities where the Black church plays a fundamental role in the social and cultural lives of many African Americans, highlighting the ways that participants used religious symbols, idiomatic expression, and Biblical scriptures to interpret and make sense of their substance-use experiences. Participants drew on diverse religious and spiritual beliefs and practices, including participation in organized religion, reliance on a personal relationship with God, and God's will to cut down and stop cocaine use. Our findings suggest that culturally sensitive interventions addressing the influence of religion and spirituality in substance use are needed to reduce cocaine use and promote recovery in this at-risk, minority population.

Introduction

Since the mid-1980s, when crack cocaine emerged as a major problem in the United States (Agar, 2003), social scientists and those in allied fields tended to focus on the experiences of crack cocaine users living in poor, urban neighborhoods (Page & Singer, 2010). It was not until the early 2000s that researchers shifted their focus from crack cocaine use in urban areas to cocaine use in small towns and rural communities (Draus, Siegal, Carlson, Falck, & Wang, 2005; Draus & Carlson, 2007). In recent years, studies have reported on the increased availability of cocaine in rural areas of the Southern United States (Booth, Leukefeld, Falck, Wang, & Carlson, 2006; Borders et al., 2008) where multiple barriers impede access to formal treatment services (Sexton, Carlson, Leukefeld, & Booth, 2008). Within these contexts, research has found that African Americans tend to draw on their religious beliefs and practices (Brown, 2006) and seek informal help from clergy (Sexton, Carlson, Siegal, Leukefeld, & Booth, 2006) to overcome the lack of available treatment services and stigmas associated with drug use and treatment seeking. While these studies illustrate that religion and spirituality influence African Americans' substance use experiences, treatment seeking behaviors, and beliefs about long-term recovery, prior research has examined only the experiences of those in rural areas of the South (i.e., Brown, 2006; Sexton et al., 2006).

Nationally, African Americans residing in rural areas have higher rates of unemployment, poverty, not having a high school degree, and a lack of health insurance coverage relative to African Americans in urban areas (Glover, Moore, Probst, & Samuels, 2004). Within the Southern U.S., rural residents regardless of race face worse access to mental health services generally than their urban counterparts (Fox, Merwin, & Blank, 1995). Because of their more limited personal financial and health care resources, it is possible that more rural African American cocaine users in the South turn to religion and spirituality to cut down their use of substances than their urban counterparts. To date, there are no published studies comparing the cocaine use experiences of African Americans in rural and urban areas in the South.

Religion and spirituality play central roles in the lives of many African Americans (Mattis & Jagers, 2001), and God and prayer are important aspects of daily life as are membership in church and church attendance (Pattillo-McCoy, 1998). Research has shown that African Americans in the South exhibit higher rates of participation in organized and non-organized religious activities compared to African Americans in other regions of the U.S. (Chatters, Taylor, & Lincoln, 1999). In addition, African Americans in rural settings tend to be more involved in organized religious activities (Levin, Taylor, & Chatters, 1995) and attend church services more frequently (Taylor, 1988) than African Americans in urban areas. Regional differences are rooted in long-standing social-cultural, economic, political, and historical factors such as residential segregation and migration patterns that condition religious expression in diverse social contexts (Lincoln & Mamiya, 1990).

In the South, the Black church has historically provided African Americans with spiritual, emotional, and social support, playing a pivotal role in the lives of those living in oppressive social, political, and economic conditions (Taylor, Chatters, & Levin, 2004). In addition, the Black church has historically provided African Americans with social opportunities within rural Southern Black communities where there is a lack of secular pathways to achieve status and leadership. Unlike in urban areas, especially in the North where there are other options to achieve status and sources of support, norms and expectations regarding church participation have influenced the continued centrality of the church in the lives of African Americans in the South (Ellison & Sherkat, 1995). Involvement in a religious community has helped African Americans deal with difficult life circumstances and poor health. Studies have documented that religion and spirituality enabled African Americans to cope with psychological and emotional distress (Taylor, Chatters, & Levin, 2003), and even manage or prevent disease (Koenig, McCullough, & Larson, 2001). At the same time, Black churches have also been shown to play key roles in promoting healthy lifestyles and employing strategies to reduce the burden of substance use among their parishioners (Hankerson & Weissman, 2012; Watson & Bisesi, 2003).

The role of religion and spirituality in substance use patterns and treatment outcomes is well documented (see Chitwood, Weiss, & Leukefeld, 2008 for a review). Research has consistently shown that religion plays a protective role in drug addiction (Hodge, Cardenas, & Montoya, 2001; Rote & Starks, 2010), and recent work found that religiosity was an especially strong deterrent in crack cocaine use (Allen & Lo, 2010). Research has also demonstrated that beliefs and practices including the belief in a caring and loving God and

prayer were associated with less substance use (Koenig, 2004; Leigh, Bowen, & Marlatt, 2005). Spirituality has also been found to improve treatment outcomes among heavy users. For example, spirituality decreased substance use among heroin-dependent individuals (Conner, Anglin, Annon, & Longshore, 2008), was associated with fewer alcohol relapses in alcohol-dependent persons (Sterling et al., 2007) and contributed to long-term recovery from cocaine dependence (Flynn, Joe, Broome, Simpson, & Brown, 2003). Religious beliefs embedded in Alcoholics Anonymous and Narcotics Anonymous, specifically Biblical scriptures that encourage individuals to surrender to a higher power (i.e., God) and to use religious practices (e.g., prayer, meditation) to become mindful and aware of self and others (Timmons, 2010), have also been influential in recovery from alcoholism (Bowden, 1998) and drug addiction (Sellman, Baker, Adamson, & Geering, 2007). In addition, a persistent reliance on faith has been shown to reduce substance use over time, suggesting that adherence to a stable belief system can minimize doubts and uncertainties in the recovery process and help to maintain pro-social attitudes and behaviors (Duvall, Staton-Tindall, Oser, & Leukeld, 2008).

There are a number of possible reasons why religion and spirituality play critical roles in individual experiences of substance use and recovery. Researchers have posited that religious doctrines which prohibit the use of alcohol or drugs, along with supportive religious communities that offer alternative coping mechanisms, might prevent the onset of substance use or its continued use (Wallace, Brown, Bachman, & Laviest, 2003). Scholars have also theorized that spirituality fosters personal growth which benefits substance users by promoting an overall sense of well-being (Fallot & Heckman, 2005; Sterling et al., 2007) and commitment to recovery (Tonigan, 2007). Others have suggested that forgiveness and purpose in life, critical elements of the 12-step and Christian-based recovery programs, are mechanisms that partially mediate the relationship between spirituality and recovery (Lyons, Deane, & Kelly, 2010). In general, these theories underscore the importance of support systems and positive coping strategies as methods to reduce stress, decrease substance use, and promote recovery.

While research has examined the contribution of religion and spirituality in improving substance use treatment outcomes among persons in treatment (Hester, 2002; Petry, Lewis, & Ostvik-White, 2008; White, 2008), little is known about how religion and spirituality influence current substance users' attempts to reduce or abstain from alcohol and drug use, especially illicit drug users, including persons who use crack and/or powder cocaine (Chitwood et al., 2008). In particular, there is relatively little understanding of how these factors play out in the experiences of African American cocaine users in the South where the Black church continues to play a fundamental role in the lives of African Americans by providing informal services, including counseling and guidance (Blank, Mahmood, Fox, & Guterbock, 2002). Clergy and members of the Black church have provided assistance to African Americans with substance use and mental health problems across the U.S. (Hankerson & Weissman, 2012), and recent work has shown that clergy play key roles in the lives of substance users in the South (e.g., Bletzer, 2007; Sexton et al., 2006). The findings from this paper provide critical insights on the spiritual and religious dimensions of cocaine use among rural and urban African Americans in the South which can be used to develop

successful, culturally relevant prevention and intervention strategies tailored to this at-risk, minority population.

Methods

Study Design

The qualitative analysis presented in this paper is part of a sequential mixed-method study of African American cocaine users' perceived need for substance abuse treatment and HIV testing services. In the first phase of the study, semi-structured interviews (n=51) were conducted with African American cocaine users residing in rural and urban Arkansas. The qualitative data were collected from 2010 to 2012 in two different field sites located in eastern Arkansas' Mississippi River Delta (rural sample) and at one Little Rock site on the campus of the University of Arkansas for Medical Sciences (UAMS, urban sample). The second phase of research included a structured survey (n=400) that administered a series of questions intended to understand the multiple and complex factors influencing perceived need for care, and it included several questions on the influence of religion and spirituality on cocaine use. For the purposes of this article, we focus on the qualitative findings but report on the preliminary findings from the questions related to religion and spirituality to illustrate their influence in cocaine use in this population.

The participants were African American, at least 18 years of age, and had used crack cocaine or cocaine hydrochloride, by any route other than injection, at least once in the 30 days prior to the interview. We excluded injection cocaine users because this route is extremely rare for persons admitted for cocaine abuse treatment as the primary drug in both the urban (4.7%) and rural (2.6%) areas where we conducted the study (Treatment Episode Data Set [TEDS], 2008). All of the participants also provided evidence of a current residence (e.g., a permanent physical address or temporary residence) within the study area. African Americans who were in formal drug treatment programs within the past 30 days were excluded.

Setting

The study sites included three counties in Arkansas, two rural and one urban. The urban portion of the study was conducted in Arkansas' largest city, Little Rock, in Pulaski County. In 2008, a large number of African Americans (431 persons) were admitted for cocaine treatment in Little Rock, representing 65% of all admissions for cocaine in the county (TEDS, 2008). Cocaine use is common in Little Rock; and, health disparities are also high in this urban setting. African Americans experience more racial, ethnic, and cultural barriers when accessing health care services as well as limited access to health care services and lower quality of care than Whites in this area (Arkansas Minority Health Commission, 2009). The rural portion of the study was conducted in two counties in Arkansas' Mississippi Delta (Lee and St. Francis Counties). The Delta is one of the most socially and economically disadvantaged regions of the Southern United States, with a very large African American population. African Americans in these rural communities have endured decades of discrimination and poverty, limited access to health care resources, and poor health (Felix & Stewart, 2005).

Sampling

Participants for both qualitative and quantitative phases of the study were separately recruited using Respondent-Driven Sampling (RDS; Heckathorn, 1997), a non-probabilistic sampling method that is particularly useful to recruit “hidden populations” such as illegal drug users. To identify initial study participants (“seeds”) and get the word out about the study, we used ethnographic mapping techniques (Carlson, Wang, Siegal, Falck, & Guo, 1994), which involved “hanging-out” in cocaine using areas (e.g., motels, shelters), talking to community members about local cocaine use, and establishing rapport with key informants. Recruitment was an ongoing process and we sought to include new pockets of cocaine users through referrals from study seeds. We purposively selected participants based on their county of residence, age, gender, and cocaine use (i.e., powder versus crack), and we sought to have approximately the same number of participants in the rural and urban areas. The initial goal was to conduct 60 qualitative interviews and to obtain approximately equal numbers of participants in each age group, gender, type of cocaine use, and urban and rural locale. We stopped interviewing when we reached theoretical saturation (Straus & Corbin, 1990), resulting in 51 interviews and larger representation of younger users in the rural sample than in the urban sample (12 vs 9, respectively). Quantitative participants were a separate sample, similarly recruited, 200 rural and 200 urban.

Qualitative Interview Procedure and Protocol

The first and second author conducted semi-structured interviews with 51 African American current cocaine users. The interviews, which lasted anywhere from one hour to two and a half hours (average = 90 minutes), were held in a private location at local offices in each field site or at the UAMS campus in Little Rock. We used a semi-structured interview protocol, with several questions intended to encourage the participants to talk about substance use in their communities; their cocaine use history; their attempts to cut down or stop cocaine use; their treatment experiences; knowledge of formal treatment programs; perceptions of treatment; perceived need for treatment; and treatment preferences. Participants received \$60 for their participation in the study, and they could receive \$10 more for each referral who completed an interview (with a maximum of three referrals).

The study received full ethical approval from the Institutional Review Board (IRB) and all participants were informed of the purpose of the study and assured that their participation was voluntary and their responses were confidential. All participants provided written informed consent.

Data Analysis

We used an inductive and iterative approach to analyze and code the data (Strauss & Corbin, 1990). After each interview, the recorded conversation was transcribed, then imported into MAXQDA, a qualitative data analysis software program (MAXQDA, 1989–2012). The first author led the initial data analysis and, with the second author’s assistance, identified eight overarching themes. We compiled a detailed codebook with inclusion and exclusion criteria and independently coded the same sample of text, meeting to reconcile disagreement between coders and to revise the codes to obtain inter-coder agreement (MacQueen, McLellan, Kay, & Milstein, 1998). We repeated this process until we reached an inter-coder

reliability of .80, which is considered to be an acceptable percent of agreement between coders (Bernard, 2002).

Early in our data analysis, before we had completed all interviews, we paid particular attention to the words participants used to talk about their cocaine use, we realized that many participants used religious expressions, analogies, and metaphors to talk about their cocaine use experiences and their attempts at cutting down or stopping (Bernard & Ryan, 2003). This discovery prompted us to further define the theme of “Cutting Down” into the analytic category of “Religion and Spirituality” and to look for more examples of this category in the narrative data to determine its dimensions (see Eyre, Hoffman, & Millstein, 1998; Kearney, Murphy, Irwin, & Rosenbaum, 1995, for examples). Once the category of “Religion and Spirituality” was defined, the first author identified and defined subcategories within the analytic category, considering how these concepts were linked to one another and to other conceptual categories (Strauss & Corbin, 1990). In this stage of data analysis, the first author used axial coding (i.e., constant comparison) to better understand the relationships between themes, and she wrote memos to further define categories and to develop theories comparing and contrasting the concepts and the participants’ narratives. The second author checked the coding schema, and any differences in the definition and application of codes was discussed until a consensus was reached. At the same time, this discovery influenced our sampling strategy. We became aware that these themes needed to be explored further. We returned to the field to conduct additional interviews (eight) with participants in rural and urban locales, saturating our data on the role of religion and spirituality in substance use experiences.

Results

A total of 28 out of 51 current cocaine-using African American men and women, the majority of whom were not prompted, discussed the influence of religion and spirituality in their cocaine use. Among these 28 participants, their ages ranged from 20 to 61 years with an average age of 38. Men and women were equally represented in this sample, demonstrating similar cocaine use patterns and treatment experiences. Seventeen of the participants were from the urban county and 11 were from one of the two rural counties. Over half (53.6%) smoked crack cocaine; 10 snorted powder cocaine; and, three smoked and snorted cocaine. The majority (60.7%) had accessed substance use treatment, including inpatient and outpatient services, and/or participated in self-help recovery groups such as AA and Narcotics Anonymous. Most of these participants attended multiple treatment programs where the teachings of the 12 steps (e.g., work with a sponsor, surrender to a higher power) were taught and reliance on faith was encouraged (See Table 1).

It is important to note, however, that twenty-three of the participants did not mention or indicate that religion and/or spirituality influenced their cocaine use. In general, this group of participants was younger (average age of 34 compared to 38); from rural settings; and smoked, snorted and/or swallowed cocaine. Furthermore, just over half (52.2%) of these participants had accessed treatment and/or self-help groups, most of whom attended only one program and often because the court mandated them to treatment because of issues related to drug possession, buying or selling drugs, and child protection (See Table 1).

Although we did not specifically ask participants to indicate their religious backgrounds, several of the participants who discussed the influence of religion and spirituality in their substance use talked about their Christian upbringings and some mentioned having parents or close relatives (e.g., father-in-law, uncle) as members of the local clergy. Furthermore, the preliminary findings from the structured survey (n=400) indicate that reliance on God played an influential role in many participants' cocaine use experiences, especially their attempts to cut down. More than half (55.2%) reported looking often (ranging from a great deal to quite a bit) for a stronger connection with God to deal with their drug use. A large percentage of participants (61.9%) also indicated that they often sought God's strength to cut down on their drug use, and the majority (59.6%) sought help from God to find ways to cut down on their drug use.

Situating Substance Use in Religious and Spiritual Frameworks

The narratives illustrate how the participants' subjective understandings of their substance use, specifically cocaine use, were interpreted in meaningful ways through religious and spiritual frameworks. We found that participants often used religious symbols, idiomatic expressions, and scriptures to interpret and make sense of their substance use experiences. Specifically, the narratives tended to fall within Biblical allusions involving Satan's use of temptation, the dualistic nature of the physical body and spirit, and the belief that God will have mercy on those who are humble. Consider the following narrative provided by a 49-year-old urban man who began using cocaine in his late 20s. He initially smoked crack when one of his band members introduced him to it. One month passed between his first and second use: "And then I didn't do it [crack] any more for another month after that. Had I only known." Clarifying what he meant by this statement, he said:

This is the example that I give, it's a scriptural reference: When the Messiah [Jesus] was taken to the mountain and shown all that He could have if He just bowed down, but He was only shown in the glimpse of an eye, quickly [snaps his fingers] Make a decision right now. Well, He made the right decision. But, in that lifestyle [drug lifestyle], you get that immediate effect of what it does [the high] ... and if you don't stop and think about it, then you fall into the trap. It [drug use] doesn't show you what's coming 5 to 10 years down the road.... You don't know there's prison; all of this coming years later.

In narratives like this man's, we see how participants' perceived themselves, similar to Jesus' experiences, to have been tempted by the devil. For instance, unlike Jesus, this man fell into the "trap" of letting immediate desire overpower rational thought.

The notion that Satan or evil spirits tempted individuals to use drugs was a pervasive image in many of the participants' narratives. A 24-year-old, urban woman who snorted powder cocaine said: "The devil is trying to get in everybody's spirit." For this young woman, the devil and all the evil associated with him, worked through others creating the temptation to use drugs. She explained, "Folks come around [they say], 'Could you get a pack? You want to drink something?' Naw, I'm okay [she says]." Similarly, an older, rural woman, who stopped smoking crack for more than four months, explained how the devil tempted her to use after several months of sobriety: "The devil in my house brought the shit [crack] in

there.... The man [the dealer with whom she has sex in exchange for drugs] brought the shit in there. That's the devil."

Other participants interpreted their drug use experiences within Christian dualistic notions of the body and soul (Brown, 1988), in which the body is perceived as both the temple of the Holy Spirit and the flesh that lay vulnerable to Satan's temptations. For instance, a 61-year-old woman with a 21-year history of crack cocaine and powder cocaine use stated that drug use was the "work of the devil" and the body on drugs was an "unclean temple" where God would not dwell. She explained her fate as a drug user: "I know if I don't stop and seek Jesus I'm gonna die and go to hell, but I don't give a damn." Conflicted about her drug use, she then said:

But I don't want to burn in a lake of fire. You know Lazarus, want to go and warn his brother about hell, but the God wouldn't let him go... was a gulf between them.... Hell cain't get you to heaven and heaven cain't get to hell. It's [drug use] gonna send you there. You're gonna burn in a lake of fire, the body never quits, the body never stops burning. It burns and burns.

Others discussed the belief that God is merciful and forgiving, and many believed that by giving themselves up to the Lord they would receive help from God to cut down or stop substance use. Phrases such as, "I turn my life over to God," "God has spared me," and "God being my Lord and Savior, He can forgive me" were present in many of the narratives. A 48-year-old rural man articulated this point when he discussed his desire to cut down on smoking crack:

You gotta have the Holy Ghost of Jesus with you. If Jesus with you, He by your side ain't nothing there gonna stop you.... You thinking about: "If I have Jesus in my life I'd be drinking and smoking and doing all kinds of drugs?" ... See, He always helping us to the point is that He waking us up in the morning, anytime you wake up in the morning, He's helping. That's a blessing.

These narratives illuminate the ways that participants situated and made sense of their substance use within religious and spiritual frameworks. As the narratives below reveal, many participants also drew on diverse religious and spiritual beliefs and practices, including participation in organized religion, reliance on a personal relationship with God, and beliefs that God can play a significant role in substance use to cut down or stop (albeit temporarily) cocaine use.

Participation in Organized Religious Activities

Participation in organized religious practices such as attending church, Bible studies, and singing in the choir helped many of the participants cut down or briefly stop cocaine use at some point in their substance use history. Attending church, for instance, occupied their time and was often a legitimate excuse to not get high. Phrases such as "Sunday I'm going to church" and "I'm going to church a little bit more now" were echoed throughout the narratives and signified a time when participants did not use cocaine. Involvement in a religious community also allowed participants to surround themselves by non-cocaine users, to develop positive support systems, and to speak with clergy about their problems related to

cocaine use. A 46-year-old urban man who struggled with his crack cocaine use expressed how his religion and involvement in the church community acted as a “steadying force” in his life helping to reduce his cocaine use:

I found that’s [religion] been kind of a steadying force in my life. That’s right now holding me [from smoking more crack]. I say going to church with my friend that’s a pastor now, and going to eat, doing the things that you supposed to do.

Similarly, a 27-year-old man, who was raised in a Christian family in a rural community, talked frequently to clergy about his powder cocaine use:

It’s more like I treat myself right now. I have been, ain’t gonna say a treatment, but I go to somebody—I have sit down like my Daddy, he’s a preacher, he got deacons in the church—basically I go talk to the youngest, the one that’s just getting off [drugs] and done gave themselves to the Lord and I’m gonna see how they feel and what they experienced in life ... I feel like I get positive mind, I pull off other people’s thoughts and what they done been through and what they done experience.

This young man struggled with depression and found that the conversations with deacons, specifically those who had also struggled with substance use, were uplifting and enabled him to treat himself “right” and cut down on his cocaine use. For this participant, like others, the support system and positive role models within his church improved his self-perception and helped him to better cope with emotional distress.

In some cases, church attendance and religious practices were ways to achieve brief periods of recovery. A 49-year-old urban man with a 21-year history of crack cocaine use described how his first episode of sobriety was initiated when he was sentenced to a minimum security prison where religion was a part of his daily life. To “straighten out” his life while in prison he read the Bible, attended church services, and interacted with “positive people.” He continued to rely on church and religion to help him maintain his sobriety after serving his sentence. At first, he explained, “My family and I were going to church every Sunday, Wednesday night Bible study. I quit hanging with the people I used to hang with.” For over a year and a half he was sober. His sobriety ended when he drove through the neighborhood where he had previously smoked crack cocaine: “I believe one of the evil spirits suggested to me to drive through there.” Prior to this point, his faith and involvement in his religious community had helped him to not use:

Every time I tried stopping or made an attempt to stop, permanently, it was always through religion so to speak.... It was always about church.... I think it’s a big part of the answer. But I don’t think that’s THE answer. It’s a combination of things that I believe is what makes it succeed.

Several participants talked about how they believed that a combination of religious practices and formal drug treatment were helpful to cut down and reach periods of sobriety; beliefs that were largely shaped by the experiences of others. For example, a 34-year-old man who grew up in a rural community and had smoked crack since around the age of 13 or 14 recounted a story of how the church helped his uncle maintain sobriety from crack cocaine use:

He [the uncle] in church and everything now, been clean for three, four years. He went one time [to treatment] and got help and it really helped by the Grace of the Lord.... He got off it, man. I congratulate him, by the grace of the Lord, he in church now.

In cases like this one, participants discussed that a combination of formal treatment, God, and the church were ways to achieve sobriety and maintain long-term recovery.

Personal Relationship with God

Other participants discussed how their personal relationship with God provided them with the support, guidance, and encouragement they needed to reduce their cocaine use and, for some, to move toward recovery. Prayer and reading the Bible were common practices that participants described doing on their own; behaviors that connected them to God and helped them to not use. “You know people do need help getting off of it,” a 27-year-old man who lived in a rural community said, “Like me I drop to my knees and pray sometimes.”

Participants described their relationship with God as critical in helping them reduce their cocaine use. A 48-year-old man with a 20-year history of crack cocaine use, who lived in a rural community, perceived his cocaine use to be a “lust of the flesh” and expressed that his relationship with Jesus Christ had been more influential in his substance use than formal treatment:

They [drug treatment center] don’t want to emphasize on Jesus ‘cause you might be Buddha or whoever.... Rehab is a good thing.... You ain’t got no drugs around you. You got all the information you need about the drugs.... But, it’s in your spirit, your spirituality.... You had to become one with yourself and Jesus Christ in order to beat this.... They need to promote more religious on Jesus.

For this man, similar to others, the lack of sensitivity toward his religious and spiritual beliefs inhibited his success in treatment and influenced subsequent help-seeking behaviors.

A 61-year-old rural woman with a 21-year history of crack cocaine and powder cocaine use explained that the only way to cut down or stop using was through God. She said, “You got to ask God to have mercy. Mercy, Lord. You got to have a one-on-one session with God. Ask Him to have mercy.” At the same time, this participant believed that seeking God was a way to strengthen the inner self and that prayer helped her to not use:

There’s a lot of days I don’t want to smoke, but if I don’t smoke, you know, I have dreams of this stuff and that is really bad. And then myself, I pray to Jesus, I believe in God, and I pray. But, I’m very weak; I hate I use drugs. I have been to rehab. I have got off of drugs. I do good five or six months but no longer. Long as they said you don’t need rehab, you need Jesus.

Similarly, a 42-year-old urban woman, with a 20-year-history of crack cocaine use, said “I don’t like me when I smoke that [crack] ... when I get bad ... if I cain’t do nothing else, I know prayer will change stuff, so I can get on my knees and God is making something happen.”

While many of the participants believed that having a relationship with God helped them to cut down on habitual crack use, some also perceived it as influential in achieving short-term sobriety. For instance, a 51-year-old urban man, who had been in and out of treatment programs during his 23 years of crack cocaine and powder cocaine use, talked about the role of prayer in his brief episodes of recovery:

I did a lot of praying, a lot of praying. I would read my Bible and when I would see people coming sometimes I wouldn't answer the door. I would say what helped me was the praying. That's how I did it. Basically that's it; a lot of praying.

Recounting the most recent relapse, he said: "I stopped praying. Man! Then I stopped praying."

Another woman discussed how God provided her with the support she needed to enter a formal drug treatment program. A 53-year-old urban woman, who had used cocaine since 1983, talked about a period of her life when she was tired of living the drug lifestyle—living on the streets and trading sex for drugs—and relied on her relationship with God to briefly stop smoking crack:

It was on my mind, it was lingering way, way in the back. And it kept easing toward the front and I would get high to push it to the back. And it come back and I just damn, one day I just woke up and I looked up and said, 'God, I can't do this shit no more. I'm done.' I just quit. Went to a rehab, checked myself in.

Expecting God to Step In and Help

Many participants described how God—His will and ability to help them—influenced their substance use, believing that God was critical in helping them to cut down, stop, and achieve sobriety from cocaine use. Most believed that their actions (e.g., prayer, church attendance) coupled with God's abilities would help them to reduce or stop (temporarily) substance use, providing them with a sense of hope and promise that life will change. A 36-year-old urban man, who had been to two treatment programs including a residential treatment program where he stayed for three months, illustrated this point:

You go through work with a sponsor, but what does he really tell you? He's not a professional. But somehow, how does this thing [recovery] work? And then you realize that it's God.... I'm not a Bible thumper, but when things start working out, is it just because they're working because you're working hard or it working because of God? That's like an ultimate question. The whole thing is hung on a pin of God. And that's powerful too.

Expressions such as "God gonna bring me through this," "I gave it [substance use problem] to God," "I turned my life over to God," and "Lord take this taste away from me" were present in several of the participants' narratives, indicating that many looked to God for help and expected God to remove their cravings for cocaine. Most of the participants played an active role in their efforts to cut down (e.g., prayer) and enlisted God in their substance use. A 26-year-old urban woman, whose brother introduced her to cocaine when she was 20, explained that she was a daily user until the Department of Health Services took her children away for testing positive on a drug test and mandated that she attend a drug rehabilitation

program. Now, she explained, “I don’t like the feeling [of using crack cocaine] anymore.” Prayer and God’s ability were ways that she cut down on cocaine use: “I just been praying and praying... I’m just taking it one day at a time... I asked God to just take the feeling away from me not to use any more.”

Several others discussed the role of personal agency and God’s ability in their attempts to stop using cocaine and maintain sobriety. A 53-year-old urban woman who was recovering from alcoholism and currently smoked powder cocaine explained:

Alcohol is gone. I can walk in a liquor store and have no trips about buying no liquor.... I gave it to God.... I dropped on my knees, and I prayed “Lord take this away. I can’t do this no more, I’m tired.” And He did. I detoxed at home by myself in my bedroom.

Continuing to describe how both agency and God’s will played out in her cocaine use, she said: “He’s [God] going to take it [crack addiction] away from me as soon as I give it to Him. See that’s the point, I got to be ready.” In this case, similar to others, we see that agency lies within individual action and that God can facilitate recovery only when the person is ready.

Similarly, a 41-year-old rural woman, who has struggled with crack cocaine use for over 16 years, explained that prayer and God’s ability helped her stop smoking crack for over four months: “I asked the Lord to please do this for me, to take this taste [for drugs] away from me.” Similar to others, however, her desire to smoke crack returned and the temptation to use undermined her efforts and those of God. This woman’s return to smoking crack coincided with a violent event in which a man with whom she had had sex in exchange for drugs entered her home and forced her to perform sexual favors. She explained, “I didn’t want to do it [oral sex], and then did that. And, dope was there and he [the devil] was too.... The temptation was fucking with me and I had to hit it [smoke crack].

Others believed that there was little that they could do to stop using cocaine, and rather than actively enlisting God in their substance use they expected Him to intervene. A 25-year-old man, who was raised in an urban neighborhood where he sold cocaine for seven years before trying it, believed that “something pretty tragic or catastrophic” would need to happen in his life to stop smoking crack; this is what happened to this father-in-law. This young man’s father-in-law, after he stopped smoking crack, became a preacher in the local church, where he now provides substance use classes to community members with alcohol and drug problems. The “tragic” event for this young man’s father-in-law was that “his wife was gonna leave him.” The participant explained:

My father-in-law, who I do odds and end jobs with, he was a crack addict for a lot of years and church saved him. That was his treatment, the church. He never went to a rehab or anything just started going to church more and more. And, just day-to-day, he just didn’t want it.... That’s why I said God would have to talk to me, really. Apparently, that’s what happened to him.

While this participant first mentioned things like “If my wife find out,” or “If I start stealing for it [crack]” as defining moments that would likely help him to stop smoking crack, he perceived God as the ultimate intervention:

God needs to talk to me. If I hear that voice, I’m done; just that simple.... As of right now I’m going to continue to be a user until I get to that point to where I gotta stop, I really don’t have a choice but to. But as long as I can do it and it’s convenient and ain’t causing me too big of a problem, I can say I’m gonna continue to use it.

This young man anticipated that he would smoke crack cocaine until it became “a problem” at which point he expected God to intervene.

Discussion

The results of this study support prior work on desistance from substance use. In both the rural and urban samples, participants indicated that pressure from family and loved ones, ultimatums (e.g., separation from children, divorce), health concerns, and unexpected events were instrumental in cutting down and stopping substance use. These results are consistent with prior work finding that motivation to abstain from substance use was linked to external influences such as peers, family, and social support as well as the subjective recognition of how continued use affected daily life and chronic health outcomes (Nyamathi, Longshore, Galaif, & Leake, 2004; Mosack, Abbott, Singer, Weeks, & Rohena, 2005; Scherbaum & Specka, 2008). In addition, participants’ discussions about drawing from one’s inner strength offer a nuanced understanding of how desires for positive identities and moral selves were critical to achieving and maintaining periods of sobriety for many of the African Americans in the study. Others have similarly found that willpower and identity transformations were key components of spontaneous remission from alcohol and illicit drug use (Ellingstad, Sobell, Sobell, Eickleberry, & Golden, 2006; Walters, 2000).

Beyond corroborating prior work, this article offers new insight on the ways that organized and non-organized religious and spiritual beliefs and practices influence substance use patterns among rural and urban African American cocaine users in the South. For instance, the narrative data indicate that church attendance, prayer, and the belief that God is merciful along with expectations that God has the ability to help, offered the participants strategies to cut down on their cocaine use, and, for some, avenues to achieve periods of sobriety. The findings shed light on emic (i.e., subjective) perspectives on the role of God in substance use—enlisting God in recovery and seeking spiritual guidance—adding to our rather limited understanding of how an individual’s relationship with God influences substance use patterns and outcomes over time (Hernandez, Salerno, & Bottoms, 2010). Importantly, the findings underscore the critical role that both the church and God can play in decreasing cocaine use among African Americans with religious and spiritual needs in rural and urban areas of the South.

Prior work on the geographical variation in religiosity found that Biblical literalism—the explicit interpretation of scriptures in the Bible—was strongest in the South compared to other regions of the U.S. and that rural residents were more likely to literally interpret

Biblical teachings than those in urban areas of the South (Chalfant & Heller, 1991). It is possible that African Americans residing in rural settings might draw on Biblical references and Christian idiomatic religious expressions more so than those in the urban areas. While our findings suggest a possible difference in the subjective experiences of religiosity and spirituality in cocaine use (e.g., we noted that rural participants articulated relationships between drug use, the devil, and hell more so than urban participants), our findings do not indicate a substantial rural and urban difference in the ways that religion and spirituality influenced participants' substance use. Rather, as others noted (Ellison & Sherkat, 1995) it seems likely that region—in this case the Southern U.S.—and race/ethnicity play more important roles in understanding why African Americans in either rural or urban settings tend to draw on their religious and spiritual resources to deal with cocaine use. As previously mentioned, many of the African Americans in our study faced social and economic inequalities (e.g., poverty, low levels of education) and lived in communities where individuals and families have endured generations of discrimination and poverty. Our findings indicate that Black churches in impoverished communities in both rural and urban settings play integral roles in the lives of disadvantaged African Americans in the South. Despite this finding, rural and urban differences might exist among other racial groups or in other regions of the U.S. Religiousness, including beliefs, involvement in religious institutions, and practices (e.g., prayer), has been shown to promote self-regulation, self-control, and pro-social behaviors, all of which can improve overall health and well-being (see McCullough & Willoughby, 2009 for a review of the literature). Furthermore, prior work has demonstrated that divine control—the belief that God controls life plans and daily life events—is a salient aspect of religiosity among African Americans of lower socio-economic status and can reduce distress such as symptoms of anxiety and depression and contribute to positive health outcomes (Schieman, Pudrovska, Pearlin, & Ellison, 2006). This seems to be the general pattern in our work: over half of the participants in our sample (the majority of whom were not prompted) mentioned using the strength they gained from prayer, the guidance they found in God, and the support they found from Black churches and leaders to gain a sense of control over their substance use.

Research has shown that a collaborative relationship with God—one in which an individual experiences a shared sense of control—tends to empower persons as they confront adverse life circumstances (Pargament & Park, 1995) and has been related to positive health outcomes (Belavich & Pargament, 2002). Enlisting God in helping with substance use, as many of the participants indicated, is not new. Others have found that God-mediated control; i.e., “the notion that problems can be overcome, and goals in life can be researched by working together with God” (Kraus, 2005, pg. 137), played a key role in the lives of older African Americans, contributing to overall well-being. This seemed to be especially salient in the lives of older women in our study who believed that God was active in their substance use and ultimately controlled their ability to cut down or abstain from use—most notably by accessing formal treatment programs. This raises an interesting point: Several participants indicated that God facilitated their entry into formal treatment programs, a finding that is consistent with previous reports (King, Burgess, Akinyela, Counts-Spriggs, & Parker, 2005), illustrating that some substance users perceive God to work through treatment.

Faith in God and reliance on the church may play an especially critical role in communities where illicit drugs are becoming increasingly available and there are barriers (e.g., stigma, lack of available resources) to accessing formal treatment services (Dickson-Gomez et al., 2011). Recent work among rural illicit stimulant users in Arkansas identified that the need for treatment utilization is high, but treatment seeking is low (Carlson et al., 2010). There are several known barriers to care in rural areas of the South, including availability and accessibility of treatment services (Rowland & Lyons, 1989); however, as our findings suggest, the lack of culturally sensitive treatment programs might create an additional barrier. Others have noted that African American cocaine users in the rural South perceived Black leaders and Black churches as integral to the prevention and treatment of substance use, but local programs were often tailored to the needs of the White majority, making some feel alienated and discouraged in their recovery process (Brown, Hill, & Giroux, 2004). Many of the participants in our study found that the local church provided them with social resources to re-structure their lives and emotional support to cut down or stop substance use (van der Meer Sanchez, de Oliveria, & Nappo, 2008; Dickson-Gomez et al., 2011). The local Black church was a place where they could go to seek advice from individuals in recovery who gave themselves up to God and had assumed positions of authority as members of the clergy (e.g., preacher, deacon), mentoring those struggling with substance abuse. Men, in particular, tended to relate to the success stories of recovering addicts (i.e., those who became members of the local clergy), providing them with a model of recovery from cocaine abuse.

While religion and spirituality can empower individuals to reduce substance use, it can also compromise their sense of agency and responsibility for it, enabling them to continue to use or relapse to cocaine use with little consequences. This was especially evident for participants who perceived God as merciful, forgiving, and all-powerful. It was also apparent in the narratives of those who perceived drugs as inherently evil. For instance, comments such as “the devil made me do it” captured beliefs that drugs are the “devil’s work”—ideas voiced by other African American cocaine users in the South (Brown, 2006, pg. 27)—highlighting the ways that the devil or evil spirits played active roles in some of the participants’ substance use histories. Furthermore, in narratives like the young man who perceived the church and God to have saved his father-in-law, we see that some participants expected God to intervene through a traumatic event (e.g., divorce) and anticipated that God would take away the desire to use drugs. Research has shown that deference to God can be a potentially poor way to cope with substance abuse and might influence health outcomes (Pargament, 1997). Furthermore, beliefs that Satan, the devil, and/or evil spirits were responsible (in some way) for cocaine use, that God was merciful to those who used drugs, and that God was in control weakened the participants’ agency and personal responsibility for their substance use, giving them leeway to continue to use (Pargament et al., 1988). These findings reinforce that religion and spirituality can play an adverse role in substance use outcomes, potentially fostering negative attitudes toward recovery and impeding help-seeking behaviors.

Prevention, interventions, and policies can benefit from the insights gained from in-depth, contextual data on the lives of cocaine-using African Americans. Perhaps one of the most notable insights from these narratives is the volatile role of religion and spirituality in

substance use (e.g., God can help to reduce substance use or enable its continued use), alerting us to its potential to negatively or positively affect treatment outcomes. Furthermore, our findings reinforce that treatment programs need to be sensitive to how cultural factors influence substance use and treatment outcomes among ethnic minorities (Castro & Alarcon, 2002) and should consider ways to address religion and spirituality for those with spiritual and religious needs. This might be especially important for programs that treat low-income African Americans who live in social contexts where the church and God continue to play critical roles in peoples' daily lives. Given that treatment retention and recovery tend to improve when religion and spirituality are combined with professional treatment programs (Watson & Bisesi, 2003), the inclusion of complementary treatments within conventional programs might facilitate recovery in this population (van der Meer Sanchez et al., 2008).

Based on the findings, one possible way to do this might be to connect African Americans who have completed formal treatment programs with church resources and members of the church community who have recovered. Prior work has shown that African American men perceived substance use treatment programs and recovery groups like AA and NA meetings as irrelevant to their needs and somewhat unhelpful because they were not able to connect to other Black men with whom they shared similar experiences (Brown et al., 2004). Our findings reinforce that involvement in Black churches, where African Americans can connect with Black leaders and positive role models, can provide substance users with a pro-social life such as a new group of friends, positive support systems, role models, and daily activities (e.g., Bible studies, choir) to help them abstain from substance use. While our findings and those of others (e.g., Brown et al., 2004; Sexton et al., 2006) indicate that this might be especially important for men, recent work among cocaine-using African American women found that creating ties with members of African American churches who served as role models and mentors for recovering substance users was helpful to both maintain sobriety and achieve long-term recovery (Stahler et al., 2005; Stahler, Kirby, & Kerwin, 2007).

Limitations

Although the findings provide rich detail about the substance use histories and help-seeking behaviors of the African Americans who participated, several limitations should be considered when interpreting the findings. The eligibility criteria to include only current cocaine users (i.e., use within the 30 days prior to the interview) might have been a limiting factor and future work should aim to better understand the critical role of religion and spirituality in long-term, continuous sobriety from cocaine use. In addition, we neither asked participants to self-report their religion nor inquired about their religious or spiritual beliefs. However, more than half of the sample (28 out of 51) discussed the role of religion and spirituality in their substance use without being prompted. Thus, we consider this to both limit and enhance the integrity of the findings. The themes related to the religious and spiritual dimensions of cocaine use were unanticipated and emerged from the participants' narratives, ensuring that our theories were well-grounded in the narrative data (Charmaz, 2000). Furthermore, feelings of shame associated with moral issues surrounding drug use can potentially lead to socially desirable responses or reluctance to disclose certain

experiences or attitudes regarding drug use because of the need for approval from the interviewer (Collins, Shattell, & Thomas, 2005). Given that we did not prompt participants to discuss their religious or spiritual background and its influence in their substance use experiences, we believe that their responses were rather genuine. However, at the same time, it is important to note that participants might have constructed narratives (during the interview process) that reproduced the norms and expectations embedded within local religious institutions, thus potentially engaging in cultural productions of what is expected of religious persons within their communities (Ellison & Sherkat, 1995).

Furthermore, we would like to note that over half of the participants in our study had attended formal treatment programs and/or self-help groups such as AA and NA and were familiar with the parlance and beliefs of the 12-step program. Enlisting a higher power and experiencing a spiritual transformation is the crux of recovery in the 12-step program and treatment seekers are encouraged to surrender themselves to a higher power (Forcehimes, 2004; White, 2008). Thus, it is possible that both the 12-step model of recovery and dominant Christian beliefs contributed (in varying ways) to perceptions that recovery from cocaine use was possible by turning to faith and surrendering oneself to God/higher power (Lyons et al., 2010). The potential role of the 12-step program in influencing substance use experiences is further substantiated by the fact that many of the participants in the non-religious sample, which included mostly younger users in rural areas, had little treatment experience and potentially less exposure to the parlance and beliefs of this program.

Conclusions

In the South, community members, including clergy, mental health providers and academics, are increasingly forming collaborative partnerships to help underserved African Americans suffering from poor physical and mental health conditions (Foster, Cooper, Parton, & Meeks, 2011; Sullivan et al., under review; Yeary et al., 2011). These efforts have led to culturally relevant, faith-based interventions to address weight loss and HIV/AIDS and have suggested ways to bridge the gap between clergy and mental health providers. Clergy play influential roles in the lives of African Americans with drug use problems, especially those in rural communities in the South, often connecting them with formal treatment programs and assisting them with daily problems (Sexton et al., 2006). However, despite their willingness to help, many pastors are not well-prepared to counsel those with substance use problems (Anderson, Grey, Nichols, Parran, & Graham, 2004). Our findings, along with those of prior work, suggest that culturally sensitive interventions addressing the influence of religion and spirituality in substance use and partnerships that bridge the gap between church-based resources and formal drug abuse treatment programs are needed to help to reduce cocaine use and promote recovery in this population.

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Table 1

Characteristics of Rural and Urban African Americans (n=51)

Religious (n=28)			
Characteristic	Rural %(n)	Urban %(n)	Total n or mean
Male	17.9% (5)	32.1% (9)	14
Female	21.4% (6)	28.6% (8)	14
Age			
< 30 yrs	14.3% (4)	21.4% (6)	10
30 yrs	25.0% (7)	39.3% (11)	18
Mean age	37.4 yrs	37.8 yrs	37.6 yrs
SU* patterns			
Smoke crack			15
Male	3.6% (1)	21.4% (6)	7
Female	14.3% (4)	14.3% (4)	8
Snort			10
Male	10.7% (3)	3.6% (1)	4
Female	7.14% (2)	14.3% (4)	6
Smoke/snort			3
Male	3.6% (1)	7.14% (2)	3
Female	0% (0)	0% (0)	0
Treatment/self-help			17
Male	7.14%(2)	25.0%(7)	9
Female	14.3%(4)	14.3%(4)	8

Non-religious (n=23)			
Characteristic	Rural %(n)	Urban %(n)	Total n or mean
Male	34.8% (8)	21.7% (5)	13
Female	30.4% (7)	13.0% (3)	10
Age			
< 30 yrs	34.8% (8)	13.0% (3)	11
30 yrs	30.4% (7)	21.7% (5)	12
Mean age	32.4 yrs	36.8 yrs	33.6 yrs
SU* patterns			

<i>Non-religious (n=23)</i>			
Characteristic	Rural %(n)	Urban %(n)	Total n or mean
Smoke crack			7
Male	4.3% (1)	13.0% (3)	4
Female	4.3% (1)	8.7% (2)	3
Snort			8
Male	17.4% (4)	4.3% (1)	5
Female	13.0% (3)	0% (0)	3
Smoke/snort			5
Male	8.7% (2)	4.3% (1)	3
Female	4.3% (1)	4.3% (1)	2
Snort/swallow			2
Male	0% (0)	0% (0)	0
Female	8.7% (2)	0% (0)	2
Smoke/snort/swallow			1
Male	4.3% (1)	0% (0)	1
Female	0% (0)	0% (0)	
Treatment/self-help			12
Male	17.4% (4)	8.7% (2)	6
Female	21.7% (5)	4.3% (1)	6

*
SU= substance use