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RELIGIOUS SUPPORT AND RELIGIOUS STRUGGLE AS PREDICTORS OF QUALITY OF LIFE IN ALCOHOLICS ANONYMOUS – MODERATION BY DURATION OF ABSTINENCE

The aim of the study was to analyze the connection between religious comfort and struggle and quality of life in Alcoholics Anonymous. The interaction effect of the length of abstinence and religious variables on the quality of life was tested as well. The participants were 100 members of an Alcoholics Anonymous group. We used the Religious Comfort and Strain Scale by Yali, Exline, Wood, and Worthington and the Quality of Life Questionnaire for Adults by Schalock and Keith. The correlation analysis showed that Religious Comfort correlated positively while fear–guilt and negative emotions towards God correlated negatively with quality of life in the AA group. Duration of abstinence played a moderating role: participants in the long abstinence period group with high religious comfort showed the highest level of quality of life.

Keywords: religious comfort; religious struggle; quality of life; Alcoholics Anonymous.

INTRODUCTION: THEORY

Researchers and practitioners who explore the issues of addiction point to the importance of religion as a factor that protects against alcohol abuse and supports quality of life in the addicted (Johnson, 2013). Empirical studies confirmed the

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existence of negative associations between religiosity measures and alcohol abuse (Johnson, Sheets, & Kristeller, 2008; Koenig, McCullough, & Larson, 2001). However, these studies are subject to criticism because they consider only global measures of religiosity, such as religious affiliation or religious practices (Booth & Martin, 1998; Gorsuch, 1995) and ignore deeper, more specific aspects of religiosity. In order to eliminate these deficiencies, we conducted research with the aim of analyzing the complex religious constructs – religious comfort and religious struggle – and their relations with subjectively assessed quality of life in individuals addicted to alcohol, depending on duration of abstinence.

The concept of “quality of life”

Interest in the notion of “quality of life” dates back to the beginning of the 1980s. It has been on a systematic rise since then, with the increasing number of publications devoted to this issue (Daszykowska & Rewera, 2012; Górnik-Durose, 2013; Muszyński, 2015; Panek, 2016; Strzelecki, Kryńska, & Witkowski, 2014). Researchers make attempts to define the scope of the notion of quality of life and to devise methods of its measurement (e.g., Bańka, 1994; Kowalik, 2000; Oleś, 2002; Sęk, 1993; Steuden & Okła, 2007). Trzebiatowski (2011) categorized the existing psychological definitions of quality of life into four groups. The first one includes so called existential definitions, approaching quality of life in relation to the “be” and “possess” orientations. The second group is definitions based on the assessment of the extent to which development and life goals have been achieved. The third group gathers definitions that refer to the subjective assessment of the extent to which individual needs are satisfied. Definitions in the fourth group are based on selected subjective and objective indicators of quality of life.

An example of a definition based on the subjective assessment of quality of life is the one proposed by Robert L. Schalock (2000, 2004). According to Schalock (2000, p. 121) – quality of life is a “concept that reflects a person’s desired conditions of living related to eight core dimensions of one’s life: emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, self-determination, social inclusion, and rights.” These areas make a hierarchical system – starting from physical well-being, through material well-being, rights, social inclusion, interpersonal relations, self-determination, and personal development, to emotional well-being. Each of these dimensions was defined by means of three indicators and descriptive cat-

egories. For example, social inclusion comprises: community integration and participation, community roles, and social supports (Schalock, 2004, p. 206).

Quality of life in alcohol addicts

Addiction to alcohol is a set of somatic symptoms in which alcohol consumption takes priority over other, previously more important behaviors (ICD-10, 2000, pp. 73-74). This syndrome is chronic and progressive, and sometimes it even leads to death (Cierpiałkowska & Ziarko, 2010; Dyjakon, 2010; Niewiadomska & Sikorska-Głodowicz, 2004; Woronowicz, 2009). Addiction to alcohol determines not only the physical well-being and behavior of individuals; it is also responsible for their way of thinking and experiencing, and a system of values; it impacts the family and close friends of an alcoholic (Cierpiałkowska & Ziarko, 2010; Niewiadomska & Sikorska-Głodowicz, 2004; Osiatyński, 2005; Woronowicz, 2009). Addiction to alcohol is incurable – it is only possible to hinder the development of symptoms and health losses in the somatic, mental, social, and spiritual sphere of the addicted individual.

Research results suggest that individuals who abuse alcohol are characterized by lower quality of life in comparison to healthy individuals (Welsh, Buchsbaum, & Kaplan, 1993). Based on the study by Foster, Powell, Marshall, and Peters (1999), it seems that very low quality of life can be improved by complete abstinence, a reduction of the amount of alcohol consumed, or controlled drinking. Similar results were obtained by Meyer, Rumpf, Hapke, and John (2004), who proved that the presence of mental disorders decreases quality of life, although this decrease is the smallest in individuals who abuse alcohol and in those who have experienced severe depression or specific kinds of phobia. Stach (1991) proved that 75% of alcoholics with an advanced level of addiction, similarly to patients with depression, scored high on measures of the sense of hopelessness. Moreover, a negative correlation between the intensity of problems with alcohol and perceived quality of life was confirmed (Foster et al., 1999; Patience et al., 1997). Individuals addicted to alcohol scored lower on measures of functioning, well-being, and the general indicator of perceived health – in comparison to individuals who abuse alcohol (Patience et al., 1997). Differences in the subjective assessment of quality of life have been observed also in groups of individuals addicted to alcohol undergoing various treatment programs (Woronowicz, 2001): for outpatients (Burdon, Dang, Prendergast, Messina, & Farabee, 2007) or sys-

tematic treatment selection – STS¹ (Harwood, Beutler, Williams, & Stegman, 2011), and in members of self-support groups (Jacobs & Goodman, 1989). In the research conducted by Stach (1991), individuals addicted to alcohol who were members of an Alcoholics Anonymous support group did not differ significantly in the assessment of quality of life from the control group of healthy patients. The results of the research by Wnuk (2006a, 2006b) also suggest that quality of life in individuals addicted to alcohol – abstainers and members of AA support groups – does not differ from the subjective assessment of quality of life in healthy individuals.

Predictors of quality of life in alcohol addicts

The authors of studies in to the conditions of quality of life in alcohol addicts stressed the buffering role of individual religiosity and spirituality (Gorsuch, 1995; Koenig, 1998a, 1998b), duration of abstinence from alcohol (Pullen, Modrcin-Talbott, West, & Muenchen, 1999), and membership in support groups (Stach, 1991; Wnuk, 2006a, 2006b).

Religious comfort. Religious comfort means personal benefits derived from faith and relationship to God. Study results invariably confirm the supportive role of religion and show the negative relation of religiosity to alcohol abuse and the positive correlation with duration of abstinence (Brown et al., 2007; Carter, 1998; Johnson, Sheets, & Kristeller, 2008; Koenig et al., 2001; Polcin & Zemoré, 2004). These relations occurred regardless of race and cultural context (Gorsuch, 1995; Koenig, 1998a, 1998b). These results have been applied in the therapeutic field. Religion has become an integral part of some forms of alcohol addiction therapy. Alcoholics Anonymous are well-known support groups, which rely on religious contents in their programs. The 12 Steps Program, which is binding for AA group members, includes five basic religious beliefs: (1) the existence of a Force Majeure (whatever it is understood to mean),² (2) the need to have a personal relationship with this Force, (3) the need to return to religious practices, in

¹ Systematic treatment selection (STS) is a method devised by Larry E. Beutler and Stephen F. Austin and consists in an empirical approach to the practice of psychotherapy, based on using the expert system to guide the physician's thinking about and selection of the best method for a particular patient.

² We replaced the term "Force Majeure" with the concept of "God," as all participants declared themselves as Catholics; moreover, the tool applied to assess religious comfort and religious struggle also includes the concept of "God" (e.g., "You feel that God supports you;" "You feel that God let you down").

particular to meditation and prayer, (4) healing thanks to intervention of Force Majeure, and (5) the need to atone for the harm done and to follow the 12-step program (Johnson, 2013). The existing studies into religiosity in AA groups have focused mainly on comparative analyses of the benefits that religious and non-religious individuals derive from membership in the group. Zemore (2007) suggested that religiosity explains the relationship of commitment to following the AA program with the duration of abstinence from alcohol. However, all items applied by Zemore (2007) to measure religiosity (except one: faith in God) were related to religious practices (prayer, meditation, reading the Bible, participation in religious services).

Recently, researchers have focused on searching for mechanisms that determine the relations between religiosity and functioning in alcohol addicts. The results obtained suggest that the relation between religiosity and alcohol consumption is moderated by personality traits (Johnson et al., 2008), gender, religious commitment, and religious affiliation (Koenig et al., 2001). Significant predictors of the relation between religiosity and alcohol consumption turned out to be beliefs about and attitudes towards substance abuse (Bachman et al., 2002), the perception of social norms, modeling, substance use encouragements (Johnson et al., 2008), satisfaction with one's own body (Mahoney, Carels, Pargament et al., 2005), religious coping with stress, and sense of locus of control in God (Murray, Goggin, & Malcarne, 2006).

The religious comfort variable applied in the present study measures the scope of benefits derived from faith and relationship with God. They include characteristics related to experiencing individual religiosity, such as the perception of God as almighty, supportive, and taking care of people, and the perception of faith as a source of strength, consolation, and meaning in life. In this light, the variable makes it possible to see a more personal and deeper aspect of religiosity in comparison to religious practices and the level of religious commitment.

Religious struggle. Despite numerous positive functions, religion may be a source of stress and internal strain. A sense of being abandoned by God may give rise to a sense of guilt or inability to forgive oneself one's own mistakes (Krause, Ellison, & Wulff, 1998). An image of God who is angry, punishing, and unwilling to react to evil induces distrust and fear. Studies have shown that religious problems and tensions are connected with high emotional distress, lower health indicators, and low quality of life, both in normal population and in various clinical samples (Exline, 2013). Data regarding the function of religious struggle in the process of developing alcohol addiction is scarce (Faigin, Parga-

ment, & Abu-Raiya, 2014), but it seems that this construct may be a risk factor for addiction. Tensions related to faith may be a source of emptiness experienced in important areas of life. This emptiness may, in turn, inspire the search for new meanings and new sense – also in potentially destructive habits, such as the use of psychoactive substances as an escape from suffering and a method of filling in the experienced deficits. Johnson and Bennett (2009) pointed to this issue when they indicated that some aspects of religiosity may contribute to a decrease in quality of life in alcohol addicts. However, these researchers did not analyze the meaning of religious struggle. On the other hand, Faigin and colleagues (2014) confirmed a significant association of spiritual struggle with eleven (out of fourteen) areas of addiction (caffeine, exercise, compulsive eating, starvation diet, gambling, pharmaceutical drugs, psychoactive substances, sex, shopping, nicotine, and work). Their research did not reveal the relationship between religious struggle and alcohol addiction, but this may stem from the specificity of the sample, consisting of young students.

Abstinence from alcohol. The results of studies on the relationship between quality of life and the intensity of problems with alcohol suggest that quality of life decreases with the increase in problems with alcohol – addicted individuals scored lower on subscales of Quality of Life in comparison to individuals who abused alcohol (Foster, Marshall, Hooper, & Peters, 1998; Patience et al., 1997). Abstinence significantly strengthens quality of life in addicts – this improvement may be observed after 12 weeks of abstinence. Quality of life is also higher in alcoholics who practice abstinence than in those who have had episodes of drinking (Habrak, Baran, Steinbarth-Chmielewska, & Woronowicz, 2000). It was also confirmed that the relationship of quality of life with the length of abstinence from alcohol is characterized by changing dynamics. The greatest increase in the subjectively experienced quality of life was observed in the early period of sobering, and with the increasing duration of abstinence the process slowed down (Chaturvedi, Kirthana, & Desai, 1997). Long-term abstinence was associated with a permanent increase in alcoholics' quality of life (Amodeo, Kutz, & Cutter, 1992).

Research problem

The aim of the present study is to analyze relationship of religious comfort and religious struggle with the subjectively experienced quality of life in alcohol addicts who are members of an AA support group, with the duration of abstinence taken into account as a moderator. Religious comfort means personal ben-

efits derived from faith and relationship with God. Religious struggle is defined by three categories: sense of guilt and God's unforgivingness, negative emotions towards God, and negative social interactions surrounding religion. Moreover, we examined the way in which these categories are related to quality of life in alcohol addicts who are members of an AA group, moderated by duration of abstinence. We formulated the following hypotheses:

H1: Religious comfort is positively related to quality of life in AA, and the categories of religious struggle (Fear–Guilt, Negative Emotions Towards God and Negative Social Interactions Related to Religion) correlate negatively with quality of life.

H2: Duration of abstinence from alcohol moderates the relationship of religious comfort and religious struggle with quality of life in AA.

The increase in quality of life as a result of abstinence is characterized by changeable dynamics (Habratt et al., 2000); therefore, the second hypothesis was supplemented with two detailed hypotheses which include assumptions related to the function of religious comfort and religious struggle in the early and later stages of abstinence. They were formulated as follows:

H2.1: Reduction of fear–guilt is correlated with quality of life more strongly in the early stage of abstinence than in its later stages.

H2.2: Religious comfort is correlated more strongly with quality of life in people with long duration of abstinence than in those who have maintained abstinence for a short time.

The moderation of the relations between quality of life in AA and other categories of struggle (negative emotions towards God and negative social interactions with religion) by duration of abstinence is analyzed in an exploratory manner.

METHOD

Participants

We examined 100 men aged between 28 and 69. The mean age of the participants was $M = 49.92$ ($SD = 10.05$). All respondents participated in meetings of AA support groups. Participation in these meetings was voluntary for 97% of the sample. The participants represented all levels of education: 41% – secondary education, 33% – vocational education, 12% – primary education, 12% – higher education, and 2% – bachelor level education. The largest group of participants

(68%) were married men; 17% were divorced and 10% were single. A majority of the respondents (65%) lived in urban areas, others (35%) lived in rural areas. The sample consisted of individuals who had been members of a support group for a period from 1 to 260 months ($M = 78.81$, $SD = 78.57$), and the declared duration of abstinence ranged from 1 to 315 months ($M = 71.31$, $SD = 81.89$). The participants had tried to overcome addiction from 2 to 20 times ($M = 2.48$, $SD = 3.61$).

Research methods

Each respondent received a research set to be completed, consisting of a biographical questionnaire, the Quality of Life Questionnaire by Schalock and Keith (1993; as cited in: Oleś, 2010a), adapted into Polish by Juros (1997) and modified by Oleś (2010b), and the Religious Comfort and Strain Scale by Exline, Yali, and Sanderson (2000) as adapted into Polish by B. Zarzycka (2014).

Religious Comfort and Strain Scale

The Religious Comfort and Strain Scale (RCSS) is a questionnaire consisting of 24 items for measuring religiosity as a source of comfort (support) and struggle (Exline et al., 2000). Participants respond to each item using an 11-point answer matrix (from 0 = *not at all* to 10 = *extremely*). The Polish adaptation of the RCSS has four subscales (Zarzycka, 2014):

1. *Religious Comfort* ($\alpha = .93$)³ – measures the sense of trust in God, perceiving God as almighty, supportive, and taking care of the human, and treating faith as a source of strength, peace, harmony, meaning, and purpose in life (examples of items: “You see your beliefs as a source of strength;” “You feel supported by God”);

2. *Negative Emotions Towards God* ($\alpha = .75$) – the result is a measure of negative feelings towards God, perceiving God as unjust, untrustworthy, cruel, and abandoning the human being (“You feel that God has let you down;” “You feel angry at God”);

3. *Negative Social Interactions Surrounding Religion* ($\alpha = .51$) – the result indicates the intensity of negative emotions and relations with believers (“You have bad memories of past experiences with religion or religious people;” “You fear that religious people will condemn you for your mistakes”);

³ Cronbach’s α reliability coefficients are given for the sample tested in the present study.

4. *Fear–Guilt* ($\alpha = .70$) – this result measures the intensity of preoccupation with one’s own sins, a sense of guilt, a sense of God’s unforgivingness (“You fear that God will condemn you for your mistakes;” “You feel excessive guilt about your sins and mistakes”).

Quality of Life Questionnaire

The Quality of Life Questionnaire (QLQ) is a method consisting of 40 statements that measure the subjectively perceived Quality of Life and its four components:

1. Satisfaction – general joy of life and satisfaction with the life situation (“How much fun and enjoyment do you get out of life?;” “How satisfied are you with your current home or living arrangement?”);

2. Competence/Productivity – satisfaction with the job and with the use of the skills acquired (“Are you learning skills that will help you get a different or better job?;” “How satisfied are you with the skills and experience you have gained or are gaining from your job?”);

3. Empowerment/Independence – self-reliance and the ability to decide about oneself in daily life (“How much control do you have over things you do every day, like going to bed, eating, and what you do for fun?;” “How did you decide to do the job or other daily activities you do now?”);

4. Social Belonging/Community Integration – satisfaction with the frequency and quality of social interactions; maintaining close relationships with neighbors and friends (“How often do you attend recreational activities (homes, parties, dances, concerts, plays) in your community?;” “How many times per week do you talk to (or associate with) your neighbors, either in the yard or in their home?”).

This method was devised to measure subjective quality of life in mentally disabled individuals (Schalock, 2000, 2004). However, studies that followed have shown that it can be applied successfully also to examine other groups, both clinical samples and healthy individuals. Each of the four components consists of 10 items, which participants respond to on a 3-point Likert scale. The reliability of the overall result, assessed as internal consistency (Cronbach’s α) on the sample tested in the present study was $\alpha = .86$.

Procedure

The research was conducted in 2012 in Lublin, Łódź, Cracow, Warsaw, Kielce, Poznań, and smaller Polish towns. It took place during occasional (annual) Alcoholics Anonymous meetings that were open to guests. Data was gathered individually or in groups at various stages of meetings, but invariably before the integration phase. Participation in the study was voluntary and anonymous, the respondents were not paid for completing the tests.

RESULTS

The analysis of relations of religious comfort and religious struggle with quality of life in AA was conducted by means of correlation methods. First, we determined the Pearson's r correlation coefficients among the analyzed variables. Next, we conducted a hierarchical regression analysis with the interaction component in order to check whether duration of abstinence moderates the relations of religious comfort and religious struggle with the assessment of quality of life.

Correlations of religious comfort and religious struggle with quality of life

Table 1 shows correlation coefficients among the studied variables. Religious comfort correlated positively with the general assessment of quality of life ($r = .52, p < .001$) and with its four dimensions: Satisfaction ($r = .41, p < .001$), Competence/Productivity ($r = .49, p < .001$), Empowerment/Independence ($r = .28, p < .01$), and Social Belonging ($r = .42, p < .001$). Fear-Guilt and Negative Emotions Towards God correlated negatively with Quality of Life (FG: $r = -.29, p < .01$; NEG: $r = -.36, p < .001$) and its components. Negative Social Interactions Surrounding Religion did not correlate with the assessment of quality of life in Anonymous Alcoholics.

Table 1

Descriptive Statistics and the Matrix of Correlations of Quality of Life and Its Four Components with Duration of Abstinence, Religious Comfort, and Religious Struggle

Variables	1	2	3	4	5	6	7	8	9	10
1. STSFC	–									
2. COMPET	.55***	–								
3. EMPOWER	.33***	.49***	–							
4. SOCIAL	.60***	.46***	.34***	–						
5. QOL	.83***	.81***	.67***	.77***	–					
6. ABST	.41***	.28**	.20*	.24*	.38***	–				
7. RC	.41***	.49***	.28**	.42***	.52***	.14	–			
8. FG	-.28**	-.14	-.27**	-.223*	-.29**	-.19	.05	–		
9. NEG	-.28**	-.27**	-.30**	-.29**	-.36***	-.07	-.32**	.39***	–	
10. NSIR	-.01	-.09	-.13	-.13	-.12	-.06	-.05	.27**	.36***	–
<i>M</i>	2.21	2.15	2.61	2.19	2.29	70.54	8.26	3.95	1.18	3.31
<i>SD</i>	0.35	0.32	0.26	0.29	0.24	82.71	2.07	2.00	1.47	2.26

Note. STSFC – Satisfaction, COMPET – Competence/Productivity, EMPOWER – Empowerment/Independence, SOCIAL – Social Belonging/Community Integration, QOL – Quality of Life, ABST – Duration of Abstinence, RC – Religious Comfort, FG – Fear–Guilt, NEG – Negative Emotions Towards God, NSIR – Negative Social Interactions Surrounding Religion; *** $p < .001$, ** $p < .01$, * $p < .05$.

Moderation of the relationship of religious comfort and religious struggle with quality of life in AA by duration of abstinence

In order to determine the relationship of duration of abstinence, religious comfort/struggle, and their interaction with the dependable variable quality of life in AA, we carried out a hierarchical regression analysis with the interaction component. Independent variables were centered. We chose the centering method based on the standardization of the results of the variable.

In the first stage of the regression equation we included the following variables: duration of abstinence, Religious Comfort, and three categories of religious struggle. Only three variables were significant in the regression equation: duration of abstinence ($\beta = -0.19$, $p < .05$), Religious Comfort ($\beta = 0.48$, $p < .001$), and Fear–Guilt ($\beta = -0.25$, $p < .01$). In total, they explained 42% of variance in the quality of life in Anonymous Alcoholics ($p < .001$). Table 2 shows the results of this analysis.

Table 2

Results of the Hierarchical Regression Analysis for Duration of Abstinence, Religious Comfort, and Three Categories of Religious Struggle and Their Interactions as Predictors of Quality of Life in AA (N = 100)

Step and variables	β	95% CI	<i>t</i>	<i>p</i>
Constant		[2.25, 2.32]	118.01	<.001
Step 1				
ABST	-0.19	[-0.08, -0.07]	-2.33	<.05
RC	0.48	[0.07, 0.15]	5.40	<.001
FG	-0.25	[-0.11, -0.02]	-2.76	<.01
NEG	-0.10	[-0.09, 0.03]	-1.04	.299
NSIR	0.02	[-0.04, 0.05]	0.24	.809
		<i>R</i> = .65		
		<i>R</i> ² = .42		
Step 2				
ABST	-0.19	[-0.08, -0.01]	-2.30	<.05
RC	0.63	[0.10, 0.19]	6.28	<.001
FG	-0.17	[-0.09, 0.01]	-1.80	.076
NEG	-0.10	[-0.05, 0.04]	-0.96	.341
NSIR	-0.03	[-0.10, -0.01]	-0.37	.712
ABST * RC	-0.24	[-0.10, -0.01]	-2.42	<.05
ABST * FG	-0.16	[-0.09, 0.01]	-1.74	.086
ABST * NEG	-0.05	[-0.08, 0.05]	-0.46	.646
ABST * NSIR	0.15	[-0.01, 0.08]	1.72	.089
		<i>R</i> = .70		
		<i>R</i> ² = .49		

Note. ABST – duration of abstinence, RC – Religious comfort, FG – Fear–Guilt, NEG – Negative emotions towards God, NSIR – Negative social interactions surrounding religion.

In the second stage of the regression equation we included four interaction variables of duration of abstinence with Religious Comfort and with each category of religious struggle. The hierarchical regression analysis with interaction components showed that Fear–Guilt, Negative Emotions Towards God and Negative Social Interactions do not contribute significantly to the regression equation that explains quality of life in AA. However, there is a significant correlation between duration of abstinence and the assessment of quality of life ($\beta = -0.19$, $p < .05$). The effect of the interaction of duration of abstinence and

religious comfort ($\beta = -0.24, p < .05$) contributed significantly to the regression analysis. It increased the proportion of the explained variable in the assessment of quality of life by 7% ($R^2 = .49, R^2 \text{ changes} = .07, p < .05$). The model with an interaction component was well fitted to the data $F(9, 84) = 8.88, p < .001$. Moreover, we noted two interaction effects in which the contribution to the regression equation was not significant, but its trend was very clear: the interaction of duration of abstinence and Fear-Guilt ($\beta = -.16, p = .086$) and the interaction of duration of abstinence and Negative Social Interactions ($\beta = -0.15, p = .089$) (Table 2).

In order to explain the effect of interaction, we divided the participants into two groups differing in duration of abstinence and conducted the regression analysis for each group separately. The division into groups was done based on the median value. The first group consisted of individuals with duration of abstinence below the median value – namely, with abstinence from 1 to 36 months ($M = 11.06, SD = 11.34$). The second group was people with duration of abstinence above the median value – namely, from 41 to 315 months ($M = 139.26, SD = 73.41$). There were 53 individuals in the first group and 47 in the second group. The regression analysis conducted in the separated groups demonstrated that the dependence between religious comfort and quality of life is more positive in people with a long duration of abstinence ($\beta = 0.66, p < .001$) than in the group with a short duration of abstinence. In contrast, the relationship of Fear-Guilt with the assessment of quality of life in AA is significant and negative ($\beta = -0.36, p < .01$) in those with a short duration of abstinence and not significant in the group with a long duration of abstinence (see Table 3). This means that quality of life in alcohol addicts with a short duration of abstinence is related to the ability to solve the problem of religious sense of guilt. Moreover, in the group with a long duration of abstinence, the increase in the subjective assessment of quality of life is related to the ability to derive support from religion. These relations have been shown on the dispersion charts (see Chart 1).

Table 3

Regression Analysis for Religious Comfort and the Three Subscales of Religious Struggle as Predictors of Quality of Life in AA Groups With a Short (up to 36 Months) and Long (41 to 315 Months) Duration of Abstinence

Variables	Abstinence up to 36 months				Abstinence from 41 to 315 months			
	β	95% CI	t	p	β	95% CI	t	p
Constant		[1.82, 2.23]	19.68	<.001		[1.21, 1.96]	8.49	<.001
RC	0.49	[0.02, 0.07]	3.71	<.001	0.66	[0.06, 0.14]	5.16	<.001
FG	-0.36	[-0.07, -0.01]	-2.74	<.01	-0.01	[-0.03, 0.03]	-0.04	.969
NEG	-0.18	[-0.06, 0.01]	-1.26	.213	-0.05	[-0.06, 0.05]	-0.30	.764
NSIR	0.14	[-0.01, 0.04]	1.08	.285	-0.17	[-0.05, 0.01]	-1.35	.186
			$R = .59$				$R = .72$	
			$R^2 = .35$				$R^2 = .51$	

Note. CI – confidence interval, RC – Religious Comfort, FG – Fear–Guilt, NEG – Negative Emotions Towards God, NSIR – Negative Social Interactions Surrounding Religion.

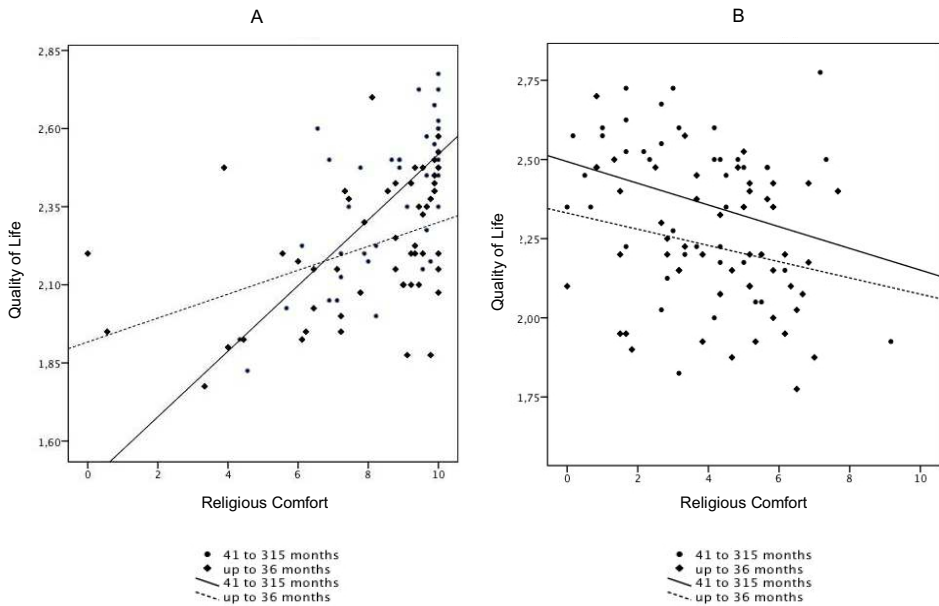


Figure 1. Quality of life as a function of duration of abstinence and (A) religious comfort or (B) fear–guilt. Inclinations of the regression line for religious comfort and duration of abstinence are presented here.

SUMMARY AND DISCUSSION

The aim of the present study was to analyze the correlations of religious comfort and religious struggle with the assessment of quality of life in alcohol addicts who are members of the Alcoholics Anonymous support group. The research has shown that religious comfort increases whereas religious struggle decreases the subjective quality of life in AA. We noted a positive correlation of religious comfort with the four components of quality of life: satisfaction, competence, empowerment and social belonging. Therefore, the ability to derive benefits from faith and relationship with God (perceiving faith as a source of strength and God as almighty and supportive) enhances satisfaction with life, productivity, the ability to take action, and integration with the community in alcohol addicts. Two categories of religious struggle decreased the assessment of quality of life in AA significantly – negative emotions towards God and fear–guilt. These categories correlated negatively with the general quality of life and its components (four/three, accordingly). These results confirmed the first hypothesis (H1). We can interpret this result with reference to the model of Search for the Sacred proposed by Pargament (2007). The search for the sacred is a process which encompasses many spheres in which a person's spiritual efforts and the history of addiction are interwoven. According to Pargament (2007), discovering and maintaining the relationship with God is a protective factor for the risk of alcohol addiction. Religious support – i.e., the experience of religiosity as a source of comfort – makes it easier for alcohol addicts to restore their positive self-esteem and respect for themselves and acquire internal harmony. As a result, it increases the quality of their life. On the other hand, difficulties in discovering or maintaining the relationship with God as well as religious strain and frustration, in particular negative emotions towards God (anger, fear, sense of guilt) significantly decrease quality of life in alcohol addicts.

It is worth pointing out that establishing a personal relationship with God and entrusting one's personal history to God are the central assumptions of the program that the members of AA groups follow. Therefore, religious support may enhance the processes of integration and identification with a group as well as the sense of efficiency in achieving group goals. On the other hand, deficits in trust towards God and a fear of God hinder the achievement of these goals. This is why they may weaken the processes of identification with a group, disrupt or even prevent the recovery from addiction and, as a result, lower quality of life. Moreover, individuals who experience religious struggle may consume alcohol as a tool to cope with strain (Johnson, 2013).

The second hypothesis required testing the effect of moderation of the relations of religious comfort and religious struggle with the assessment of quality of life in AA by the duration of abstinence from alcohol. We expected that the reduction of the sense of guilt and fear of God would increase quality of life in the early stage of sobering. In the case of a long duration of abstinence – we expected that religious comfort (trust in God, the ability to experience religion as a source of strength) would be a factor enhancing quality of life. The results obtained have confirmed these hypotheses. Religious comfort increased the subjective assessment of quality of life in men with a long duration of abstinence more significantly than in those with a short duration of abstinence. Furthermore, a decrease in the sense of guilt and a decrease in the fear of God increased quality of life more strongly in men with a short duration of abstinence than in the group with a long duration of abstinence.

Interest in religious struggle related to the sense of guilt and God's unforgiveness as well as their relation to well-being and quality of life has not been present in academic research until quite recently (Exline & Rose, 2013). The results obtained indicate positive relationships of religious sense of guilt with distress indicators and a positive association between well-being and breaking free from guilt in various samples of adults. For example, Lawler-Row (2010) demonstrated that in the sample of ageing individuals the sense of being forgiven by God correlated positively with forgiving oneself and satisfaction with ageing. On the other hand, Toussaint, Williams, Musick, and Everson-Rose (2008) observed a negative relationship between the sense of breaking free from guilt thanks to God and depression. To the best of our knowledge, there has been no research conducted on alcohol addicts. Nevertheless, the negative correlation between struggle caused by the sense of being unforgiven by God with quality of life in AA is consistent with the tendencies observed in other groups (e.g., Lawler-Row, 2010; Toussaint et al., 2008). But why is this correlation stronger in individuals with a short duration of Abstinence than in those with a long duration of abstinence? The reason is that a sense of guilt usually appears when a person trespasses against their own moral code, breaks a rule or an accepted norm, or breaches their own system of values. Alcohol abuse, along with its all behavioral effects, can be an example of breaching the moral code and, as a result, may cause a sense of guilt. On the other hand, there is often a circular relation between sense of guilt and alcohol abuse: alcohol abuse induces a sense of guilt, and then alcohol becomes a tool to relieve the sense of guilt (Johnson, 2013). Ceasing to use alcohol is the first real step towards sobriety. It results in a sense of relief and even in hope to return to social, family, professional, and religious

structures. In addition, even the first steps of the program realized by AA show the necessity to familiarize group members with knowledge about the addiction mechanisms and to make them aware of their lack of control over the style of alcohol consumption (Step 1). The following steps indicate the necessity to anchor their sobering process in the force stronger than man (*Force Majeure*) and to encourage them to perform moral assessment of their own actions (Steps 2 and 3). Therefore, even the very decision to stop drinking, the growth of awareness of addiction mechanisms, moral assessment, and restoring the religious relationship seem to relieve strain related to the sense of God's unforgivingness even at the early stage of abstinence. This in turn this enhances the perceived quality of life.

In people with a long duration of abstinence (from 41 to 315 months) the ability to derive support from religiosity turned out to be a factor increasing quality of life significantly – in comparison to the group with short abstinence. We can interpret this result with reference to knowledge about the function of religiosity in the processes of self-control and self-regulation (McCullough & Carter, 2013). The concept of self-control is related to situations in which a person makes efforts to overcome an obtrusive type of behavioral, emotional, or motivational reaction – for example, he or she tries to overcome the craving for alcohol (Baumeister, Vohs, & Tice, 2007). Self-regulation refers to processes governing a person's behavior in a more generalized way, taking into account personal goals, self-monitoring, and enhancing the self-regulatory strength (Carver & Scheier, 1998). Research suggests that religiosity enhances both self-control mechanisms and self-regulatory processes (McCullough & Willoughby, 2009). Alcohol addicts who are able to derive support from religiosity use religious resources as tools to enhance self-control efficiency in the face of the risk of alcohol consumption. Experiencing benefits derived from faith may also relativize the attractiveness of alcohol consumption and thus make it more distant in the psychological sense. Experimental research conducted by Fischbach, Friedman, and Kruglanski (2003) confirmed that religious contents are activated automatically, directly after the activation of temptation, and that, in some way, they also move away the perspective of temptation. Moreover, religiosity strengthens self-regulatory processes: it conditions the selection of goals, the meanings attributes to goals, the processes through which religiosity becomes an important personal standard, and self-monitoring (Mahoney, Pargament, Cole et al., 2005; Saroglou, Delpierre, & Dernelle, 2004). Long-term ability to derive benefits from faith and relationship with God, accompanied by the experience of efficiency in practicing

abstinence, is therefore an important factor which increases subjective quality of life in alcohol addicts.

Our study has some limitations. Its main drawback is the cross-sectional character, which makes it possible to pin down only the current relations between variables. Applying a longitudinal strategy would make it possible to capture of changes and to look for mechanisms underlying the observed associations. The second flaw of our study is the high diversity of the examined sample in terms of age and duration of abstinence. Moreover, the functions of religiosity change during a person's life. It would therefore be reasonable to conduct analyses in separate age groups. A significant diversity of participants in terms of duration of abstinence and length of membership in the AA group makes it impossible to capture specific patterns of phenomena related, for instance, to the stage of the AA program. These weaknesses limit the possibility of generalizing the obtained results to other samples. The way the duration of abstinence variable was operationalized is also imperfect: it was expressed as the length of time (in months) during which the participant had not consumed alcohol. For some participants, the duration of abstinence equaled the duration of membership in the AA group – it is, therefore, difficult to discern between the effects of these two variables. Despite the limitations mentioned above, our study provides valuable data about the function of religiosity in shaping quality of life in alcohol addicts. To our knowledge, it is one of the first attempts to capture the moderators of dependencies between religious comfort/religious struggle and quality of life in men addicted to alcohol who are members of an AA support group.

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