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PSYCHOSOCIAL PREDICTORS OF PERCEIVED RELIGIOUS GUILT IN PEOPLE WITH ALCOHOL USE DISORDER

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ABSTRACT

Alcohol use disorder (AUD) is not only a medical and psychological issue, but also a deeply moral and spiritual one in religious communities. In many cultures, alcohol intake is considered a religious offense, causing individuals to experience tremendous religious shame in addition to addiction. The present qualitative study looked into the psychosocial factors of reported religious guilt in people with alcohol use disorders. The study sought to determine how personal, societal, cultural, and religious factors influence the development and endurance of religious guilt in people battling with alcohol use disorder. A qualitative research design was employed using semi structured interviews with individuals diagnosed with alcohol use disorder. Participants were selected through purposive sampling to ensure rich, experience-based data. Interviews were analyzed using thematic analysis to identify recurring patterns, meanings, and psychosocial influences associated with religious guilt. Findings revealed that perceived religious guilt was shaped by multiple interconnected psychosocial predictors. Key themes included internalized religious beliefs and fear of divine punishment, family expectations, moral pressure, social stigma and community judgment, identity conflict, self-blame, and the ongoing struggle between repentance and relapse. Participants frequently described a cycle in which guilt intensified emotional distress, which in turn reinforced alcohol use as a coping mechanism. Cultural norms and societal expectations further amplified shame, isolation, and identity disruption. The study highlights that religious guilt plays a complex dual role: while it can motivate repentance and recovery efforts, it can also exacerbate psychological distress and perpetuate addiction cycles when accompanied by stigma and lack of support. These findings emphasize the importance of culturally and spiritually sensitive interventions that integrate psychological treatment with religious and social understanding.

Keywords: *Alcohol use disorder, qualitative study, stigma, coping mechanism, religious beliefs, identity conflict*

INTRODUCTION

In prosperous nations, alcohol use problems rank among the most common and undertreated mental illnesses (Barry et al, 2015). The frequency of binge drinking raises the likelihood of developing an Alcohol Use Disorder (AUD), even

though problem drinkers do not fit the criteria for alcohol dependence (Brewer et al, 2011). Less than 15% of people with more severe alcohol use disorders (AUD) receive treatment, making them one of the most undertreated mental illnesses (Kranzler et al, 2007).

Despite extensive research on the psychological and physical consequences of AUD limited attention has been given to the spiritual and moral afflictions of the disorder. Even fewer studies have been devoted to examining the impact of spiritual and moral issues on lived experiences of individuals with AUD.

The present study addresses a significant gap between spiritual health and mental health treatment in the hope of providing more comprehensive and culturally sensitive recovery pathways for individuals with AUD. In order to provide an exhaustive understanding of how individuals with AUD perceive and interpret religious guilt within their social and psychological contexts, this study is needed. Through the analysis of their lived experiences, this study aims to understand how cultural and religious norms influence self-identity, coping mechanisms, and feelings of guilt.

The findings can help improve therapeutic approaches, faith-based counseling practices that recognize the moral and emotional dimensions of addiction, and culturally sensitive mental health interventions in Islamic societies such as Pakistan. This study contributes to a broader understanding of addiction by examining the psychosocial predictors of perceived religious guilt, extending beyond clinical symptoms to include individuals' moral, cultural, and emotional challenges.

In addition, this study carries broader societal implications, particularly in cultures where alcohol consumption is highly stigmatized for religious reasons. The findings may help policymakers, rehabilitation facilities, and faith-based organizations develop integrated support networks by identifying how religious guilt can serve both as a potential motivator for change and as a barrier to recovery.

Furthermore, the study has clinical implications, specifically in the development of therapy and intervention strategies that address perceived religious guilt in people with AUD. The findings of the study have implications for future research, such as the creation of studies about the efficacy of treatment and intervention techniques to address the issue of perceived religious guilt among individuals with AUD.

Study Objectives

To investigate how people with AUD experience and express shame in relation to their religious beliefs and values.

To investigate how felt religious guilt is shaped by social interactions, familial ties, and community opinions.

To determine how the emotional and psychological health of individuals with AUD is impacted by moral judgment, shame, and stigma from social and religious environments.

To explore the coping mechanisms individuals, use to manage religious guilt and their perceived role in recovery.

To offer guidance on culturally and spiritually aware counseling or rehabilitation strategies that deal with religious guilt in individuals suffering from AUDs.

Literature Review

Sixty different diseases have been causally linked to alcohol usage. Its main causes of premature mortality include gastrointestinal issues, cancer, heart disease and stroke, alcoholic liver disease, and traumas (Rehm et al, 2014). For middle-aged males (usually between the ages of 40 and 60), relatively low levels of alcohol consumption may provide cardiovascular advantages; however, these benefits are observed in developed nations with high heart disease risk. Even in these nations, the overall. The negative effects of both drunkenness and these conditions require to be avoided in order to lessen the burden of alcohol-related injuries (Babor et al, 2005). Because more people routinely drink to drunkenness and other causes of death are lower in industrialized countries, this burden is highest there. The average amount of alcohol drank and drinking habits are linked to the negative effects of alcohol. The hazards of accidents, injuries, aggression, and heart disease are significantly increased when people drink intoxicatingly on occasion (Patra et al, 2009). Numerous neurotransmitter systems in the brain

that are connected to motivation, emotion, and thought processes are impacted by alcohol (Elsevier et al, 2014).

AUDs are a product of complex interaction of biological, psychological, and social factors rather than solely reflecting the moral failings of an individual. Among certain cultures, AUDs are more common among the general population as these societies offer inexpensive, easily accessible alcohol, permit its use in social situations, and foster a culture where drinking till intoxicated is accepted and encouraged by pervasive alcohol marketing (Caetano et al, 2010). A family history of drinking, insufficient parental monitoring and family support, mood and behavioral issues in childhood, impulsivity and lack of self-control, and positive alcohol expectations are additional risk factors. The age of commencement and length of alcohol consumption, as well as the pattern of use and circumstances surrounding any periods of sobriety, should be evaluated (Chartier et al, 2010).

Approximately half of people with AUDs go untreated if clinicians depend solely on clinical judgment (Chartier et al, 2010). Doctors are well positioned to assess and manage AUDs, yet diagnosis and treatment are frequently delayed. Patients who initially reject

abstinence as a goal should be offered one or more psychological and pharmaceutical treatments of comparable efficacy, and the stigma associated with seeking therapy should be reduced. Common, moderate diseases frequently resolve in young adulthood however, more severe disorders can become chronic and require long-term medical and psychological therapy (Connor et al, 2016). Heavy alcohol consumption is the primary risk factor for AUD, and alcohol consumption is associated with a high rate of morbidity and mortality. Patients with high levels of alcohol use can be identified by using simple and reliable screening techniques, and the presence of an AUD can then be evaluated. Patients who are diagnosed with the illness should receive brief counseling, be given a first-line medication (such as naltrexone), or be referred for more in-depth psychosocial intervention (Soyka et al. 2018).

Method

The study adopted a qualitative research design to explore the subjective experiences of psychosocial predictors of perceived religious guilt in people with use AUD. Semi-structured interviews were used as the primary data collection method.

The semi-structured nature of the interview allowed researchers to explore the participant's identity perceptions and emotional responses in depth thereby enabling a richer understanding of their experiences.

Sampling Strategy

The study recruited a sample of 10 individuals with AUD from rehabilitation centers. Participants were selected using purposive sampling based on their experiences of AUD and perceived religious guilt. Data was collected through in person interviews conducted in a private setting. Interviews with audio recorded with the participant's consent and reassurance of confidentiality and anonymity.

Inclusion Criteria

Participants must meet the criteria for AUD as per the Diagnostic and Statistical Manual of Mental Disorder (DSM-5).

Participants must have the cognitive ability to provide informed consent and participate in the study.

Participants must be fluent in the language in which the study was conducted.

Participants were recruited from rehabilitation centers.

Participants with no diagnosed psychiatric comorbidity were included.

Exclusion Criteria

Participants with severe mental illnesses, such as psychosis or suicidal ideation, were excluded.

Participants with significant cognitive impairment, such as dementia, was excluded.

Conceptual Definitions

Perceived Religious Guilt

The feeling of shame or regret that comes with one's religious or spiritual beliefs and activities, particularly in relation to alcohol consumption.

Shame

A negative self-evaluative emotion that includes

feelings of worthlessness, self-blame, and shame.

Spiritual Struggle

Difficulty or struggle in one's spiritual or religious life, such as feelings of isolation, doubt, or uncertainty (Excline et al, 2013).

Measures/Interview Protocol

Semi-structured interviews were conducted, with each interview lasting between 60 and 90 minutes. Interviews were audio-recorded with the participants' permission. The interview guide consisted of open-ended questions designed to elicit participant perspectives on psychosocial factors associated with perceived religious guilt in individuals with AUD.

Procedures

Upon obtaining informed consent, participants were interviewed individually in private setting. Interviews lasted approximately 60 to 90 minutes and were audio-recorded. Participants were assured of confidentiality and anonymity.

Ethical Considerations

Participants were provided detailed information regarding the objectives procedures risks and benefits of the study prior to providing informed consent. All responses remained anonymous, and the data to securely stored to ensure the protection of participant privacy. Participants who experiencing distress during the interview were provided immediate support from an onsite therapist as well as information regarding appropriate mental health resources and support services for ongoing support.

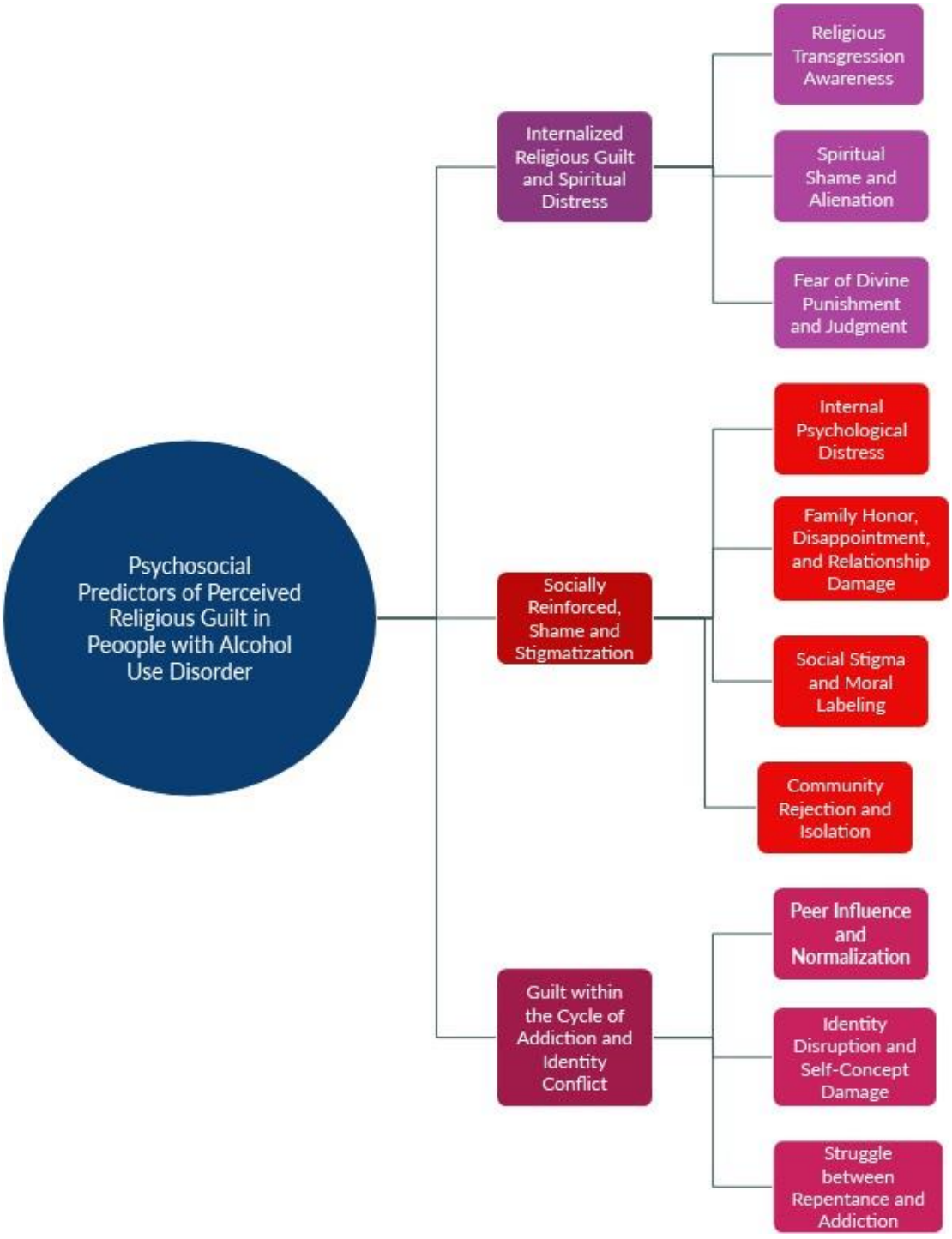
Data Analysis

Data was analyzed using thematic analysis. Audio-recorded interviews were transcribed verbatim, read repeatedly to achieve familiarity. Initial codes were generated from participant's narratives and subsequently organized in broader categories and themes. Themes were then reviewed and refined to unsure accurate representation of participant experiences.

To ensure trustworthiness, an independent second researcher coded a subset of transcripts and discrepancies were resolved through discussion. Furthermore, member checking was conducted by providing participants with a summary of the findings to confirm accuracy and credibility.

Results

This chapter presents the results of a qualitative study investigating the psychosocial aspects of the reported religious guilt in AUD sufferers. The aim of this chapter is to describe the results of the theme analysis completed on the response of the participants without interpretation, which will be discussed in the next chapter. Semi-structured interviews were administered to capture information about people's experience of guilt, religion, family relationships, social expectations and recovery. The analysis was a rigorous application of thematic analysis technique. Initially, descriptive codes were directly generated from participant narratives. In total, 83 initial codes were identified across the dataset. These codes were subsequently refined and organized into seven subthemes, which were further grouped into three overarching major themes. The results of the study found that perceived religious guilt is a complex and diverse construct that is affected by spiritual beliefs, psychological pain, familial obligations, peer pressure, and sociocultural expectations. The resulting thematic structure illustrates the interweaving of the ways in which religious, social, and personal variables contribute to the feelings of guilt in and battles with alcohol.


Psychosocial Predictors of Perceived Religious Guilt in Peoople with Alcohol Use Disorder
Internalized Religious Guilt and Spiritual Distress
Religious Transgression Awareness
Spiritual Shame and Alienation
Fear of Divine Punishment and Judgment
Socially Reinforced, Shame and Stigmatization
Internal Psychological Distress
Family Honor, Disappointment, and Relationship Damage
Social Stigma and Moral Labeling
Community Rejection and Isolation
Guilt within the Cycle of Addiction and Identity Conflict
Peer Influence and Normalization
Identity Disruption and Self-Concept Damage
Struggle between Repentance and Addiction

Discussion

The current study aimed to examine the psychosocial factors of reported religious guilt among people with AUD. The findings demonstrate that religious guilt is not simply an individual, spiritual experience; rather it is a socially and psychologically constructed emotional response that develops as a result of familial expectations, stigma, identity conflict, cultural standards and the constantly recurring process of repentance and relapse. By relating these findings to the aims of the research, the study uncovers how religious guilt is the result of the interaction of personal beliefs interacting with wider social and cultural forces.

According to the finding, religious shame is created and perpetuated at the societal level. Guilt was significantly related to perceived social criticism as shown by participants reporting their feelings of guilt increased upon imagining how other people might perceive them for their alcohol use. This approach is in line with the social cognitive paradigm, which emphasizes the importance of social learning, observation and reinforcement in shaping moral feelings. The accounts of the participants showed that the expectations of the social world and the standards of the community made a huge difference for their feelings of guilt, which they did not feel on their own in a vacuum. These results give credence as literature suggests higher levels of guilt are linked to perceived societal censure (Albert Bandura's et al, 1986).

One of the most powerful of the psychosocial determinants of religious guilt was found to be family expectations. According to the participants, alcohol taking affects the honor and reputation of the family and leads to parental disappointment. These results are consistent with the collectivistic cultural beliefs, in which social status and family identification have high association with one's individual conduct. Sociological viewpoint maintains that moral regulation in the society is maintained on the basis of common norms and values. In this environment, drinking was seen as a violation of social and familial obligations besides the personal moral failure. This explains the reason behind the relational nature of guilt and corroborates the study finding that experienced religious guilt is highly influenced by culture and familial expectations (Émile Durkheim's et al 1912).

Additionally, societal shame and stigma were major factors in the escalation of religious guilt. Participants talked about how their addiction led to them being called weak, sinful, or immoral. The stigma theory, which describes how people absorb labels that are socially disparaging, is reflected in these experiences (Erving Goffman et al., 1963).

The findings suggest that addiction is presented as a moral failure as opposed to a clinical illness leading people to feel that they are becoming a failure and feel guilty. This internalization initiates a vicious cycle whereby stigma leads to shame, shame leads to humiliation and humiliation leads to religious guilt, which leads to mental discomfort and continued alcohol consumption. Previously available literature shows that shame and guilt are related with poorer treatment results and greater relapse in addiction to support the theory that excessive guilt may prolong rather than prevent alcohol consumption (Luoma et al., 2007).

Identity disruption has become another important sign of religious guilt. Participants described themselves accordingly as hypocrites or "bad believers," indicating that there is a great deal of conflict between their religious identity and addictive behavior. This discovery is in line with identity theory that holds that psychological discomfort arises when activities clash with vital self-beliefs. Alcoholism abused individual's moral, spiritual and social identities so that a crisis of self-concept arises. Religious shame was thus a response to evident identity failure rather than a reaction to religious beliefs (Erik Erikson's et al 1968).

Cultural expectations and masculine standards had a great effect on perceived guilt, particularly for the male participants. Participants were pressured to be strong, self-controlled, morally responsible, and addiction was a failing to meet the standards. According to studies on masculinity and health behavior, male often experience distress when they are unable to fulfill gender assigned culturally (Courtenay et al, 2000). These results illustrate the role of gender norms as psychological predictors of religious guilt, which connects addiction to weakness and lack of moral

strength.

A very striking finding was the repeated cycle of repentance and relapse. Participants reported recurrent patterns of drinking, guilt, repentance, hope and relapse, suggesting that religious guilt has a multifaceted role in addiction. This trend is consistent with the relapse prevention theory established by which highlights the importance of negative emotions in recurrence. While the experience of guilt may first promote repentance, it may also promote feelings of pessimism and deficits in self-efficacy that may lead to a sustained consumption of alcohol. These results challenge the assumption that guilt invariably leads to a change in behavior, and that excessive guilt can thus be maladaptive (G. Alan Marlatt et al, 1985). Also, participants showed high internalized standards of morality (i.e., they felt guilt without external judgment). This conclusion is in line with classification of religious coping as positive or negative. Many participants seemed to adopt negative religious coping habits and believe addiction is a punishment or spiritual failure. This theory explains why guilt became self-punitive and persistent leading to psychological anguish (Kenneth Pargament's et al, 1997).

Limitations of the Study

First of all, the research design of this study was qualitative design with a small sample size, which limits the degree to which the study results can be applied to others. Because the goal of qualitative research is not breadth but depth, the findings don't represent all people with AUDs, but represent lived experiences of the individual participants. Religious shame may be felt differently in different places, cultures, sects, ways of worship.

Second, the study was based on self-reported data, which may be distorted by conscious underreporting, social desirability bias or recall bias. At the time participants may have been unwilling to disclose their full experiences because of the sensitive nature of alcohol use and religious guilt, particularly in a society where substance abuse is stigmatized and negatively.

Third, the candor of the participants during the interviews could have been affected by social stigma and fears of criticism. Although confidentiality was guaranteed, discussing alcohol use and religious guilt may lead to embarrassment, anxiety, or uneasiness. This may have made this disclosure less in-depth and may have affected the richness of the data.

Fourth, the main focus of the study was felt religious guilt in a specific cultural and religious situation, which would limit the applicability of the study to groups with other cultural norms or religious beliefs. Findings may differ in more secular or religiously diverse contexts because religious guilt affects the opera by cultural conceptions of morality, sin, and repentance.

Implications

Present study has given a better understanding of the idea of perceived religious guilt and its psychosocial correlates in people with AUD. This study's findings had help to shape treatment and intervention techniques that address perceived religious guilt in people with AUD. This study has discussed effective coping methods and support networks to foster spirituality and emotional well-being for those suffering from AUD. This study had filled a gap in the literature by looking at the psychosocial factors of reported religious guilt in people with AUD.

The implications of the study findings are important in terms of clinical practice, especially the development of therapy and intervention strategies that focus on perceived religious guilt among persons with AUD. The findings of the study had an impact on the policy of mental health, particularly the development of policies that address the spiritual and emotional needs of individuals with AUD. The findings of this study had implications for future research such as the development of research into the effectiveness of treatment and intervention techniques that tackle perceived religious guilt in people with AUD. The implications of this study included spiritual and religious communities in developing support systems and resources to address the spiritual and emotional needs of individuals with AUD.

Conclusion

This is a qualitative study that examined the psychosocial aspects of reported religious guilt in those with AUD. This study's findings give a more comprehensive picture of the complicated associations between felt religious guilt, shame, self- blame, spiritual difficulties, and coping methods in people with AUD. Participants reported that perceived religious guilt hindered recovery by increasing feelings of shame and self-blame. These findings align with previous research indicating that shame and self-blame mediate the relationship between perceived religious guilt and adverse outcomes, including increased substance use and lower self-esteem. Perceived religious guilt was also associated with spiritual struggles, particularly feelings of alienation from a higher power. At the same time, participants identified prayer, meditation, and support from spiritual communities as valuable coping strategies for managing religious guilt and facilitating recovery. Overall, this qualitative study enhances understanding of the complex relationships among perceived religious guilt, shame, self-blame, spiritual struggles, and coping mechanisms in individuals with alcohol use disorder (AUD). The findings highlight the importance of addressing perceived religious guilt while fostering spiritual well-being within alcoholism treatment and intervention programs.

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