

RELIGIOUS BELIEFS AND PRACTICE, AND ALCOHOL USE IN THAI MEN

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Abstract — Buddhism, the Thai state religion, teaches that use of intoxicants should be avoided. Nonetheless, many Thai people drink alcohol, and a proportion are alcohol-dependent or hazardous or harmful drinkers. This study examines the relationship between Buddhist upbringing and beliefs and alcohol use disorders in Thai men. Three groups, comprising 144 non/infrequent/light drinkers, 77 hazardous/harmful drinkers and 91 alcohol dependents were interviewed regarding their early religious life and current religious practices and beliefs. No protective association was shown between early religious life and later alcohol use disorders; indeed, having lived as a boy in a temple for a period was commoner in those with adult alcohol problems. Few subjects reported frequent involvement in current religious activities (9, 8 and 6% in the non/infrequent/light drinkers, hazardous/harmful drinkers, and alcohol dependents respectively). Hazardous/harmful drinkers [odds ratio (OR) = 0.4, 95% confidence interval (CI) = 0.2–0.9] and alcohol dependents (OR = 0.5, 95% CI = 0.2–0.9) were less likely to report being moderately to strongly religious, than were non/infrequent/light drinkers. Understanding the association between religious beliefs and drinking behaviour can potentially assist in the development of prevention and treatment programmes.

INTRODUCTION

Religious beliefs and practices influence attitudes towards alcohol consumption, and these in turn influence the risk of excessive drinking and related problems. A number of religions teach against alcohol use or intoxication. Studies of general populations, clinical samples and college students have established an inverse relationship between religiosity and alcohol and drug use (Gorsuch and Butler, 1976; Larson and Wilson, 1980; Gartner *et al.*, 1991). Most of these studies have focused on Christianity, though Sikh, Hindu and Muslim subjects have also been examined. Buddhism teaches that drinking or using other kinds of drugs can cause carelessness and should be avoided, and strong Buddhist beliefs would be expected to have a significant impact on alcohol use. However, few data are available on the impact of Buddhism on drinking behaviour.

As the state religion in Thailand, Buddhism has a very significant influence on Thai lives. Approximately 95% of the population in Thailand declare themselves to be Buddhist, mostly of the Hinayana (or Theravada) school. The Buddhist layman is expected to conform as closely as possible to certain moral injunctions known as the Five Precepts (Silas Ha). These list five immoral actions which a lay-Buddhist should train himself or herself to avoid, namely: destroying life; taking what is not given; wrong-doing in sexual desires; false speech (including lies, harsh words, tale-bearing and idle gossip); and consumption of distilled and fermented intoxicants causing carelessness. Besides the Five Precepts, on Full Moon, New Moon and two intermediate holy days in the lunar month, devout Buddhists go to a temple and declare their desire to observe for that day, extra precepts, the Eight Precepts.

There are a number of religious activities which an ordinary Buddhist generally practises. These include: (1) going to a temple on a holy day or Buddhist festival, or to a Buddhist

ceremony to listen to a sermon and 'make merit'; (2) for the average person, often worshipping the Triple Gems: the Buddha, the Dhamma (the Buddha's teaching) and Sangha (the Noble Order of the Enlightened Followers) (Khantipalo, 1970), by saying a Pali prayer before going to bed; (3) giving alms to monks who walk by people's houses in the early morning; (4) morning and evening chanting, which can be practised at home or in a temple, but is usually only performed by strongly religious people. Apart from participation in various religious activities, lay-people are encouraged to 'make merit' (making 'punna' which means those actions which clean and purify the mind) by practising Dhamma (Khantipalo, 1970) and meditation. In Thailand 40–60 years ago, boys were often sent to stay with a monk in a temple either on a permanent or part-time basis and were known as 'temple boys'. A Buddhist temple or monastery in those days often also served as a dormitory for boys. Boys who lived there permanently were usually children of poor homes who were given food, board and informal education, in return for performing domestic duties. In addition, boys came during the school term from outlying areas to attend school or college in a provincial capital or Bangkok.

An important moment in a Thai man's life is his ordination. This is part of both Thai culture and Buddhist ceremony. Most men aim to attain a token monkhood at some point in their lives, usually at the age of 21 years and before marriage, to experience the discipline and tranquility of the monastic life. Before 21, a boy can be ordained as a novice. Men usually live as a monk for three months. However, some live as monks for shorter or longer periods or even for life. The novices or monks can study Buddhist teaching in up to three levels of Dhamma and nine grades of Pali, each with their separate examinations.

Buddhist beliefs include belief of merit and sin, Khamma (the result of one's deeds), and belief in an after-life. Because of the influence on Bharmma (an ancient Indian religion), some Thai Buddhist people believe in heaven and hell. Some also believe in the supernatural as evidenced by beliefs in magical amulets, spirits, incarnation, ghosts and magical

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incantation. These Bharmma and supernatural beliefs are not part of Buddhist beliefs.

Despite the influence of Buddhism, many Thai people consume alcohol and a proportion are alcohol-dependent or hazardous or harmful drinkers. Most previous studies on the relationship between religiosity and alcohol use have investigated Christian religions. The present study focuses on another major religion, Buddhism, and its association with alcohol consumption and alcohol use disorders. We postulated that subscribing to Buddhist beliefs, value and teaching would be inversely related to the development of hazardous/harmful alcohol use and dependence.

SUBJECTS AND METHODS

Subjects were recruited for a case-control study of factors associated with the development of alcohol use disorders in a Thai population. Cases included 91 alcohol-dependent subjects and 77 hazardous/harmful drinkers, while controls were 144 non-, infrequent or light drinkers. The subjects were recruited by screening medical or surgical in- and out-patients who were seeking medical care for non-alcohol-related reasons from a regional hospital, university hospital and a community hospital. Because of difficulties achieving target sample size, additional subjects were recruited from hospital personnel, their friends and relatives. In total, 312 subjects (282 hospital patients and 30 non-patients) were included. All subjects were Thai Buddhists, currently residing in the Southern region of Thailand. Details of the subject recruitment are presented elsewhere (Assanangkornchai *et al.*, 2000). The non-, light or infrequent drinkers (mean age \pm SD = 46 \pm 14 years) were subjects who drank less than once a month or <30 g of alcohol in a typical drinking day. The hazardous/harmful drinkers (mean age \pm SD = 39 \pm 13 years) were subjects who drank \geq 30 g per drinking day on at least 2 days per month, or had one or more alcohol-related adverse consequences in the past 12 months which are described in the ICD-10 criteria for harmful use of alcohol. The alcohol dependents (mean age \pm SD = 41 \pm 12 years) were subjects who fulfilled the ICD-10 (World Health Organization, 1992) criteria for alcohol dependence during the past 12 months. The classification of the subjects was based on information obtained from a structured interview, that included the World Health Organization 'Tri-level' questionnaire for alcohol consumption (Saunders and Aasland, 1987) and the Alcohol Use Disorders and Associated Disabilities Schedule (AUDADIS) for alcohol-related adverse experiences (Grant *et al.*, 1995).

There were no significant differences between the three groups with regards to level of education, location of residence, working status and social class. However, the hazardous/harmful drinkers were more likely to be single, widowed or divorced than were the other groups ($P < 0.05$). Half of the subjects were living in urban or semi-urban areas.

A structured interview questionnaire was used to obtain information regarding the subjects' religious life and practices. It included items on common religious activities and experiences of Thai Buddhist men, i.e. whether the subject was brought up in a religious family, the experience of staying with monks in a temple, and the experience of ordination as a Buddhist monk. It also included items on attendance at a temple on a holy day

or festival, giving alms to monks, morning and evening chanting, and whether the respondent worshipped the Triple Gems. Other questions enquired about current observance of the Five and the Eight Precepts, and the subject's Buddhist and supernatural beliefs. Affirmative responses to items on current and past involvement in religious activities were summed to form composite variables reflecting current and past frequency of participation in any religious activities.

This questionnaire was developed on the basis of available literature on Buddhist life and discussions with Buddhist monks and scholars of Buddhism. The questionnaire was reviewed for its face validity by experts in Buddhism, psychiatrists, sociologists and clinical psychologists experienced in drug and alcohol research. It was then pre-tested on 10 patients with alcohol dependence and 10 light drinkers. Their acceptance and comprehension of the questionnaire were judged to be satisfactory.

To examine the association between religious beliefs and activities, and alcohol use disorders, an odds ratio, adjusted for socio-demographic variables was calculated for each religious variable, using polytomous logistic regression. Diagnosis of alcohol use disorders was used as the dependent variable. This variable has three categories, and the non/infrequent/light drinking group was used as the reference category for comparison with either the hazardous/harmful drinking group or with the alcohol-dependent group. Any variable in the early religious life or current religious practices and beliefs with $P < 0.25$ according to the univariate test was considered as a candidate for the multivariate model, along with demographic variables. This approach was adopted to provide as complete a control of confounding as possible within the data set. It was based on the fact that individual variables which do not exhibit strong confounding, when taken collectively, can exert considerable confounding. The $P < 0.25$ level was used as a screening criterion for selection of candidate variables in order to identify potentially important variables which might not be included if a more traditional cut-off ($P < 0.05$) was used (Hosmer and Lemeshow, 1989). Variables whose removal from the model caused significant change of the model's fit ($P < 0.05$) were retained in the model.

RESULTS

Early religious experiences

Table 1 shows the responses of the subjects to questions on early religious life, i.e. while they were living with their family up to the age of 16 and their experience of ordination as a Buddhist monk. Similar percentages of subjects in the three study groups considered themselves as having been brought up in a religious family and having been involved in religious activities during their childhood. The majority of subjects said that their parents were moderately-strongly religious and often went to the temple or practised religious activities during their childhood. However, only a small number of the subjects in each group (8–13%) perceived that they were forced by their parents to be involved in religious activities.

The alcohol-dependent subject was more likely to have stayed in a temple as a temple boy, than were hazardous/harmful drinkers and controls. Those who had had this experience typically entered the temple at the age of 10–12 years (mean \pm SD = 11.7 \pm 3.4, 10.2 \pm 3.0 and 10.2 \pm 2.5 for alcohol dependents,

Table 1. Early religious experiences by drinking categories

Variable	Non/infrequent/ light (<i>n</i> = 44)		Hazardous/ harmful (<i>n</i> = 77)		Alcohol dependents (<i>n</i> = 91)	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
Brought up in a religious family	41	(28)	22	(29)	26	(29)
Parents were moderately–strongly religious	128	(90)	64	(86)	78	(88)
Parents often participated in religious activities	103	(71)	59	(77)	68	(75)
Parents forced subject to be religious	11	(8)	8	(10)	12	(13)
Childhood participation in religious activities	64	(44)	42	(55)	42	(46)
Having been a temple boy	46	(32)	27	(35)	41	(45)*
Studying in a temple school	50	(35)	18	(23)	35	(38)*
Experience as a monk	114	(79)	53	(69)	69	(76)*
Having undertaken Pali study	7	(5)	3	(4)	3	(3)
Having undertaken Dhamma study	52	(36)	20	(26)	36	(40)*

* $P < 0.25$.

non/infrequent/light drinkers and hazardous/harmful drinkers, respectively). The alcohol dependents and the non/infrequent/light drinkers lived in a temple for a mean of 36 and 38 months, whereas the hazardous/harmful drinkers were there for a mean period of 29 months. The most common reasons for being a temple boy were having a relative who was a monk (15, 13 and 16% in non/infrequent/light drinkers, hazardous/harmful drinkers and alcohol dependents, respectively), and needing to attend school far from home (12, 13 and 22%). Other reasons, including being from a poor family, being not physically or mentally healthy and having no one to care for them at home, were reported by 5–9% of subjects.

Current religious activities

More than 85% of the subjects reported never or seldom engaging in a group activity in a temple. Worshipping the Triple Gems, which is regarded as a simple everyday activity for a Buddhist man, was sometimes practised by half or fewer of the men (50, 41 and 33% of the non/infrequent/light drinkers, hazardous/harmful drinkers and alcohol dependents, respectively). Offering alms to a Buddhist monk was performed by

17–29% of subjects. Morning or evening chanting and meditation are activities a strongly religious person would do, and were performed by only 5–6% of subjects. Numbers of affirmative responses to these activities were summed to form a combined variable reflecting frequency of participation in any current religious activities. About half of the subjects across the three groups (58, 60 and 52% of the non/infrequent/light drinkers, hazardous/harmful drinkers and alcohol dependents, respectively) were sometimes or often involved in any of these activities.

Current religious practices and beliefs

There were no statistically significant differences between the three groups with respect to their interest in studying Dhamma, their beliefs in merit-sin, Khammma, next life, selected supernatural beliefs, and the regularity of their observance of the Five and Eight Precepts (Table 2). However, when asked which of the Five Precepts the subject observed most and which precept Thai men in general should observe most, hazardous/harmful drinkers and the alcohol dependents were less likely to select Precept V (not becoming intoxicated) than were non/infrequent/light drinkers.

Table 2. Current religious practices and beliefs of drinking subjects by drinking categories

Variable	Non/infrequent/ light (<i>n</i> = 144)		Hazardous/ harmful (<i>n</i> = 77)		Alcohol dependents (<i>n</i> = 91)	
	<i>n</i>	(%)	<i>n</i>	(%)	<i>n</i>	(%)
Interest in studying Buddha's teaching	76	(53)	29	(38)	44	(48)*
Observing Five Precepts regularly	63	(44)	25	(33)	32	(35)
Observing Eight Precepts regularly	4	(3)	3	(4)	2	(2)
Selecting Fifth Precept as the subject's most observed one	27	(19)	1	(1)	3	(3)**
Selecting Fifth Precept as the one that should be observed by Thai men in general	40	(28)	6	(8)	13	(14)**
Refraining from drinking during a Lent period	34	(38 ^a)	27	(35)	32	(35)
Always refraining from drinking on a holy day	31	(35 ^a)	10	(13)	8	(9)**
Believing that drinking is a sin	56	(39)	25	(32)	38	(42)
Perceiving self as moderately–strongly religious	124	(86)	57	(74)	68	(75)**
It is important to believe religious teaching	140	(98)	74	(96)	83	(91)
It is important to practice religious activities	132	(92)	66	(87)	78	(86)
Religious teaching always influences daily life	42	(29)	14	(18)	24	(27)
Believing in merit-sin, Khammma, and next life	141	(98)	73	(95)	86	(95)
Believing in some supernatural things	121	(84)	72	(94)	77	(85)*

^aPercentage based on infrequent–light drinkers (*n* = 89), excluding non-drinkers.

* $P < 0.25$; ** $P < 0.05$.

During a Buddhist lent period, which lasts for 3 months from August to October, and on a Buddhist holy day, it is traditional for a Thai Buddhist to refrain from drinking. Of the infrequent/light drinkers (excluding abstainers), 35% reported always stopping drinking on a holy day, while 13 and 9% of the hazardous/harmful drinkers and alcohol dependents did so. A higher percentage of non/infrequent/light drinkers claimed to be currently moderately–strongly religious, compared with alcohol dependents and hazardous/harmful drinkers. A lower percentage of alcohol dependents and hazardous/harmful drinkers than non/infrequent/light drinkers reported that religious beliefs and teaching always influenced the way they acted in their daily lives.

Significant associations between religious life and alcohol use disorders

Being a temple boy was the only factor relating to early religious life that was associated with an increased odds of being alcohol dependent in adulthood (Table 3). With regard to current religious practices and beliefs, hazardous/harmful drinkers or alcohol dependents were less likely to select the Fifth Precept (not becoming intoxicated) as the one most observed by themselves and by Thai men in general, were less likely to express an interest in studying Buddha's teaching, or to refrain from drinking on a Buddhist holy day. In addition, the hazardous/harmful drinkers and alcohol dependents were less likely to report being moderately–strongly religious or as always employing religious teaching as a guiding principle in their daily lives than were non/infrequent/light drinkers.

DISCUSSION

To our knowledge, this paper provides the first published data on associations between religious upbringing, current Buddhist practices and beliefs, and alcohol use disorders in Thai men. In this sample there was no evidence of an inverse association between Buddhist upbringing and alcohol use disorders. Subjects who were hazardous, harmful or dependent drinkers were less likely to report being currently strongly religious than were non/infrequent/light drinkers, and also not surprisingly were less likely to consider the Buddhist precept relating to intoxication as the most important.

All three groups of subjects were similar in terms of their early religious life and about a half never participated in family religious activities during childhood. We had postulated that a

highly religious environment in early life would be inversely related to alcohol use disorders in adulthood but no such relationship was evident. In fact, having been a temple boy was the only childhood religious factor which was significantly associated with alcohol dependence, but was positively, rather than negatively, associated. Subjects who had been temple boys were twice as likely to be alcohol dependent as those who had not. Up to 45% of subjects had been temple boys when they were about 10–12 years old. They did this for various reasons, e.g. to obtain accommodation when schooling was far from home. In the past, a temple had an additional role as a dormitory for boys. These boys may have had fewer restrictions and increased opportunity to experiment with alcohol as a group of teenagers living together. Monitoring of the boys may have been difficult, particularly in large temples with many boys. In addition, it is possible that families with alcohol-related problems and consequent difficulties in providing adequate care for their children could have sent their sons to stay in a temple. Being a temple boy in some cases might be a proxy for physical, psychological, or socio-economic difficulties. Life as a temple boy could also result in stress through separation from family. Today the role of the temple as a dormitory for boys has become less important and temples play little role in the education of children in Thailand.

In keeping with tradition, most of the subjects had been ordained as a monk at an average age of 22 years. It is therefore not surprising that we did not see any relationship between this experience and the later development of alcohol use disorders. Most subjects did relatively little Buddhist study during this period.

Consistent with studies of the Christian religion (Gorsuch and Butler, 1976; Larson and Wilson, 1980; Gartner *et al.*, 1991), a significant inverse relationship was found between self-perception of being moderately to strongly religious, and current hazardous/harmful drinking and alcohol dependence. Two indirect measures of religiosity, 'being interested in studying Buddha's teaching' and 'perceiving that religious teaching always influenced daily life', were also inversely associated with odds of being a hazardous/harmful or dependent drinker.

The selection of the most important precept to observe was also different between alcohol dependents, hazardous/harmful drinkers and non/infrequent/light drinkers. Those who chose the Fifth Precept (refraining from alcohol or other intoxicants) as the most important precept to observe, either for themselves or for men in general, were one in ten to one in two times as

Table 3. Adjusted odds ratio (OR) and confidence interval (CI) for factors significantly associated with alcohol use disorders

Variable	Hazardous/harmful (<i>n</i> = 77)		Alcohol dependents (<i>n</i> = 91)	
	OR ^a	CI	OR ^a	CI
Having been a temple boy	1.34	(0.73–2.55)	2.04	(1.14–3.61)*
Fifth Precept as the most observed for subject	0.06	(0.01–0.46)*	0.15	(0.04–0.55)*
Fifth Precept as the most important to be observed by men	0.24	(0.09–0.61)*	0.42	(0.20–0.87)*
Being interested in studying Buddha's teaching	0.51	(0.28–0.93)*	0.81	(0.47–1.41)
Always refraining from drinking on a holy day	0.60	(0.27–1.34)	0.39	(0.16–0.91)*
Self-perception as moderately–strongly religious	0.41	(0.20–0.86)*	0.48	(0.24–0.97)*
Religious teaching always influences daily life	0.3	(0.14–0.83)*	0.5	(0.21–1.06)

^aOdds ratios adjusted by subject's age group, marital status, education, working status, social class and area of residence. Comparison group is non/infrequent/light drinkers.

**P* < 0.05.

likely to be in the alcohol-dependent and hazardous/harmful drinking groups, respectively. Some of these respondents explained that they considered the Fifth Precept as the most important one to observe, because the use of intoxicants is a potential source of carelessness; if one is intoxicated, one is more prone to engage in immoral activities, such as adultery. The low adherence to the Five Precepts in the hazardous/harmful drinkers and alcohol dependents may reflect a consequence of their involvement with alcohol or alternatively their heavier drinking may result from a lack of interest in, or ability to follow, Buddhist teaching.

The three groups of subjects did not differ significantly in most current religious practices. It may have been difficult to demonstrate a relationship between Buddhist religious life and alcohol use disorders, even if there were such a relationship, because of the difficulty in assessing Buddhist religiosity. Buddhism emphasizes behaviour and outcome of the deed. A good Buddhist is required to control his or her actions by observing precepts, by purifying and concentrating the mind by meditation, and by developing wisdom. A strongly religious Buddhist is not obliged to visit a temple or participate in any formal religious functions, so there is no regular group activity, such as the Sunday church services in Christian denominations, which can be readily measured. Indeed, when Buddhists go to a temple and participate in a religious ceremony (e.g. a funeral ceremony) or in a religious festival, their attendance is partly tradition and partly a social obligation. It is not uncommon to see people drink or even get drunk in the temple grounds during these events. Accordingly, one cannot measure how religious a Buddhist is simply by his involvement in religious ceremony. Religiosity also includes aspects of affiliation, devotion, and beliefs (King and Hunt, 1975) which may be difficult to measure. Furthermore, difficulties in obtaining reliable information on religious belief may have been increased in some cases by limited skills of communication or defensive attitudes (Crossley, 1995). Accordingly, in the current study, only a superficial measure of religious practice and beliefs was possible.

The case-control study offers us the opportunity to assess associations between several aspects of religious upbringing and religiosity in relation to current alcohol use behaviours, but may be subject to recall and reporting error. A prospective cohort study of the effect of religious upbringing on later development of alcohol use disorders would allow a fuller analysis of causative or protective factors, but would be an expensive, large and long-term undertaking.

While a high percentage of subjects expressed a belief in the importance of religious teaching and of practising religious activities, a low percentage enacted it. It is generally accepted that a Buddhist man should conform to the Five Precepts, but less than half of the subjects across the three groups observed them regularly. As Thai people are already aware that Buddhism teaches against drinking, a strategy to

enhance their conformity to the Buddhist principle could be considered as a preventive or therapeutic measure, particularly in those who have firm Buddhist beliefs. Care would need to be taken so that this was done sensitively, so that it helped those with alcohol use disorders rather than amplifying the problem through generating guilt.

The incorporation of community-based educational activities into some religious activities may be a feasible approach. For example, on Buddhist holy days, the temple is a place for social gathering of villagers after the religious ceremonies have finished. It could therefore provide an opportunity for health personnel to hold an educational event, such as a 'drink-free day' to promote 'drink-less' or 'safe-limit' drinking concepts. This would be in keeping with the Buddhist custom of refraining from alcohol, particularly on Buddhist holy days and during the Lent period. To date, there has been no exploration of whether Buddhist beliefs can be sensitively integrated into treatment programmes for alcohol dependence, in the way Christian concepts were introduced into the 12-step programme of Alcoholics Anonymous. Thai Buddhist traditions of restraint with regard to alcohol could be sensitively incorporated into prevention and treatment programmes and this is an area that requires further research.

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