SPIRITUALITY AND RELIGION IN THE RECOVERY OF ADDICTED PERSONS

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Abstract

Addiction is a persistent, compulsive dependence on a certain behaviour (ex. gambling, eating) or substance (alcohol, drug abuse and smoking). Studies proved that addiction is seen in different ways: pleasure, disease, moral condition, neuropsychiatric disorder. The study presents a literature review on addiction, the profile of an addicted person, methods of intervention, treatments and guiding lines for health and educational policies.

Keywords: addiction, drug, spirituality, religion, treatment

1. Understanding addiction: disease, pleasure or moral condition

Addiction is a persistent, compulsive dependence on a behaviour or substance. The term has been partially replaced by the word dependence for substance abuse. Addiction has been extended, however, to include mood-altering behaviours or activities.

Addiction is a power greater than us that result in bondage. This bondage destroys the addicted and/or the addict and his or her family in a cycle of inter-generational self-perpetuation. Addiction as a bondage is characterized by the loss of choice over one's desires, beliefs, and actions: the insanity of being unable to 'just say no'. Historically, the Christian church has attempted to address this bondage of addiction by using a model of atonement that identified addiction as sin. This sin is therefore in need of confession, forgiveness and a demonstration of new behaviour [1].

According to World Health Organization, 230 million people or 1 on 20 adults is estimated to have used an illicit drug at least once in 2010. For example, the harmful use of alcohol results in 2.5 million deaths each year. 320,000 young people between the age of 15 and 29 die from alcohol-related causes, resulting in 9% of all deaths in that age group. At least 15.3 million persons have drug use disorders. Injecting drug use reported in 148 countries, of which 120 report HIV infection among this population [World Health Organization, *Management of substance abuse. World Report Drug*, 2012].

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Some researchers speak about two types of addictions: substance addictions (for example, alcoholism, drug abuse and smoking); and process addictions (for example, gambling, spending, shopping, eating and sexual activity). There is a growing recognition that many addicts, such as polydrug abusers, are addicted to more than one substance or process. Addiction is a chronic brain disorder and not simply a behaviour problem involving alcohol, drugs, gambling or sex, experts contend in a new definition of addiction, one that is not solely related to problematic substance abuse.

Researches about addicted persons describe the behaviour as a disease, a pleasure or a moral condition. Addiction is view as a neuropsychiatric disorder [2], a moral condition [3], some combination of the two [4], a pleasure-seeking preference [5].

There continues to be a debate on whether addiction is best understood as a brain disease or a moral condition [6]. This debate, which may influence both the stigma attached to addiction and access to treatment, is often motivated by the question of whether and to what extent we can justly hold addicted individuals responsible for their actions. In fact, there is substantial evidence for a disease model, but the disease model per se does not resolve the question of voluntary control.

Recent research at the intersection of Neuroscience and Psychology suggests that addicted individuals have substantial impairments in cognitive control of behaviour, but this 'loss of control' is not complete or simple. Cohen contradicts Hyman sustaining that an appropriate framework is delivered by the affective neuroscience. This domain link the disease brain process to the moral struggles addicts face in recovery and their relations to the others [7].

The causes of addiction depend on the availability of the drug, its action, potential for dependence or social factors. Nevertheless, because of dependencies is often not very clear. It is likely that many different factors cause or trigger an addiction. Lack of insurance or the opposite: too much self-esteem, malleability (group effect, particularly during adolescence, such as parents and people you trust), boredom, inability to address the problems, inability to manage conflict, desire to increase performance (at work, in sports), relational disorders, diseases (mental and physical), disruption of family relationships.

The stages of development of dependence are:

1) Test phase: During this phase, the subject wants to try and experience something new. Usually, the substances do not create immediately dependency but for some, one needs only a single consumption (heroin, crack).

2) Abuse phase: excessive consumption, most often psychotropic substances or alcohol. During this phase, physical damage and psycho-social may already occur, but they are ignored by the subject.

3) Habituation phase: the psyche and the body has adapted to the pollutant (development of tolerance). Therefore, the dose should be increased frequently to get the desired effect.

4) Psychic dependence, physical: once developed this phase, is almost impossible to give up and the life of the subject is driven by his addiction. Friends, family and employment of the subject are into the background. The person attempts to cope by itself fail. It is not uncommon for subjects experiencing their first trouble with the law when they have reached this phase.

2. Psychological profile, socio-cultural traits and behavior of addictive people

The symptoms are more or less pronounced depending on the substance: sweating, tremors shivering, muscle cramps, heart palpitations, headache, sensation of being cold, dizziness, dilated pupils, gastrointestinal pain, agitation, sleep disorders, fatigue, seizures, short memory loss (blackout), weakness, sometimes skin changes or neurological symptoms due to insufficient power, exhaustion, psychic signs of withdrawal, hallucinations, delusions, behavioural perceptual disorders, psychosomatic disorders (neurosis, anxiety), affective disorder (manic-depressive), memory disorders, impaired concentration and performance, dementia.

If such symptoms appear, it should be noted that addictive substances are often consumed to make the symptoms of mental illness bearable. Withdrawal symptoms of dependence are not related to an addictive substance. For this type of addiction, psycho-social difficulties predominate over physical signs, which may, however, also be present. The following signs may suggest dependence: frequent and insurmountable desire (e.g. to connect to the internet, go to casinos, play, chat, watch TV, resulting in isolation and severe restriction of other interests), loss of control with increasing feelings of guilt, inconvenient singularity within the circle of people around (friends, partner, family) and neglect, decreased work capacity, concealment/dramatization habits, debt and therefore, passing illegally, loss of sense of time, satisfaction always disappears more quickly (a sort of tolerance development). The psychiatric disorders in case of withdrawal are: nervousness, irritability, depression, sleep disturbances, aggression, suicidal thoughts, repeated attempts to restrict himself [World Health Organization, *Management of substance abuse. World Report Drug*, 2012].

Addiction treatment is the use of any planned, intentional intervention in the health behaviour, personal and/or family life of an individual suffering from alcoholism or from another drug addiction, and which is designed to enable the affected individual to achieve and maintain sobriety, physical, spiritual and mental health, and a maximum functional ability [American Society of Addictive Medicine (ASAM), available at http://www.asam.org/docs/publicy-policy-statements/1treatment-4-aod-1-10.pdf?sfvrsn=0, accessed on February 2013]. Drug use (licit or illicit) is harmful and has many adverse consequences. Multiple physical health, emotional, and interpersonal problems are associated with illicit drug use. Cardiovascular disease, stroke, cancer, HIV/AIDS, anxiety,

depression, sleep problems, as well as financial difficulties and legal, work, and family problems can all result from or be exacerbated by drug abuse.

For example, smoking addiction determines biological changes. The neurotransmitter released in the nucleus accumbens has been linked to self-administration and learning following drug use. This endogenous reward system is also activated following food intake or sex. During the period of treatment against smoking, most of the subjects gain weight [8]. The recovery makes this process difficult and sometimes long because the subjects become anxious or depressed about the new transformations of their body. That is a good reason for the subject to regain the addicted behaviour.

Studies about the smoking behaviour proved that a high rate of this behaviour is associated with strong persistent social norms against smoking [9] and socio-cultural behaviours (for example, religious people do not smoke in the neighbourhood of churches or mosques), family restrictions or immigrant associated behaviours (for examples, immigrant Bangladeshi smokers appeared to have increased their use of shisha, a popular alternative method of smoking tobacco in this community [10]. Low rate were associated to the educational level [9].

On the psychological plan, smoking is associated with different non-traditional attitudes (about marriage, sex, family, etc). The rejection of conventional values and acceptance of deviance contribute both to non-traditional attitudes toward sex and marriage and to teenage smoking [11].

Considering the smokers gender, the studies do not reveal important differences, but depression seems to be an important determinant factor for smoking on males. Also for the males, the male-model is shaping the smoking behaviour. Other factor is the non-smoking programs developed in the educational area. The implications of social psychological influences on smoking behaviour are important [12, 13]. Important factors like initiation to and maintenance of smoking are examined with particular reference to normative influences, expectations about consequences, and personality and social variables [13]. These proved factors are indicators for goals during the prevention programs.

Three areas of masculinity are described by Sanders: substance abuse, juvenile delinquency, and recreation. Based on this sample, Sanders sustains that masculinities are constructed via a menu of adolescent behaviours that are descriptive for a working class lifestyle. It is the cultural context that sets the stage for substance abuse and its meaning to identity formation in adolescence, as well as in adulthood. Substance abuse in adolescence, along with other forms of juvenile delinquency and recreation, is a means of achieving masculinity. Unfortunately, for these men the use of substance abuse to achieve masculinity in adolescence becomes problematic later in adulthood. This article concludes that to successfully recover from substance abuse and addiction, these men must revisit and reframe their adolescent constructions of masculinity to better fit the problems and challenges they face as adults [14].

The treatment of addicted people should meet their psychology profile, their culture, meaning of life, usual behaviours, moral raisons, moral behaviour, and their religious believes and the intervention should take care about their cognitive and emotional aspects.

Age is also o factor to be considered. Research on youth focused on risk factors associated with children who were already abusing alcohol and/or other drugs and the idea of 'protective factors' was taken into consideration [15]. Among different ways of interventions, family is involved as s support factor in the treatment of alcoholic addiction. The resistance to treatment that is typical among substance abusers may be heightened for adolescents who are typically compelled into treatment and who are experiencing standard developmental issues [16].

During their treatment with the addicted persons, the practitioners care about three levels of the being [17]: 'being of the world' (meaning the body and its functionality), 'being in the world' (meaning freedom, attitude and responsibilities) and 'being for the world' (meaning the sense of meaning in life).

The consumer experiences internal fragmentation and perceives being invalidated by others, and these losses often prompt challenges to his or her quest for life meaning. Spiritual preoccupations can have positive or adverse effects on consumers [18]. On the negative side, a person may experience grandiosity, frightening delusions and hallucinations, or episodes of major depression due to self-deprecating religious beliefs.

Several socio-cultural factors have also greatly influenced the evolution of the illicit drug problem. These include the changing societal value systems and an increasingly prominent youth culture, though some of these phenomena are difficult to measure and quantify. The most significant socio-cultural driving factor for the evolution of the drug problem appears to have been the popularization of a youth culture. In many developing countries, this has taken place alongside an orientation towards a Western way of life, which may, for some, include the temptation to use illicit drugs [World Health Organization, *Management of substance abuse. World Report Drug*, 2012].

A number of vulnerable groups have become increasingly affected by illicit drug use. In that context, drug use may be linked to such factors as poverty, instability, exposure to violence, difficult job conditions, work overload, post-traumatic stress disorders, neglect and abuse, household dysfunction [UNODC, *World Drug Report*, 2012, available at http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf, accessed on February 2013] and inmates [19]. Substance abuse is used by inmates for recreational activities or intentional as a way to escape for several days from the prison. It seems that the quantity of substance is never so great in order to create major problems or coma.

Most of the currently predominant religions denounce illicit drug use and intoxication. Some surveys have shown that individuals for whom religion plays an important role in their daily life are less prone to taking drugs. In the United

States, for example, high school students who attended religious services frequently were more likely to abstain from illicit drug use than their less religious counterparts [20].

Although research has begun to broadly address gender differences in alcohol and drug dependence and despite the increased research emphasis on the role of spirituality in the recovery process there is a dearth of research on gender differences in spirituality on this area [21].

A negative relationship between religiosity and Internet addiction tendency was found to be replicable for females across all four religions studied (Islam, Hinduism, Buddhism and Christianity). However, no such relationship was found for any of the corresponding male groups [22].

From a social control perspective, there is a relationship between religiosity and various acts of self-reported deviance studied in different researches. As an extension of social control theory, Ross's study [23] sought to assess the importance of religion relative to other forms of social control in explaining deviance. The significant variables were moral beliefs, family attachment, and respect for authority. If religion affects deviance, it might do so indirectly.

3. Spirituality and the meaning of life – important factors in treating addiction

An important study of Fallot revealed that the recovery is helped by positive spiritual stories, as the following: a whole-person spiritual language, rather than an acceptance of limiting psychiatric labels; faith-based perseverance in the recovery journey; assurance of hope; the power of loving relationships, both human and divine; the experience of serenity; the promotion of genuineness and authenticity as goals; participation in spiritually informed activities that express their core beliefs [18].

Several studies identify the importance of religious believes for the consumers' meaning of life [24]. In a naturalistic study of 42 consumers proved that personal prayer is important to over half the respondents, and was generally used in constructive ways, much as it had been in the person's life prior to the illness. Another study or 235 consumers also found that prayer was a major holistic healing practices engaged in to enhance their sense of mental health [25]. The research of Sullivan [26] 48% of the 40 respondents stated that spiritual beliefs were central to their success.

Other results indicated that spirituality and meaning in life were statistically significantly associated to alcoholism and depressive symptoms. In particular, depression was statistically significantly correlated with the onset of alcohol use and the dimensions of spirituality and meaning in life [27]. The spiritual interventions are not appropriate for all types of consumers (for example, if meaning in life does not represent a value for the persons or the person does not represent herself in good image in the next future). For spiritual addicted persons, the specialists are going to encourage consumer disclosure of

spiritual concerns when appropriate, to consider consumer functioning within a broad context of meaning (bring consistency to the consumer's present and ultimate concerns), to help consumers identify meanings and purposes that can guide them in making growth-enhancing decisions and to appreciate their own spiritual beliefs and their impact on recovery practice [28].

Fitchett presents seven ways of using the religious aspect for recovery [29]:
- beliefs and meanings (how the person develops a sense of purpose);
- vocations and consequences (how the person understands his or her obligations and the consequences of meeting or not meeting them);
- experiences and emotions (the affective tone of spiritual life);
- courage and growth (how the consumer faces challenges and doubts);
- rituals and practice (how the person enacts key beliefs);
- participation in a religious or spiritual community;
- where the person locates authority and guidance for his or her core beliefs.

The intervention plan is taking into consideration the person-therapist collaboration or group therapy.

There are also studies that show that the religious and spiritual interventions do not determine important changes for addicted persons [30], but spiritual side is more important than the religious aspects. A sample of 301 outpatient clients from a large substance abuse treatment facility was surveyed on spirituality and treatment outcome constructs utilizing a pretest/posttest design. Clients were surveyed prior to participating in outpatient treatment and then approximately seven months after discharge from treatment. Spirituality was measured multidimensionally to determine any contribution to treatment outcomes, including health, mental health, and substance use outcomes. Analyses were conducted to determine if spirituality changed over the study period and whether spirituality was affected by client characteristics at the beginning of treatment or impacted outcomes after treatment. Results indicated that many spiritual dimensions were important in treatment outcomes and that treatment history had some effect for posttest substance use. In general, the relationship was stronger for the spiritual dimensions than the religious dimensions [31].

Jarusiewicz proves that recovering individuals have statistically greater levels of faith and spirituality than those continuing to relapse; also that relapsing individuals show significantly lower levels of spirituality than those in recovery [32].

Many recovering substance users report quitting drugs because they wanted a better life. The road of recovery is the path to a better life but a challenging and stressful path for most. There has been little research among recovering persons in spite of the numbers involved, and most research has focused on substance use outcomes. The study of Laudet examines stress and quality of life as a function of time in recovery [33] and uses structural equation modelling to test the hypothesis that social supports, spirituality, religiousness, life meaning, and 12-step affiliation buffer stress toward enhanced life

satisfaction. Osman describes the importance of religion in aftercare treatment [34].

Addicted persons are torn between the urge to consume addictive substances and the drive to break with the substances and get free of them. The LifeRing approach anchors itself in the addicted person's drive to get free of the substances and works to empower that urge and to enthrone it permanently in the addicted person's character. Positive peer support focusing on small decisions made in everyday life is the primary psychodynamic engine for recovery in the LifeRing context. Working through nine principal domains, each participant constructs a personal recovery program founded on complete abstinence from all drugs of addiction [35].

The most frequently recommended social form of outpatient treatment is the twelve-step program [33]. Such programs are also frequently combined with psychotherapy. According to a recent study reported by the American Psychological Association (APA), anyone, regardless of his or her religious beliefs or lack of religious beliefs, can benefit from participation in 12-step programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) [33, 35]. The number of visits to 12-step self-help groups exceeds the number of visits to all mental health professionals combined. There are twelve-step groups for all major substance and process addictions. The twelve steps are: 1) admit powerlessness over the addiction; 2) believe that a Power greater than one could restore sanity; 3) make a decision to turn your will and your life over to the care of God, as you understand him; 4) make a searching and fearless moral inventory of self; 5) admit to God, yourself, and another human being the exact nature of your wrongs; 6) become willing to have God remove all these defects from your character; 7) humbly ask God to remove shortcomings, 8) make a list of all persons harmed by your wrongs and become willing to make amends to them all; 9) make direct amends to such people, whenever possible except when to do so would injure them or others; 10) continue to take personal inventory and promptly admit any future wrongdoings; 11) seek to improve contact with a God of the individual's understanding through meditation and prayer; 12) carry the message of spiritual awakening to others and practice these principles in all your affairs.

Even if the treatment and the post-treatment success is correlated to family support, cultural aspects, gender, age or employment, religiosity and spirituality are important factors improving the recovery of addictive persons [36]. Over the years, religion and spirituality were integrated in therapies (individual or group therapy) and projects for different kind of addictions. The medical stuff, psychologists, social workers or addictive professionals should be aware about the importance of these and the possibility to empower the recovering persons with strong beliefs and fulfilling desires of a normal life.

References

[1]   M.A. Fifield, American Journal of Pastoral Counseling, **8(1)** (2005) 67-72.
[2]   A.I. Leshner, Issues on Science and Technology, **Spring** (2001), available at http://www.issues.org/17.3/leshner.htm, accessed on February 2013.
[3]   S.L. Satel, Psychiatr. Serv., **50(7)** (1999) 861.
[4]   S. J. Morse, Cerebrum, **6(4)** (2004) 81–90.
[5]   B. Foddy, and J. Savulescu, Bioethics, **20(1)** (2006) 1–15.
[6]   S. Hyman, The American Journal of Bioethics, **7(1)** (2007) 8-11.
[7]   P. Cohen, The American Journal of Bioethics, **7(1)** (2007) 21-23.
[8]   C.C. Hodgkins, K.S. Cahill, A.E. Seraphine, K. Frostpineda and M.S. Gold, Journal of Addictive Diseases, **23(3)** (2004) 55-65.
[9]   T.F. Vedøy, Ethnicity & Health, **18(2)** (2013) 190.
[10] G. Highet, D. Ritchie, S. Platt, A. Amos, K. Hargreaves, C. Martin and M. White, Ethnicity & Health, **16(6)** (2011) 519-533.
[11] I. Waldron and D. Lye, **16(3-4)** (1990) 23-46.
[12] J. Koval, L.L Pederson and X. Zhang, American Journal of Health Education, **37(6)** (2006) 344-355.
[13] M. Morgan and J.W. Grube, The Irish Journal of Psychology, **15(1)** (1994) 179-190.
[14] J. Sanders, Journal of Ethnicity in Substance Abuse, **10(1)** (2011) 48-70.
[15] L.L. Lyter and S.C. Lyter, Journal of Social Work Practice in the Addictions, **3(2)** (2003) 3-23.
[16] D.E. Orr-Brown and D.C. Siebert, Journal of Social Work Practice in the Addictions, **7(3)** (2007) 5-28.
[17] J. Lantz and J. Walsh, *Short-term existential intervention in clinical practice*, Lyceum, Chicago, 2007.
[18] R.D. Fallot, International Review of Psychiatry, **13** (2001) 110–116.
[19] T. Ciuhodaru, M. Iorga and S.N. Romedea, Eur. J. Sci. Theol., **9(Suppl.1)** (2013) 195-206.
[20] J.D. Hawkins, R.F. Catalano and J.Y. Miller, Psychol. Bull., **112(1)** (1992) 64-105.
[21] D.L. Bliss and S.S. Eckmark, Alcoholism Treatment Quarterly, **31(1)** (2013) 25-37.
[22] J.P. Charlton, P.C.-H. Soh, P. Hwa Ang and K.-W. Chew, Information, Communication & Society, (2012), DOI: 10.1080/1369118X.2012.735251.
[23] L.E. Ross, Sociological Spectrum: Mid-South Sociological Association, **14(1)** (1994) 65-86.
[24] N.L. Holford, Dissertation Abstracts International, **43(6-B)** (1982).
[25] Z. Russinova, D. Cash and N.J. Wewiorski, J. Nerv. Ment. Dis., **197(1)** (2009) 69-73.
[26] W.P. Sullivan, Psychosocial Rehabilitation Journal, **16** (1993) 125–134.
[27] G. Kleftarasa and I. Katsogianni, Journal of Spirituality in Mental Health, **14(4)** (2012) 268-288.
[28] J. Walsh, Journal of Spirituality in Mental Health, **14(4)** (2012) 229-241.
[29] G. Fitchett, *Assessing spiritual needs: A guide for caregivers*, Augsburg, Minneapolis, 1993.
[30] C. Stewart, American Journal of Pastoral Counseling, **7(4)** (2004) 71-83.
[31] C. Stewart, Journal of Religion & Spirituality in Social Work: Social Thought, **27(4)** (2008) 385-404.
[32] B. Jarusiewicz, Alcoholism Treatment Quarterly, **18(4)** (2000) 99-109.

[33] A.B. Laudet, K. Morgen and W.L. White, Alcoholism Treatment Quarterly, **24(1-2)** (2006) 33-73.
[34] M.M. Osman, Journal of Social Work Practice in the Addictions, **2(3-4)** (2002) 97-117.
[35] M. Nicolaus, Journal of Groups in Addiction & Recovery, **7(2-4)** (2012) 118-129.
[36] C. Stewart, G. Koeske and J. L. Pringle, Journal of Social Work Practice in the Addictions, **7(4)** (2008) 75-92.