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ADDICTION, NARRATIVE AND SPIRITUALITY: THEORETICAL-METHODOLOGICAL APPROACHES AND OVERVIEW

God has done for us what we could not do for ourselves.
Alcoholics Anonymous

Summary

In the article the author presents different theoretical and methodological approaches to substance addiction: biological, socio-cultural, psychological, and narrative theories. The author argues that we have to develop a comprehensive theory of addiction that should include not only biomedical, psychological and socio-cultural factors but spiritual aspects of the individual as well. A more holistic and yet fully empirical model of research in addictiology as a human science must indeed include the spiritual dimension. Therefore, a comprehensive theory of addiction has to address all aspects: physical, psychological, social, and spiritual for effective treatment and recovery.

Key words: *Addiction, spirituality, religiousness, narrative.*

Introduction

Over the last few decades interest in research on the problems of drug abuse has grown rapidly. What is particularly intriguing is that each of scientific disciplines has explored the problem. All theorists in addictiology equally agree that the notion of addiction is an extremely complex one. Its complexity derives in part from the impact it has on the individual user psychologically, socially, and biologically, and in part from its effects on society, law, economics, and politics (Lettieri, Sayers & Pearson, 1980: xiii). Consequently, drug addiction has been portrayed alternatively as a disease, behavior or in religious discourse as a sin. This article intends to explore, what addiction is, whether addiction is a disease and if so, what kind of disease? Whether addiction can be determined from a medical or behavioral angle? What a theory of drug addiction is and what are its components?

How is spirituality relevant to the theory of addiction? Can spirituality help addicts in the recovery process? Because of the limitation of the article, this article cannot offer a complete and comprehensive history of the field or a complete review of its vast literature. It will, however, provide a brief overview of various models of contemporary theoretical orientations and perspectives in the drug abuse research field, derived from the socio-psychological and biomedical sciences. In the second part, I will present a narrative approach to addiction research. Finally, the last section will provide an overview on religious approaches to the addiction problem, examining the role of religiosity and/or spirituality in substance abuse and recovery.

Defining Substance Addiction

Before we go further, we first have to clarify the concept of drug addiction. In current addictionology there has been a huge debate concerning the nature of addiction. There is no single etiopathogenic model. The dominant view in addiction science sees addiction as a disease triggered by the substance; others see addiction either as a syndrome of varying degrees or as a behavioral pattern (Heyman, 2009). There are numerous definitions of addiction which reflect the complexity of this phenomenon. They also mirror the diverse interests and perspectives of those who study and work in this field.

Traditionally, the term addiction has been used to identify self-destructive behaviours that include a pharmacological component (DiClemente, 2003: 3). The medical discourse of addiction defines drug addiction as a chronically neurobiological disorder that is defined by two major characteristics: a compulsion to take the drug with a narrowing of the behavioral repertoire toward excessive drug intake, and a loss of control in limiting intake.¹ According to the United States National Institute on Drug Abuse (NIDA), addiction is defined as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain - they change its structure and how it works.”² There are two important aspects of NIDA’s definition. First, addiction is a chronic disorder and most addicts fail in their attempts to achieve long-term abstinence. The second aspect is that drug addiction is a brain disease. It is a disease entity that is characterized by compulsion, loss of control, and its tendency to be repeated despite significant negative consequence. The disease is progressive and often fatal if untreated. Drug use significantly changes brain function and these changes persist

¹ American Psychiatric Association, “Diagnostic and Statistical Manual of Mental Disorders”, (Washington DC: American Psychiatric Press, 2004, 4th ed.); World Health Organization, “International Statistical Classification of Diseases and Related Problems”, (Geneva: World Health Organization, 1992, 10th ed.).

² <http://www.drugabuse.gov/scienceofaddiction/addiction.html>

long after the individual stops using drugs. The disease paradigm identifies addiction as a treatable condition rather than a criminal behavior and tries to place the issue of addiction in a public health and medical context (Smith & Seymour, 2004: 29). However, most disease paradigms concentrate on etiology of addiction rather than on how to change them.

Carlo DiClemente in "Addiction and Change" defines addiction from a more behavioral angle. For him, addiction is "learned habits that once established become difficult to extinguish even in the face of dramatic, and, at times, numerous negative consequence." (DiClemente, 2003: 4). Similarly, Cami and Farre define drug addiction as a chronic condition in which compulsive drug-taking behavior persists despite serious negative consequences (Cami & Farre, 2003). Koski-Jännes tries to give more comprehensive model of addiction. She defines addictive behavior as "fixed activity patterns that are characterized by immediate rewards but problems in the longer run, conflicted ways of thinking and acting, and changes in the neuropsychological processes of the brain." (Koski-Jännes, 2004: 56). For the purpose of this article, however, it is important to mention the religious/theological understanding of addiction. Some theorists have suggested that substance addictions are spiritual illness, a condition resulting from a spiritual void in one's life or from a search for connectedness (Miller, 1998). For chemically dependent people, drugs become their counterfeit god (Ringwald, 2003). Therefore, addicts may be unconsciously seeking to fulfill their spiritual need with drugs.³

All of these definitions imply a negative judgment on drug use, but because addiction is so complex, no single definition is likely to be completely adequate. For most theorists in addiction science, there is neither a stable specific psychological structure nor a specific personality disorder (Taïeb, 2008: 990). However, all theorists in addiction research equally agree that the critical elements of addictive disease are: 1) the development of problematic pattern of an appetitive addictive behavior; 2) the presence of physiological and psychological components of the behavior pattern that create dependence; 3) the interaction of these components in the life of the addict that make the behavior resistant to change (DiClemente, 2003: 4).

Eight Traditional Models for Understanding Addiction

In the history of addiction research, various theories and models of addiction have been proposed. The most prominent explanatory models include: 1) social/environment models; 2) genetic/physiological models; 3) personality/intra-

³ For more theological understanding of addiction see: Oliver J. Morgan and Merle R. Jordan, "Addiction and spirituality: a clinical-theological reflection" in: *Addiction and Spirituality: a Multidisciplinary Approach* (St. Louis: Chalice Press, 1999), 251-267 (eds. Oliver J. Morgan and Merle Jordan).

psychic models; 4) coping/social learning models; 5) conditioning/reinforcement behavioral models; 6) compulsive/excessive behavior models; 7) integrative biopsychosocial model and 8) transtheoretical model of change (DiClemente, 6). Here I will shortly present each of these eight explanatory models of addiction.

The first explanatory model of addiction is the *social/environment models*. Many models of substance abuse have been criticized for failing to attend sufficiently to social and contextual factors (Coppelo & Orford, 2002). However, many research studies have shown that some of the greatest risks of becoming a drug addict come from the social factors a person is exposed to. The social/environment perspective emphasizes the role of societal influences, peer pressure, and family systems on the development of addiction (DiClemente, 2003: 7; Johnson, 1980). Therefore, predisposing factor in the etiology of narcotic addiction is the prevailing degree of attitudinal tolerance toward the practice in the individual's cultural, subcultural, racial, ethnic, and social class milieu. For instance, the use of heroin increased rapidly among Serbian drug users in the end of 1990s mostly due to its hard economic situation, post-war and post-traumatic situation, lowering price of heroin and high rate of unemployment particularly among young people.

Some theorists in addiction field suggest that drug-taking behavior is a function of certain variables that emerge from the psychosocial environment of the family (Coleman, 1980). The drug addicts come not only from the problematic societal backgrounds, but from homes where family life is most disrupted. Therefore, some proponents of the social/environmental paradigm focus on the more intimate environment of family influences as a central factor contributing of addiction. They emphasize that problematic family situations such as conflicted and broken marriages, and use of alcohol and other drugs on the part of the parents, are important influences on the child's decision to experiment with the drugs (Chassin, Curran, Husson & Colder, 1996). Deficits in parental support and ineffective parental control practices have been identified as risk factors for adolescent substance abuse (Hawkins, Catalano & Miller, 1994). Some research studies have confirmed that childhood trauma has been recognizing as a key component for drug abusers (Giaconia, Reinherz, Paradis, & Stashwick, 2003). Other studies investigated whether a history of childhood sexual abuse was associated with alcohol-related expectancies and recalled effects of drinking (Simpson, 2003). However, social/environmental model obviously has relevance for addictive behavior, but often fails to explain in any comprehensive manner individual initiation or cessation (DiClemente, 2003: 9).

The second model is genetic/physiological models. Many have suggested that chemical dependence runs in families and that it may be transmitted across generations. Twin studies suggest that a genetic transmission of chemical dependence is possible, even though many years of researching have been unable to identify the genes responsible for drug addiction (Blume, 2004: 73). Also, familial

transmission can also be explained by behavioral factors, such as modeling by parents of using drugs or alcohol to escape and cope with stressful and crisis events. However, the familial transmission more fits in the social/environment model than in genetic model.

For a long time substance abuse was seen as synonymous for physical dependence characterized by increasing drug tolerance and onset physical withdrawal symptoms. Withdrawal symptoms are not seen with all drugs of abuse but, if they occur, can include intense and erratic changes in body temperature, fever, sweating, tremors, sneezing, chills, increased pulse rate, tachycardia, spontaneous orgasm, depression, anxiety, paranoia, panic disorder and delusions. Theorists of the genetic/physiological model of addiction argue that those physiological signs of addiction are critical indicators that addictions are biological entities and medical problems. As a result, the primary goal of treatment was detoxification, reducing or relieving withdrawal symptoms while helping the addicted individual adjust to living without drug use. However, drug detoxification is not meant to treat addiction but rather an early step in long-term treatment. Though the genetic/physiological model was the most widely accepted and affirmed, it has attracted a number of critiques, some of which are quite important and must be considered for their implications upon the study of addiction (Blomqvist & Cameron, 2002; Moos, 2003). For example, the physiological model, or sometimes called the disease model, has not discovered any biological mechanisms to identify addictive behaviour, and that it therefore does not fit the definition of disease. DiClemente correctly recognizes that so many “different individuals can become addicted to so many different types of substances or behaviors, biological or genetic differences do not explain all the cultural, situational, and intrapersonal differences among addicted individuals and addictive behaviors.” (DiClemente, 2003). There is also increasing evidence of occurrence of recoveries both with and without formal treatment (Sobbel et al., 2000).

Proponents of personality/intrapsychic perspective links personality intrapsychic dysfunction and inadequate psychological development to juvenile delinquency and antisocial behavior disorders, including drug addiction (Weiss, 1992). Many theorists believe that some internal mechanism or conflict drives can be considered as predictors to addiction. For example, antisocial disorders, depression, low self-esteem, hyper activism, and high novelty seeking and emotionality have been identified as precursors or predictors of later addiction (Jessor & Jessor, 1980). However, theorists in addiction science have attempted for many years to determine a psychological profile for people who are substance addicted but have not found a single addictive personality, in spite of commonly held beliefs that there is such a personality (Blume, 2004: 73). Blume affirms this when he said: “there are certain psychological disorders with specific clusters of symptoms that have a high co-occurrence with substance abuse and dependence...but there is no single personality type for people with addictive

behaviors.” (Blume, 73). Personality/intrapsychic approach obviously has valuable contribution for better understanding narcotic addiction, but as DiClemente claims, personality factors and inner conflicts do account for a possibly important but small part of the needed explanation for addiction (DiClemente, 2003: 13).

Some of the most interesting behavioral research concerning addictions is related to a person’s ability to cope with stressful situations. Therefore, the fourth coping/social learning models are associates drug abuse with inadequate coping skills and critical personality deficits. Addictions are considered to be the result of a poor or inadequate coping mechanism and prevent adequate coping skills. Unable to cope with life stresses and crises drug addicts turn to their addiction as an escape or comfort. From this perspective individuals use substances as alternative coping mechanism and rely on their addiction to manage a situation, particularly those that engender feelings of frustration, anger, anxiety or depression (Wills & Shiffman, 1985). Ones ability to cope with crisis has been identified as a critical deficit area in many theories of addiction. According to DiClemente emotion-focused coping has been identified as an important dimension (DiClemente, 2003: 13). Although still little is know about factors that potentially mediate the relationship between posttraumatic stress disorder and drug addiction, some studies consistently show that coping skills play an important role in the relapse-recovery process (Monti, Rohsenow, Colby & Abrams, 1995). Other investigations have similarly shown that increased drinking after rehabilitation treatment is associated with both skills deficit and the failure to use alternative coping responses (Marlatt & Gordon, 1985).

The social learning perspective emphasizes social cognition and not simply coping. Also, this perspective emphasizes the role of peers and significant others as models. However coping deficits are an important aspect of developing addictive behavior, one can not narrow addiction only to a coping repertoire.

The fifth conditioning/reinforcement behavioral models focus on the direct effects of addictive behavior, such as tolerance, withdrawal, other physiological responses, and rewards. Compulsive use of drugs is governed by reinforcement principles.⁴ Addictive substances tend to stimulate the pleasure centers of the brain in such a way that makes the person seek such experience over and over (Blume, 2004: 64). This stimulation of the pleasure center produces the euphoric experience that tends to positively reinforce the act of using the drugs. But as tolerance on drugs develops and the euphoric experience becomes more difficult to get, the addict may find that pleasurable rewards come only intermittently and without any

⁴ The term reinforcement can be confusing. There are some differences between positive and negative reinforcement. Positive reinforcement involves pleasurable consequences related to substance use for the user. Negative reinforcement occurs when a person is rewarded by the dissipation or withdrawal of an aversive consequence, such us a substance reducing withdrawal or psychiatric symptoms. Both positive and negative reinforcement play a part in developing the addictive process. See: Arthur W. Blume, “Understanding and Diagnosing Substance Use Disorder”, 65.

predictable pattern (Blume, 64). However, it is important to be note that not all reinforcement is related to pleasure. Sometimes drug use is reinforcement because it helps addicts to overcome withdrawal symptoms and bad feelings.

The sixth compulsive/excessive behavior models conceptualize addiction as due to “excessive appetites.” (Orford, 2000). Increasing appetite leads to excess and the developmental process of increasing attachment similar to a social learning model. In general, the sense that the behavior is out of the control of the individual and appears to be trying to satisfy a psychological conflicts. This same perspective can encompass both the compulsive and excessive behavioral model (DiClemente, 2003: 16). These models are very similar to those described earlier and there are no any new insights of substance abuse except adding some explanatory potential.

The seventh, an integrative biopsychosocial model is beginning to dominate clinical and research discussions of addictions in the last decade. This model attempts to unify competing addiction theories into an integrated conceptual framework. The term biopsychosocial indicates the integration of biological, psychological, and sociological explanations that are crucial for understanding substance abuse. Therefore, according to this model, addictive behaviour is understood as a complex disorder multiply determined through biological, cognitive, psychological, and sociocultural processes. As Donovan claims that in the biopsychosocial model “addiction appears to be an interactive product of social learning in a situation involving physiological events as they are interpreted, labelled, and given meaning by the individual.” (Donovan and Marlatt, 2005). It is important to be noted that the biopsychosocial model was one of the first models to recognize the importance of treating the whole person, not just the addiction.

Finally, the eighth model is the trans-theoretical model of change. The trans-theoretical model of change is not a model of addiction per se, but it describes people at various stages of change in addictive behaviour. The trans-theoretical model offers an integrative framework for understanding and intervening with human intentional behaviour change (DiClemente & Prochaska, 1998). Therefore, this model attempts to bring together all of these divergent models by focusing on how individuals change behaviour and by identifying key change dimensions involved in this process. The main developer of trans-theoretical model of change, Carlo DiClemente argues for this model, stating that “It is the personal pathway, and not simply the type of person or environment, that appears to be the best way to integrate and understand the multiple influences involved in the acquisitions and cessation of addictions.” (DiClemente, 2003: 19). In my view, the weakness of this model is that it does not address the spiritual element of change in the recovery process even though it is claimed to be a “trans-theoretical” model.

So far I have present eight models of substance addiction. Although substantial progress has been made in addiction research, a number of conceptual problems remain to be resolved. However, it is clear that no single approach is

sufficient in and of itself to explain addictive behavior. Neither the genetic/physiological model nor a psycho-social behavioral concept can explain fully the complexity of addictive behavior. Also, the search for a single explanatory model at a single point in the life of individual seems to be useless. In spite of many different discourses about models and definitions, Oliver Taïeb raised the question: "Could a narrative approach renew the comprehension of these individuals' identities and of the way changes occur, especially during the recovery period?" (Taïeb, 2008: 990). Therefore, next I want to focus on narrative approach to addiction.

Narrative Addiction Research

In recent years, several authors have presented the narrative approach in the field of addiction research (Häninen & Koski-Jännes, 1999; 2004; McIntosh & McKeganey, 2002; Taïeb, 2008; Castel, et al., 1998; Hurwitz et al., 2006). Those theorists focus on the lived experience, narrative descriptions, and stories of the recovering person. The narrative approach seems to be productive in providing a more holistic understanding of addiction and recovery. Its focus also allows for understanding about the experience of women, as well as of migrants and cultures, which were areas of interest that had been largely excluded from investigation before. The narrative approach provides a prolific perspective for studying the ways in which addicted people try to carry out their addiction, how they cope with it and what they make of it. It helps us to hear the voices of the people who have "been there". Therefore, if we want to know the addicts' unique experiences, there is no better way to understand them than from the addict's own voice, and to focus on the way such an experience is structured through narration. Also, it has been argued that the narrative approach may provide insights with the spiritual element that is at play in the experiences of recovering persons. Kurtz, for example, claims that spirituality is so deeply ingrained in the realm of personal experience that attention to narrative may be the only way that spiritual dynamics will reveal themselves (Kurtz, 1986). As Morgan and Jordan correctly recognize, "Indeed, it may only be through attention to narrative and personal story that the real experience of spirituality will reveal itself." (Morgan & Jordan, 1999). As a matter of fact, the spiritual dimension is of great importance in both the addiction itself as well as in recovery, therefore narrative approach may help us to better understand those processes. (I will cover spirituality and addiction in greater detail at a later point in this article).

Patrick Biernacki in his book "Pathways from Heroin Addiction: Recovery without Treatment" was one of the first theorists who used the narrative approach and emphasized the role of identity work in resolving drug addiction (Biernacki, 1986). Similarly, McIntosh and McKeganey point out that the recovery narrative has also been delineated and understood as a method of constructing 'a non-addict

identity' and transformation into a positive outcome. They are of the opinion that what stimulates drug addicts to stop using drugs is their desire to restore their "spoiled identity," (McIntosh & McKeganey, 2002: 44) or in this sense, their spoiled narrative. In their research they interviewed 70 recovering addicts in Scotland and found out three key areas in which the addicts' narratives of recovery could be seen to be constructing a non-addict identity for the individual; firstly, in relation to the reinterpretation of aspects of their drug using lifestyle; secondly, in relation to the reconstruction of their sense of self and thirdly, in relation to the provision of convincing explanations for their recovery (McIntosh & McKeganey, 2000). Those three areas involved looking at past addictive behaviour in a negative light, constructing a new sense of self narrative, and providing a convincing explanation of recovery.

Likewise, Koski-Jännes in her research revealed that quitting addiction often involves remarkable personal and social identity projects (Koski-Jännes, 2002). Another study of the same subjects further revealed that this reorientation may vary from minor changes to a major reconstruction of one's identity. Hänninen and Koski-Jännes studied 51 life histories of former drug addicts. Their investigation revealed five different story types called AA, growth, codependence, love, and mastery story. All of these helped subjects to make the addiction and recovery process understandable. They argue: "If the narrative anticipation of recovery passes the test of reality, the full recovery story results; if not, a new cycle begins." (Hänninen & Koski-Jännes, 2004: 244).

Furthermore, Lena Wiklund uses a hermeneutical-narrative approach in order to describe caring needs associated with the existential and spiritual aspects of living with addiction (Wiklund, 2008). She found several themes in her research such as: meaning – meaninglessness, connectedness – loneliness, life – death, freedom – adjustment, responsibility – guilt, control – chaos. Caring needs associated with those themes are identified as "the need to create a new frame of reference for interpreting of life, the need to experience coherence in life, restored dignity as well as the need for a sense of community and attachment, confirmation and acceptance." (Wiklund, 2435). Reasoning further, Wiklund argues that spirituality is considered as a driving force not only in addiction but also in recovery from it. Therefore, in their stories, recovering addicts take an active role in construing and reconstructing their identities through narration. The main feature of the recovery narratives is addicts' constant quest for meaning, freedom, and redemption in their disability.

Addiction, Spirituality and/or Religiousness

So far we have seen that research recognizes and incorporates psychological, biomedical, and social determinants in modern scientific theories of addictive behaviour. Likewise, spirituality and religiousness has become a topic of

increasing interest to clinicians and theorists interested in substance addiction. The notion that some spiritual element is involved in both addiction and recovery has been the consistent witness of many faith-based programs such as Teen Challenge or Alcoholics and Narcotics Anonymous and Twelve Step fellowship. Needless to say, many theorists describe spirituality and religiousness as an essential component and holistic account of the origins, diagnoses, treatments of drug problems - and therefore worthy of considerably more clinical and research attention (Benda & McGovern, 2006).

Spirituality and religiousness are multidimensional concepts in their philosophical, theological and healthcare connotations (McGovern & McMahon, 2006). However, spirituality and religiousness are concepts which are difficult to define and to operationalize for study and research in the healthcare field. Cook recently did a descriptive study of 265 published books and papers on spirituality and addiction and concluded that, "spirituality as understood within the addiction field is currently poorly defined." (Cook, 2004: 539).

But before we go further let us first consider spirituality and religiousness. In the last few years there has been a huge debate on the question of spirituality that draws some distinctions between spirituality and religion. Many current theorists, therefore, are attempting to create theoretical and operational definitions of spirituality that either distinguish it from personal religiosity or show how the two concepts are related. The connotations of spirituality are more personal than institutional, whereas the connotations of religion are more institutional. Spirituality is more psychological and religion more sociological (Spilka et al., 2004: 9). In this understanding, the two terms are not synonymous but distinct. Thus, spirituality is a more personal and less formal search for meaning and relationship to the sacred, while religiousness has specific behavioral, social doctrinal and denominational characteristics because it involves a system of worship and doctrine that is shared with a particular faith community (Koenig, McCullough & Larson, 2001). For example, while some religious behaviors such as church attendance or prayer are correlated with some dimensions of spirituality, many aspects of spirituality are independent of self-reported religious behavior. Spirituality is generally thought of as more basic and more inclusive than religiousness; spirituality is a subjective experience that exists both within and outside of traditional religious system. However, by spirituality I refer to transpersonal processes that transcend ordinary material existence and it's characterizing the quest for meaning. This includes, but is not limited to systems of religion. For example, people can be involved in a relationship to a God, deity, or what Alcoholic Anonymous refers to as a "higher power". The fellowship of AA is often described as "a spiritual program for living" (Chappel, 1993) where "there is no dogma, theology, or creed to be learned." (DeMarinis, 2003).

However, not all theorists are satisfied with this distinction. For example, Zinnbauer, Pargament and Scott are ambivalent towards contemporary views of

religion, which has been narrowly viewed by restricting its meaning to institutionalized dogma, whereas spirituality has been viewed more personally as an individual connectedness with the transcendent. They offer guidance to prevent a polarization of these realms introducing the concept of the sacred. Religion is, according to Pargament, “a search for significance in ways related to the sacred” (Pargament, 1997: 32) and spirituality is defined as “a search for the sacred.” As such, spirituality is the heart and soul of religion, and religion’s most central function (Zinnbauer, Pargament & Scott, 1999: 909). Therefore, they attempt to find a compromising solution stating that “whereas religion encompasses the search for many sacred and nonsacred objects of significance, spirituality focuses specifically and directly on the search for the sacred.” (Zinnbauer, Pargament & Scott, 909). In a nutshell, according to those theorists, there is no true spirituality apart from religion. Here I will use both terms, because I believe that both dimensions are essential for successful recovery. Even though recovering individuals tend to report high levels of religious faith and religious affiliation, they choose to rate themselves as being more spiritual than religious (Pardini, Plante, Sherman & Stump, 2000). However, research on substance abuse has historically tended to take a more religious factor approach, whereas the research conducted on recovery predictors tends more to spiritual dimensions.

Scientific literature strongly supports the notion that religious and spiritual beliefs play a positive role in physical and mental well-being; reduced psychopathology, greater emotional well-being and improved coping (Matthews & Larson, 1995). Other investigations have similarly shown how spiritual health affects bodily health and conclude that religious people in general live longer, experience less anxiety, cope better with stressful life events, have less rate of depression and have lower blood pressure (Dossey, 1997; Koenig, 1998). Likewise, scientific research on addiction supports the notion that spirituality and religiousness is an important topic to include in addiction treatment. Some empirical researches have shown an inverse relationship to exist between spirituality and drug addiction, suggesting that spiritual involvement may act as a protective mechanism against developing addiction (Miller, 1997). Equally, religious and spiritual involvement “could act as means of ridding oneself of an addiction.” (Morjaria & Orford, 2002). A larger study noted that substance abuse patients with stronger religious faith experienced more favorable mental health outcomes in comparison to their less religious peers. Therefore, spiritual and religious involvement has been presumed to be a key to recovery, because it provides individuals with an effective means of dealing with stressful and life crisis events, including more optimistic life orientation, lower levels of anxiety, and positive effective coping skills. (Pardini, Plante, Sherman & Stump, 2000; Laudet, Morgen & White, 2006).

Furthermore, Miller finds in his study that chemical abuse is associated with a lack of the sense of meaning, relatively to normal samples (Miller, 2003: 40-

44). Therefore, the benefit of spirituality serves as a means of obtaining a deeper sense of meaning for addiction suffers (Carroll, 1993). This is an extremely important fact because the quest for meaning – constructing meaning from life's events – is an essential human characteristic, a critical element of psychological well-being. The importance of meaning provides context that is essential to understand and successfully cope with life's difficulties. A sense of meaning and purpose is closely related to hope. As we know, hopelessness is common among drug addicts. Therefore, another area for those who suffer under addiction is in their sense of hopelessness. The prominent feature of the biography of most drug addicts is their unsuccessful efforts to stop using drugs and therefore, they face multiple losses and disappointments. Thus, empirical findings show that those who have the faith and hope are better able to cope with life's crisis especially during the process of recovery (Asher, 2001).

Another important aspect of successful recovery process is forgiveness and spirituality provides a means for this process. According to Benda and Belcher, forgiveness can function as prevention mechanism in terms of the potential stresses of interpersonal insults, and health promotion in terms of tension associated with pathophysiology and psychopathology (Brenda & Belcher, 2006). In the context of addiction research forgiveness is seen as an integral component on the road to recovery. For substance addicts, however, more attention will likely be directed toward forgiving the self and seeking forgiveness (Worthington, & Cooke, 2006). Worthington et al., in their empirical investigation of alcohol dependent persons, focused on the stress-and-coping theory to understand unforgiveness as an emotion, which is contextualized inside of the violations of justice, and emotional forgiveness as emotion-focused coping that juxtaposes positive emotions against negative ones. In a similar investigation, Benda and Belcher did research on 310 women and 315 men among homeless veterans. They found that forgiveness reduces the relationship of abuse, distress, and depression to alcohol and other drug abuse (Brenda & Belcher, 2006).

Attention should also be placed on religious communities, or what Stark refers to as "moral communities" (Stark, 1987) who have direct influence over addicts who belong to those communities. Some empirical research has shown that increased church attendance was associated with reduced cocaine and alcohol use among patients who had participated in a residential treatment program (Richard, Bell & Carlson, 2000). The same research furthermore revealed that self-assessed religious conviction was not associated with changes in drug abuse. In the context of recovery, the religious community can be seen as significant others who are willing to accept addicts' new identity. Addicts become fellow believers who now belong to the same "family" of faith. The awareness of that acceptance helps addicts to overcome their stigma and shame and to feel welcome in a new community. Therefore, these community factors play a key role in the maintenance of personal change and recovery.

It has been argued that solid empirical investigation of religious coping has rarely been investigated among substance abuse patients (Conners, Whiteside-Mansell & Sherman, 2006). Conners et al. study examined ties between religious variables and mental health in a high risk population: lower-income chemically dependent pregnant women participating in a residential treatment program (Conners, Whiteside-Mansell & Sherman, 2006). In their investigations, they examined the relationships between various facets of religiousness and mental health symptoms, including depression and post-traumatic stress. Negative religious coping was associated with greater post-traumatic stress disorder symptoms and greater depressive symptoms. In other words, women who struggled with their faith experienced more extensive emotional difficulties. Other aspects of religiousness, including positive coping and involvement with organized religion, were not associated with mental health outcomes. According to Conners and his colleagues these results suggest that negative aspects of religiousness, particularly religious struggle, merit greater attention from clinicians and investigators.

Finally however for our purpose here, it is important to consider the influence of spiritual transformation, particularly the phenomena of conversion in addicts' life which has clear psychoemotional, cognitive, and behavioral dynamics. Harry A. Tiebout, a pioneer psychiatrist in the treatment of recovery was one of the first theorists who focused on conversion in the recovery process. He came to the conclusion that the ultimate source of help for the alcoholic was spiritual in nature, and that what was necessitated was a conversion experience whereby the person completely surrendered all illusions of power and control (Tiebout, 1951). In many studies the immediate post-conversion changes were observed to be most significant. Morgan arguing for the post-conversion changes in recovery process states: "The change that occurs gives rise to new ways of thinking, feeling, and seeing the world as well as to alterations of life stance and lifestyle, that is, to cognitive, affective, and behavior consequences." (Morgan, 1999: 13). The recovered addict, who experienced conversion feels more comfortable with self, develops a new identity, has a higher measure of purpose in life, and is more open to others. Some researches have documented that as a subject moved through the rehabilitation program, they came to reject the drug culture as they found new goals and purpose in life, having gained self-acceptance and the acceptance of others, and of God (Ng & Shek, 2001). Similarly, Bennett and Rigby found in their study that for female drug addicts undergoing a Christian rehabilitation program, there was an increase in self-esteem and a reduction of depressive symptoms within the first three months of residence (Bennett & Rigby, 1991). Ng and Shek suggest that benefits derived from religious faith can be applied to drug rehabilitation and that religious faith can serve to resocialize chronic heroin addicts through their conversion and to increase improvement in mental health (Ng & Shek, 2001: 406). Therefore, the experience of recovery may be seen as gradual "transformation of the self in context." (Morgan & Jordan, 1999: 259). In sum, conversion changes

result in a radical re-orientation of identity as well as radical changes in attitudes, feelings, beliefs, lifestyles, values, and personal frame of reference.

Before leaving this discussion of spirituality and religiousness and its influence on recovery, it may be well to summarize. Based upon this short review there is support that spirituality and religiousness can play a positive role in minimizing addictive behavior, and there is empirical evidence that the spiritual dimension may also play a key role in the recovery process. Therefore, spirituality and religiousness are one of the essential foundations for the remediation of an addictive disorder and need to be taken into account in the theoretical and methodological approaches.

Conclusion

As we have seen in this article, there are many ways to address the issues of addiction; biological, socio-cultural, psychological, and narrative theories are all important in this task. Also, I presented the different theoretical perspectives of spirituality and/or religiousness and its relation to addiction and recovery. However, in general, scientific knowledge does not at present provide the basis for a comprehensive theory of addiction encompassing the available socio-cultural, psychological, biological and spiritual evidence. One of the difficulties for a comprehensive theory of addiction is the increasing “medicalization” of the notion of disease. As Morgan points out that the search for biological and genetic explanations for addictive behavior has obscured the classic, more holistic, interdisciplinary point of view (Morgan, 1999: 11). In substance abuse both biological and environmental or contextual factors are involved. However I am not saying that the context and the environment and spirituality are everything or that biology is irrelevant. Rather we have to develop comprehensive theory of addiction that should include not only biomedical, psychological and socio-cultural factors but spiritual aspects of the individual as well. A more holistic and yet fully empirical model of research in addictions as a human science must indeed include the spiritual dimension. As Smith and Seymour notes that “by their nature, human beings are entities composed of interpretative and interactive physical, psychological, and spiritual aspects, and that the disease of addiction, like the human beings that it afflicts, has a tripartite nature and manifests physically, psychologically, and spiritually.” (Smith & Seymour, 1999: 96). Therefore, a comprehensive theory of addiction has to address all aspects; physical, psychological, social, and spiritual for effective treatment and recovery.

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Rezime

U tekstu autor predstavlja različite teorijske i metodološke pristupe bolesti zavisnosti; biološki, socio-kulturološki, psihološki i narativni pristup. Autor smatra da je potrebno razviti sveobuhvatnu teoriju zavisnosti koja uključuje ne samo, medicinske, psihološke i socio-kulturološke faktore, nego takođe i duhovni aspekt. Stoga, sveobuhvatni i empirijski model istraživanja na polju bolesti zavisnosti zahteva uključivanje duhovnog aspekta. Dakle, sveobuhvatna teorija bolesti zavisnosti treba da uključi sve aspekte: fizički, psihološki, sociološki i duhovni u cilju efektivnijeg tretmana i rehabilitacije zavisnika.

Ključne reči: zavisnost, duhovnost, religioznost, naracija.