A Comparison of Relapse Rates after Religion-based and Non-religion-based Rehabilitation for Drug and Alcohol Addiction.

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27th June 2016
Master Thesis
Word count: 21,867

First reader: Elpine de Boer
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Abstract.

Comparing the effects of rehabilitation for drug and alcohol addiction from both religion-based and non-religion-based rehabilitation programs, specifically concerning relapse rates. The focus of religion-based programs will be Christian and all programs will be from the United States of America. Surrounding this is the “war on drugs” culture President Nixon waged in the 1970s and which has not been won yet; if anything, it has worsened in the last few decades. Concurrently, the laws regarding drug abuse have become harsher. The relationship between religion and health is fundamental to the discussion, and five specific relationships as defined by Hood, Hill, and Spilka will be applied to three selected studies. Hood et al’s relationships portray the core concepts of “self-control,” “coping,” and “emotion regulation” which are needed to deal with addiction and which rehabilitation is designed to provide tools to help with. The studies will cover a spectrum of religious rehabilitation, non-religious rehabilitation, and the “grey area” between. Pertinent questions for analysing these studies will be outlined and the results and their implications will be compared before ideas for further research are given.

Keywords: rehabilitation, addiction, relapse, self-control, coping, emotion regulation, employment, life-meaning.

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Introduction.

1. Overview.

One simple question underlies this entire investigation: why is rehabilitation important? The statistics may speak for themselves. The United Nations Office on Drugs and Crime (UNODC) published a worldwide drug report in 2015 which found the following results:

The magnitude of the world drug problem becomes more apparent when considering that more than 1 out of 10 drug users is a problem drug user, suffering from drug use disorders or drug dependence. In other words, some 27 million people, or almost the entire population of a country the size of Malaysia, are problem drug users. Almost half (12.19 million) of those problem drug users inject drugs, and an estimated 1.65 million of those who inject drugs were living with HIV in 2013... The annual number of drug-related deaths (estimated at 187,100 in 2013) has remained relatively unchanged. An unacceptable number of drug users continue to lose their lives prematurely, often as a result of overdose, even though overdose-related deaths are preventable. (2015, p.ix).

A global health report carried out by the World Health Organization (WHO) in 2014 found thus:

Globally, harmful use of alcohol causes approximately 3.3 million deaths every year (or 5.9% of all deaths), and 5.1% of the global burden of disease is attributable to alcohol consumption. We now have an extended knowledge of the causal relationship between alcohol consumption and more than 200 health conditions, including the new data on causal relationships between the harmful use of alcohol and the incidence and clinical outcomes of infectious diseases such as tuberculosis, HIV/AIDS and pneumonia. Considering that beyond health consequences, the harmful use of alcohol inflicts significant social and economic losses on individuals and society at large, the harmful use of alcohol continues to be a factor that has to be addressed to ensure sustained social and economic development throughout the world. (2014, p.vii).

Put in such simple figures, it is not difficult to see that drug and alcohol addictions are significant problems, for both the health of individuals and also the societies which can help or hinder their recovery from these problems.

The focus of this thesis will lie on these addictions in the United States of America. A fundamental reason for this is that the relevant studies need to be in English and the majority of these have been carried out in America. Given that there is a rich field of statistics available here, more reliable conclusions can be drawn than if the focus were to lie on lesser investigated subjects. That so much research into religion in general has been carried out in America is perhaps due to the fact that in the 21st century, contrary to expectations, “the United States is regarded as one of the most religious societies in the industrial West” (Ellison and McFarland, 2013, p.21). In this context, laws on drugs and alcohol have become harsher over time and this

provides an interesting psychological background to the investigation of rehabilitation. Unfortunately, any potential relationship between high religiosity and the growing strictness of drug-related punishments cannot be discussed in detail here, but it is safe to say that it is present.

Salient features of the history of drugs and alcohol in America are useful here. Rum made its first appearance in records in 1651, though within a decade warnings were issued against it. Morphine was discovered through isolation from opium in 1804 by the German chemist Sertürner and was subsequently used to treat soldiers during the American Civil War (1861-1865), leading to a rampage of morphine and opium addictions in war veterans. The German drug company Bayer started selling over-the-counter heroin in America as a cough suppressant and subsequently the Harrison Narcotics Tax Act was passed in 1914 to control the sale and distribution of it, allowing it to be prescribed for medical purposes. California became the first state to criminalise cannabis for non-medicinal purposes in 1915. In 1919, the Eighteenth Amendment banned the manufacture, transportation, or sale of intoxicating liquors: this led to the Prohibition Era in 1920 which ended with abject failure in 1933 with the Twenty First Amendment. The Marihuana Tax Act was passed by Congress in 1937, taxing the sale of cannabis, but this was repealed in 1970. The same year saw the passing of the Controlled Substances Act regulating the manufacture, importation, possession, use, and distribution of certain substances. This stated the accepted medical use of substances in various treatments and categorised them into five classifications based on potential for abuse (a term which remains undefined). The first category includes heroin, ecstasy, marijuana; the second, cocaine and morphine; the third, ketamine and anabolic steroids (containing testosterone); the fourth, rohypnol (the "date-rape" drug); the fifth, cough suppressants, anticonvulsants, and antidiarrheals. The "free love" hippy period of the 1960s was characterised by recreational drug use amongst younger generations. The Vietnam War, from 1955-1975, saw drug abuse become common amongst disillusioned American soldiers. President Nixon's famous waging of the "war on drugs" in 1971 declared: "If we cannot destroy the drug menace in America, then it will surely in time destroy us."[1] The Drug Enforcement Agency was created by the Nixon Administration in 1973.

In 1981, Pablo Escobar's Medellin Cartel began to dominate the cocaine trafficking industry in Colombia and Escobar became immune from prosecution when he was elected into the Colombian Congress in 1982. Colombian and American officials then worked together to destroy over $1 billion worth of cocaine in a series of raids in the Colombian jungle. This sparked a host of murders by the Cartel's henchmen and it appeared as if they had become more powerful than the Colombian government. Colombian police killed Escobar in 1993. The "Just Say No" campaign was launched by President Reagan and his wife in 1986 in the national campaign against drug abuse. The same year saw President Reagan sign the Anti-Drug Abuse Act which created mandatory minimum sentences for drug crimes and led to a large increase in the number of people incarcerated in federal prisons. A widespread hysteria over the dangers of crack cocaine lasted through this decade. A North Carolina Senator Jesse Helms passed legislation in 1988 increasing the penalties for possession of crack cocaine 100 times higher

[1] http://www.presidency.ucsb.edu/ws/?pid=3048

than powder cocaine on the basis that he thought it was 100 times more addictive. In 1989, 46% of all arrests made in New York City were for the possession or distribution of crack cocaine. The same year saw the emergence of drug courts to reduce drug use and recidivism, which will be explored in greater depth later on.

Nixon's battle does not seem to have been won despite the growing "war" on drugs. According to the Substance Abuse and Mental Health Services Administration's National Survey on drug use and health in America of people aged 12 and older, the use of illicit drugs has increased since 2002 from 8.3% of the population having used illicit drugs in the past month to 10.2% in 2014 (Center, 2015, p.5). To put this alternatively, 10.2% of the American population in 2014 was 27 million people. Of those, 7.1 million people met criteria for an illicit drug use disorder in 2013-2014 alone. The same survey found that approximately 14% of adults with illicit drug dependence had received treatment in 2013-2014, a concerningly low number which does not necessarily represent "successful" treatment. Reasons for this low percentage might include insufficient treatment centres or that most of those with drug dependencies cannot afford treatment or do not have the support to assist them in seeking help. A report by Columbia University's National Center on Addiction and Substance Abuse (CASA) in 2015 estimated that more than 20% of deaths in America are attributable to tobacco/nicotine, alcohol, and other drug use (National Center, 2015, p.3).

UNODC argued that problems related to drug abuse place...

a heavy burden on public health systems in terms of the prevention, treatment and care of drug use disorders and their health consequences. Only one out of every six problem drug users in the world has access to treatment, as many countries have a large shortfall in the provision of services. (2015, p.ix).

Similarly, WHO claimed:

In the light of a growing population worldwide and the predicted increase in alcohol consumption in the world, the alcohol-attributable disease burden as well as the social and economic burden may increase further unless effective prevention policies and measures based on the best available evidence are implemented worldwide. (2014, p.vii).

Evidently, the treatment available for drug and alcohol addictions are lacking either in number or efficacy - or both. America is surely not exempt from this worldwide "burden" of addiction. Rather than focus on why this burden exists in the first place, instead this discussion will concentrate on the treatment of it and the successes or failures thereof.

It is clear that money is a significant part of this burden. A CASA report in 2015 claimed that data from 2005 found that the taxpayer tab for American government spending on the consequences of risky substance use and untreated addiction totals an estimated $468 billion a year (National Center, 2015, p.3). Of every dollar federal and state governments spend on risky substance use and addiction, an estimated 96 cents goes toward dealing with their consequences; only 2 cents go toward prevention and treatment and the remaining 2 cents go toward research, taxation, regulation, and interdiction (National Center, 2015, p.3). This is an

immense amount of money that could be spent effectively on treatment and discovering which type of rehabilitation is most useful, in order to ensure spending money on programs which will benefit more people. If a particular type of treatment is rarely successful, then what is its purpose? It becomes not only a waste of money for those who fund it but also, and more importantly, a wasted opportunity for those who need help for addiction. Because rehabilitation is expensive for those participating, it is imperative that they are given treatment which is more likely to bring about positive effects. The mental elements of rehabilitation must not be considered as less important than the physical; a holistic approach underlies this investigation because rehabilitation is as much about improving an individual's mental health even if it is seemingly geared towards helping physical health. The root of the word "rehabilitation" comes from the Latin meaning "to restore" and is defined as restoring someone or something to health, to normal life, or to good condition.[2] This requires good condition of both the mind and the body: both are necessary for "successful" rehabilitation. One's belief system is inherently important in this process and thus the concept of religion-based rehabilitation is an interesting one to investigate.

For the purposes of this study, "religion," "faith," and "spirituality" will henceforth be used interchangeably although "religion" will feature most prominently. There are some blurred lines between these terms which are not helpful for this discussion because within this context they all provide the same function: using the belief of something other-worldly or intangible as a tool to treat addiction. To provide a brief insight into religiosity in America, the following results were found in 2014 in a survey of over 35,000 Americans by the Pew Research Center: of the general American population, 70.6% were affiliated with Christianity, 5.9% with all other non-Christian religions, and 22.8% were religiously "unaffiliated" which includes atheism, agnosticism, and "nothing in particular."[3] The vast majority of those who are affiliated with a religion are part of Christian movements (though, of course, its countless denominations make this a wide spectrum in itself) and this domination should be kept in mind. Consequently, a very high percentage of religion-based rehabilitation programs are likely to be Christian-based. Choosing America for case studies is thus for the following reasons: the focus can be sufficiently narrowed to be in the English language investigating Christianity (and most of the relevant studies have been relating to these two factors) and the combination of this heavily Christian context and the "war on drugs" makes for both an accessible and interesting psychological background. It is not possible to fully analyse whether it is this context which not only directly caused this "war," but also potentially created an environment where it could not be won. However, this context is important to remember during the discussion ahead.

The outcome of rehabilitation for any individual is unpredictable and might depend on many factors at play: the continued support of their rehabilitation program or a separate therapy group as well as family and friends, their financial situation, their emotional wellbeing, and finding a purpose to focus and motivate themselves, amongst a constellation of other elements. It would be interesting and useful to compare programs which are religiously or spiritually oriented and programs which do not involve religion or spirituality. This comparison will centre

[2] http://www.oxforddictionaries.com/definition/english/rehabilitate
[3] http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

around the examination of relapse after rehabilitation in order to discover if one particular kind of rehabilitation is more effective or beneficial.

2. Objectives.

The main objective of this thesis is to investigate relapse after individuals have participated in either religion-based rehabilitation (RBR) or non-religion-based rehabilitation (NRBR) to treat drug or alcohol addiction. Whether discussing drug/substance or alcohol addictions, or both, does not affect the general conclusions. In all types of rehabilitation there are intangible elements to take into account - it is as psychological as it is physical. Personal beliefs about how the world works and how one gains life-meaning and motivation are significant factors in the relationship between religion and health. Within this relationship, the three concepts of coping, self-control, and emotion regulation will be fundamental in showing how individuals can use rehabilitation to find replacements for and tools to deal with addiction. Using intangible belief systems to “fix” the body is inherently tricky both to execute and to analyse. Relapse functions as the main focus firstly because it is an easily quantifiable measurement (a physical “use or not use” matter) and secondly because this can be indicative of the “success” of rehabilitation in stopping or helping with addictions. Given the aforementioned constellation of other elements, relapse is not the sole marker of whether or not a particular treatment is successful, but it is perhaps the best place to start: it can give a sense of progress between “before” and “after” rehabilitation. The underlying question to successful rehabilitation in this dissertation is thus: how long after treatment finishes does it tend to take for someone to relapse, if it all? Other important questions are listed in the Method section below.

3. Underlying theoretical perspectives.

There are many reasons why drug or alcohol use or abuse might start in the first place. In an American context, drinking alcohol is much more widely socially acceptable than taking drugs, but some areas of society will also frown upon the former. Johnson claims that people choose to use drugs to induce specific effects or to meet important goals like having fun, socialising, or escaping from pain (2013, p.298). Factors like curiosity or experimentation or giving in to social pressure might feature quite heavily in the initial choice to use drugs. Drug use may also start with prescribed medication and spiral into addiction. Donovan’s definition of addiction is thus:

a process whereby a behavior that can function both to produce pleasure and to provide escape from internal discomfort is employed in a pattern characterized by (1) recurrent failure to control the behavior and (2) continuation of the behavior despite significant negative consequences (Johnson, 2013, p.298).

This definition characterises addiction mostly in a negative sense, both in the act itself and for the effects it causes. However, the lines between use, habit, and addiction are blurry. Johnson refers to drug-related problems as being on a “continuum” rather than as a disease state that is either present or absent; the trajectory varies for different individuals (2013, p.298). For this reason, the term “substance use disorders” (SUDs) is often used. Any kind of drug use affects moods or behaviours but over time, “addictive behaviors take on a life of their own” and the National Institute on Drug Abuse has emphasised that drug induced changes in brain function are involved in the continuum from use to addiction (Johnson, 2013, p.298). In addition, available sources of reinforcement, developmental issues, family and larger social contexts, personal motivations and goals and other risk and protective factors contribute to the maintenance of SUDs (Johnson, 2013, p.298). What addiction is is therefore a potentially grey area and will vary from case to case.

Drugs or alcohol can be used as a form of emotion regulation or coping and addictions to them might be due to, or continue because of, a lack of self-control. These concepts are fundamental to the discussion ahead. McCullough and Carter define self-regulation as an individual’s process which uses information about their present state to change that state toward greater conformity with a desired goal, though this need not be a deliberate process and can be automatic (2013, p.213). They hypothesise that religion fosters the development and exercise of self-regulation (2013, p.123) and reasons for this will be outlined later. Rehabilitation might be understood as successful if drug or alcohol use is no longer necessary to regulate emotions and/or cope with stressful situations, meaning that rates of relapse is a useful measure of this success.

Hood, Hill, and Spilka claim that religion did not begin drawing sustained systematic attention from scientific researchers as a health-related factor until the 1980s but since then there has been an explosion of research, the vast majority of which link religion and spirituality positively to physical health (2009, p.437). However, there have also been reviews of these studies which call into question the strength of the alleged religion-health linkages on a methodological basis (2009, p.437). Hood et al discuss the possible relationships between religious or spiritual involvement and physical and emotional health. One relationship mentioned is the idea of coping. Religious involvement might provide additional ways of dealing with life’s stressors which complement non-religious coping, improving health, and giving a unique source of meaning and purpose (2009, p.438). A significant difference between religious coping and non-religious coping is the use of belief in a transcendent being as a source of support and rationality. How this belief is “used” will vary for individuals: their focus may lie either on conforming to the transcendent being’s will or using religion as a practical form of self-control. For some, praying to a divine figure may provide comfort and the sense of being listened to and cared for in times of stress. Some believe that addiction is sinful and their god will be angry with them for giving into it, thus preventing entry to heaven. This would act as powerful motivation to exert the self-control necessary to avoid addictive substances. The promise of a positive afterlife may hence act as a way of coping with addiction withdrawal or craving. Believing that a divine figure is looking after you and wants you to abstain might be the sense of purpose Hood et al refer to, giving life a sense of purpose and direction that is potentially not the same as when religion or spirituality are not involved.

However, in practice religious coping offers some of the same things as non-religious coping, support from the community being a significant common factor. The nature of rehabilitation in general is community-based, with an unusually high amount of sources of comfort or guidance at unusually regular rates which are not present in "normal" life either before or after the treatment. It is therefore difficult to disentangle whether it is the communal environment or the religious element within it which contributes to making a program successful or not. An explanation for successful rehabilitation may hence be social or sociologically centred. Extracting a purely "religious" element from rehabilitation may not be possible and this confusion between religion and community is present throughout this thesis. For Hood et al, the relationship between physical health and religion in general is not simple, for even though some research finds "direct" connections between physical well-being and religion, these may work indirectly by fostering other benefits (for example, good health habits which might include abstaining from all alcohol and drugs) (2009, p.437). For the connected matters of health and coping it is difficult, if not impossible, to separate out religion from the complicated constellation of factors it encourages and claim that these are specifically related to religion and will not be found in non-religious lifestyles.

Hood et al cite Bergin's 1983 meta-analysis of studies relating indices of religion and psychopathology up to that time, which found that fourteen studies showed a favourable relationship between religion and mental health; nine evidenced no association; and seven indicated religion to be positively associated with pathology (2009, p.445). They infer that it is thus "an overgeneralization to say that religion is necessarily good or bad for one's health" (2009, p.445). This is indicative of the unclear field of results that research into this area has been thus far and the importance of doing more. They go on to consider five possible relationships of how faith might be associated with psychology:

1. Religion may be an expression of mental disorder.

2. Institutionalised faith can be a socialising and suppressing force, aiding people to cope with their life stresses and mental aberrations.

3. Religion can serve as a haven: a protective agency for some mentally disturbed people.

4. Spiritual commitment and involvement may perform therapeutic roles in alleviating mental distress.

5. Religion can be a stressor, a source of problems; in a sense, it can be "a hazard to one's mental health." (2009, p.445).

These will act as a basis for the discussion ahead. The second and third relationships are related to the community element of religion, and the fourth is related to emotion regulation. These are both means of self-control and coping with issues like addiction and are present in all forms of rehabilitation. In the chapter which analyses specific studies, these relationships will apply to NRBR as well as RBR: "community" can be substituted for "religion." For example, the third relationship would become "community can serve as a haven: a protective agency for some mentally disturbed people." This will be detailed further on. In general, the three concepts of emotion regulation, coping, and self-control go hand in hand with each other: if one improves, the other two will probably to improve also. These concepts are more likely to be found positively in the second, third, and fourth relationships than in the first and fifth.

4. Method.

The topic necessitates exploring the meaning of “addiction” in general. Next, the central focus of physical and psychological elements of relapse and prolapse will be introduced and placed in the context of rehabilitation. The relationships outlined by Hood et al will then be explored in greater detail. Also discussed are other pertinent issues which exist in the constellation of factors surrounding addiction, including post-rehabilitation integration into employment and the community because this can be used as a measure of reintegrating into “normal” life. More difficult to quantify are the emotional effects of rehabilitation and a sense of life-meaning and purpose which may have changed for the subject. These issues do not directly affect the conclusion of this dissertation and will not be explored too thoroughly, however they are useful to comment on because they provide a more rounded context to the matter of relapse.

A discovery from researching this thesis is that fully relevant studies are hard to find; in fact, no study was found which compares RBR and NRBR in even an indirect manner. This gap in research is surprising: why have these two types of programs not been compared with each other? Given the fact that each has been studied separately, and RBR quite extensively, it seems remarkable that there has not been sufficient overlap between the two. Of course, it is not possible to read every study which has the potential to be relevant because of the vast research which has been carried out in the crossover between religion and psychology. One must always be limited in research and select a choice few studies to investigate and thus naturally ignore many others. To undertake this thesis, therefore, bits and pieces of studies relating to each of these kinds of programs separately have had to be pulled together in the attempt to make a coherent whole. Of the research found, the most informative and relevant studies were chosen, the aims and details of which will be explained in the third chapter.

Three studies have been selected to illustrate a spectrum of rehabilitation which gives as broad a picture as possible whilst still focussing in on specific results. Taken together, these cases represent the non-religious “extreme,” the religious “extreme,” and the “grey area” in the middle. The first study is a report on 24 of 275 drug courts in America, which will be representative of non-religious addiction programs. The second is a study of 501 individuals who underwent various programs for drug addiction in Chicago, of which it is unknown whether they were RBR or NRBR. This is included to provide an “unknown quantity” and its results remain as important as the others. The third study is of the Lazarus Project in the south of America, which is sponsored by a Pentecostal-Charismatic based Christian congregation and treats drug and alcohol addictions through a strong emphasis on religious discipleship. The first two studies relate only to drug addictions, and the third includes both alcohol and drug addictions. However, the fact that two do not address alcohol addictions will not affect the conclusions reached. As well as representing a broad spectrum, these studies have also been chosen because they offered the most relevant data to the discussion ahead. A lot of apparently relevant research which discussed rehabilitation or addiction in relation to religion had to be discarded because their foci were not aimed at the questions that this thesis asks. It seemed more important to use the questions as a starting point, even though this made finding relevant research more difficult, than reiterate conclusions that had already been made. A discussion on

how this extraordinary gap in research could be rectified will be outlined in the final part of this investigation.

The relationships between religion and health, as outlined by Hood et al, will function as ways of understanding and categorising different approaches to rehabilitative programs as shown in the three studies. The essential questions which will this thesis will ask of the studies are as follows:

- What were the studies' findings?
- How do these relate to the main issue of relapse in RBR or NRBR in this thesis?
- How do Hood et al's relationships apply to any conclusions?
- Does the specific study show (or focus on) a positive or negative relationship between religion/community and rehabilitation?
- What is demonstrated about the core concepts of self-control, coping, and emotion regulation?

These questions offer a logical way to then provide comparisons between different types of rehabilitation, which will be assessed in the conclusion. The studies will also be evaluated regarding their methods of data collection; possible improvements will be discussed in the conclusion with relation to further research.

It is important to mention the issues regarding the source of funding for studies. If a study finds a positive correlation between religion and good health or successful rehabilitation and it is funded by a religious organisation, this may arouse suspicion. It is, of course, possible that these are the legitimate results of the study but the questions might be geared in such a way to provoke specific results. In turn, even if this expectation is true then the desired results might not necessarily follow. However, the idea that this might be possible must be borne in mind.

In America, the Templeton Foundation was founded by the investor and philanthropist Sir John Templeton in 1987. It has a printing press and its "mission" is described as funding discoveries...

relating to the Big Questions of human purpose and ultimate reality. We support research on subjects ranging from complexity, evolution, and infinity to creativity, forgiveness, love, and free will. We encourage civil, informed dialogue among scientists, philosophers, and theologians and between such experts and the public at large, for the purposes of definitional clarity and new insights. Our vision is derived from the late Sir John Templeton's optimism about the possibility of acquiring "new spiritual information" and from his commitment to rigorous scientific research and related scholarship. The Foundation's motto, "How little we know, how eager to learn," exemplifies our support for open-minded inquiry and our hope for advancing human progress through breakthrough discoveries.[4]

It is natural to assume that if the Foundation's mission is to acquire "spiritual information" then the research they sponsor might be specifically aimed at those supporting a religious worldview - though this cannot be definitely claimed.

[4] https://www.templeton.org/who-we-are/about-the-foundation/mission

A chapter named “Religion, Self-Control, and Self-Regulation: How and Why are they Related?” by McCullough and Carter in the *APA Handbook of Psychology, Religion, and Spirituality Volume 1* is used in this thesis. In small print on the first page reads: “Preparation of this chapter was supported by a grant from the John Templeton Foundation” (2009, p.123). This chapter links people’s positive capacities for tolerating, cooperating, and self-control with particular forms of religion (2009, p.126) through a cultural-evolutionary perspective. McCullough and Carter write that they will “limit” themselves to describing what is currently known about links between self-control and religion (2009, p.127) but also claim that the thesis of this chapter “departs dramatically from previous ideas” in its description of the interplay of (a) an evolved human psychology designed to promote the regulation of impulses and desires and (b) culturally evolved religious beliefs such as belief in moralising gods and in the afterlife (2009, p.126). It is possible that a conflict arises from the constraints of current information and a religious agenda wanting to show religion in a positive light, and thus presenting revolutionary ideas from this information. Without going into details of their investigation, it is entirely plausible that the Templeton Foundation funded the preparation of this chapter, which connects religion with beneficial evolutionary attributes both in the past and present, because of this agenda. Of course it is difficult to know whether this is an accurate claim but it is worth considering in the process of analysing studies which investigate the relationship between religion and health.

5. Outline of chapters.

I The relationships between religion and health.
- An introduction to relapse and prolapse.
- Why relapse might prove “successful” rehabilitation.
- Introducing self-control, coping, and emotion regulation.
- Outlining Hood et al’s relationships.

II The relationships between religion and rehabilitation.
- Religious stances on addiction.
- A brief exploration of conversion, which is sometimes used in RBR.
- Exploring reintegration into the community and life-meaning after rehabilitation to provide further context of relapse.

III The analysis of studies.
- Discussing three particular studies.
- Investigating the questions asked in the Method section above.

IV Conclusion and further research.
- How do the results from the studies compare to each other?
- Which questions have been left unanswered and have any new questions been raised?
- What should be investigated by further studies?
- What are the implications of these findings?

The Relationships between Religion and Health.

Exploring relapse.

The definition of what relapse is must be explored. As a basic introduction, the Oxford Dictionary describes it as a deterioration of health after a period of improvement or a return to a less active or worse state.[5] In the academic context of discussing relapse prevention models, Marlatt and Witkiewitz define relapse as both an outcome (a dichotomous view of the person either being ill or well) and a process, which encompasses any transgression in the process of behaviour change (2005, p.2). "Relapse" is understood as an individual returning to previous negative habits, whereas "prolapse" is not a return but a positive change. In 1987, Marlatt obtained detailed information from 70 male chronic alcoholics about what led them to relapse in the first 90 days after leaving an abstinence-based inpatient treatment facility (2005, p.2). From this information, he proposed a cognitive behavioural model of the relapse process when there is a high risk situation, revolving around the interaction between the person (coping, affect, self efficacy, outcome expectancies) and the environmental risk factors (social influences, access and exposure to the relevant substance) (2005, p.2). Marlatt believes that if the individual lacks the correct coping response and/or confidence to deal with the situation then the tendency is to give in to temptation and hence relapse (2005, p.3). The decision to "use or not use" is then mediated by the person's outcome expectancies for the initial effects of using (2005, p.3). Whether an individual relapses or prolapses is thus partly down to their coping mechanisms and partly their external environment. These personal, social, and environmental factors are part of the wider context which relapse may occur in and remain relevant throughout the discussion.

Redich, Jensen, Johnson, and Kurth-Nelson have written on the biological explanation of addiction relapse. They state that it occurs:

[W]hen the neural representation falls back into the old state, returning to the original representation which leads to an overvalued addictive path to drug use. As with extinction processes, this implies that relapse will be particularly sensitive to context and other cues which can drive the representation back to the original representation. Consistent with these predictions, drug-craving and relapse is strongly influenced by drug-associated cues and by context. This learning-theory explanation of relapse is independent of whether the association produces positive desire for drugs or negative symptoms which need to be relieved. In either case, relapse occurs when the representation returns to the original state... and makes the pathway to drug use available again. (2007, p.799).

Addiction is both physical and mental: Redich et al argue that neural representation can be influenced by external social environments and the relating emotions. This relates to alcohol as well as drug addiction. Taking this into account, there is a chance that once treatment of either RBR or NRBR has finished and individuals return to previous "cues," biology will take over and craving will be more present than during treatment, though of course the amount and intensity

[5] http://www.oxforddictionaries.com/definition/english/relapse

will vary from person to person. Because of the physical facets of addiction, perhaps nobody is ever completely "cured," but different tools can be utilised to manage addiction with varying degrees of success. To prolapse, one's body must be taught to resist physical craving.

The phrase "mind over matter" is important here. To varying extents, everyone with cravings uses their personal beliefs as a mental tool to either overcome the physicality of it or to provide support during it. Either religious or non-religious beliefs could be used as personal motivation to suppress or cope with physical or goal-oriented craving. This "mind over matter" idea does not mean that the addiction craving has disappeared, but that emotions and principles can be useful coping mechanisms in dealing with addiction management. For some (perhaps those with more fervent personal convictions), exerting mental self-control over physical withdrawals will be easier than for others. This would also depend on the severity of the addiction problem and each substance has its own withdrawal symptoms, which are both physical and mental. Recovery from heroin is notably extremely physically unpleasant (including vomiting, diarrhea, muscle spasms, impaired respiration) as well as inducing anxiety and depression. Serotonin levels are extremely lowered in recovery from ecstasy which would have the same result as depression. It is often thought that marijuana is the most difficult drug to stop abusing; the most common withdrawal effects are insomnia, depression, and headaches. Alcohol withdrawal symptoms vary widely but include anxiety and seizures. Evidently, both the causes and effects of drug and alcohol addiction and recovery are psychological and physical. In the battle of rehabilitation, it is difficult to predict which will win between mental willpower and physical and psychological cravings.

This "use or not use" idea of relapse versus prolapse is a simple way to assess the "success" of rehabilitation because there is no grey area in this dichotomy. Of course, there is a large spectrum within the relapse itself: for example, someone may take only one sip of an alcoholic drink or they may drink two bottles of wine every day for a month and there is clearly a difference between the two. However, there is still a division between whether any alcohol has passed their lips or whether it has not, and this is what a relapse is. The same is true for injecting, inhaling, swallowing, or snorting substances: either they have been physically imbued into the body or they have not. A comparison between those who relapse after RBR and NRBR programs is therefore a good place to start a wider discussion of which kind of rehabilitation is more useful overall.

Self-control, coping, and emotion regulation.

The three concepts of self-control, coping, and emotion regulation have been already mentioned in connection with addiction and relapse. These are fundamental "tools"of addiction recovery and are central to the success of prolapse. McCullough and Carter explain the concept of self-control as being used in situations in which people override a prepotent response (for example, a behavioural tendency, emotion, or motivation):

In other words, when people exert self-control, they modify their response tendencies by suppressing one goal so as to pursue another one that is more highly valued - especially when one is not actively within the thrall of that prepotent motivation to action. (2013, p.123).

Those who suffer from addiction do not have the self-control to overcome their cravings or motivations for using drugs or alcohol, whether these are physical or emotional or both. The function of rehabilitation is to provide methods of coping and emotion regulation as alternatives to addiction so self-control can be exerted when these cravings or motivations occur. This suppression of the temptation (or enaction thereof) to use drugs or alcohol to gain a specific feeling or satisfaction is in order to pursue a different goal of sobriety. Sobriety can be more highly valued for a variety of reasons: for example, maintaining better relationships with loved ones, gaining childcare access, retaining employment, or for furthering life-meaning and happiness. For some, sobriety is not more valued than succumbing to addiction and if these people do enter a rehabilitation program, it is easy to predict that they would be more likely to drop out early or relapse after completion.

Self-control is hence fundamental to successful rehabilitation. Whether it enables tools of coping and emotion regulation to be exercised or whether it is a consequence of these tools is not an easy question to answer: this is a complicated relationship between various positive factors or outcomes of rehabilitation. However, what is important is that these three factors are connected and they are central in investigating successful rehabilitation programs. They are inherent to the relationships discussed next.

Hood et al's five relationships.

The relationships between faith and psychology as outlined by Hood et al were listed in the Introduction chapter should be repeated here:

1. Religion may be an expression of mental disorder.
2. Institutionalised faith can be a socialising and suppressing force, aiding people to cope with their life stresses and mental aberrations.
3. Religion can serve as a haven: a protective agency for some mentally disturbed people.
4. Spiritual commitment and involvement may perform therapeutic roles in alleviating mental distress.
5. Religion can be a stressor, a source of problems; in a sense, it can be "a hazard to one's mental health" (2009, p.445).

The first relationship is irrelevant to this discussion; the other four apply in varying ways to the topic at hand and will now be investigated further. As stated in the Introduction, this thesis will also depend on the substitution of "community" for "religion" when discussing NRBR.

The second relationship illustrates religious institutions as providing positive communal surroundings. Churches and congregations can serve to create and strengthen the natural human desire to belong and to maintain and reinforce the group's bonds; a religious community "actively functions to socialize, suppress, and inhibit what the community considers deviant and unacceptable behavior" (Hood et al, 2009, p.449). However, these communities can also provide negative surroundings - something that is referred to in the fifth relationship but is also fitting with regards to the "institutionalised faith" of the second. Each institution will select its own behaviours they approve of and for many Christian denominations in America, addiction falls into this category of deviant and unacceptable behaviour. There is a consensus that churchgoers overwhelmingly represent the more conservative and conforming members of the

North American social order (Hood et al, 2009, p.449). Johnson writes that conservative Christian denominations tend to view all alcohol use as a sin rather than an illness, whereas many liberal Protestant bodies view addiction as an illness separating an individual from God (2013, p.299). Johnson states the following alcohol-related figures among Christian denominations:

- Catholics, Episcopalians, and some Lutherans use alcohol in the Eucharist.
- Latter Day Saints, Pentecostals, some Baptists, Churches of Christ, and other denominations require complete abstinence.
- Mormons (82.1%), Assembly of God (92.9%), Seventh Day Adventists (89.7%), Church of God (80.2%), and some Baptists (69.4%) had high percentages of abstainers.
- Catholics and individuals with "no religion" had the lowest rates of abstinence (28.7% and 25.1% respectively) and highest rates of heavy drinking (6% and 9.9%).
- Some reviews conclude that when those with Protestant backgrounds of strict abstinence drink, there is a strong chance they will become problem drinkers. This might not hold true for all Christian denominations which forbid alcohol: it has been found that an individual's perception of their denomination's position on alcohol is the biggest indicator of behaviour. (2013, p.299).

These figures are to give an insight into various Christian denominations' attitudes towards alcohol use which can also serve to represent drug use: if a movement condemns the former, it is very likely to condemn the latter as well. This insight underlies the general context of Christian religion in America. Not all Christian groups view addiction as deviant but each institution will approach a disorder like this in a unique way and it is inevitable that some, like the more conservative groups, will attach negative stigmas to using drugs and alcohol. This easily leads to adverse consequences for those with addiction problems. When religious precepts are treated in an inflexible manner, which Hood et al do not connect with conservative religious groups, members of a religious community can become victimised by parents, clergy, or influential others who misuse religion to gain power and personal gratification (2009, pp.456-457). If this happens, the fifth relationship of religion becoming a stressor or problem for one's health is applicable.

This will have effects both before and after the possible event of rehabilitation. If an individual within one of these congregations suffers from addiction or uses drugs or alcohol in a way not deemed appropriate by their community, they would probably feel anxious about approaching someone to talk about it. They are also potentially less likely to seek help outside of their religious community because of instilled feelings of guilt. An obsession with sin and guilt can be a correlate of religious frameworks that stress moral perfection: "Such an emphasis can incite feelings of low self-esteem and worthlessness, which have the potential of contributing to mental disorders" (Hood et al, 2009, p.458). SUDs might come under the same umbrella as mental disorders in this context given that they are psychologically related, cause distress, and are causes for concern. This obsession can eventuate in "serious mental pathology" (Hood et al, 2009, p.458) and coupled with addiction this could have severe and dangerous results. If someone does receive treatment for addiction despite these potential hindrances, and their

congregation is aware of it, the negative stigma might be waiting for them when they return to the folds of their community and reintegrating could be stressful and trigger feelings which might lead to relapse.

However, on the other end of the spectrum lies the positivity of the third and fourth relationships (if “mentally disturbed” and “mental distress” are replaced by and relating specifically to those suffering from addiction problems). Some religious communities would provide an environment where one would feel comfortable seeking assistance relating to an addiction problem, even if they were taught that it is deviant behaviour. Some authorities are approachable enough to warrant this type of assistance-seeking and therefore treatment is more of an option. Ministers, priests, biblical heroes and figures, and youth group leaders may stand as spiritual exemplars to be imitated: “Explicitly and implicitly, these figures enact roles that may significantly influence the behavior and thinking of religious people along approved lines” (Hood et al, 2009, p.451). Hood et al cite one study of over 3,000 children and adolescents which discovered that clerics were rated as more supportive than parents, suggesting the potential of priests and ministers as positive role models (2009, p.451). The important roles of religious authorities naturally could have both negative and positive effects, but this study suggests the latter more than the former. Expanding on this, in the last half century, the role of faith as “therapeutic” has increasingly been recognised and some clergy are undertaking psychological training as therapists to better help their congregation (Hood et al, 2009, p.454). This includes elements such as glossolalia (talking in tongues), ritual, and conversion. If the clergy have relevant training, this could have beneficial effects for those they support in the community.

After treatment has been completed, an individual may return to a welcoming and supportive religious environment which would lessen stressful triggers and thus reduce the chance of relapse. Religion may offer coping tools useful in recovering from addiction through the idea of divine reassurance or guidance, the practical help of others in the religious community, and the relief of prayer. In this way, a religious surrounding can act as a distraction or haven away from more stressful or painful environments. Hood et al describe three ways in which this refuge can occur:

1. Everyday existence may be circumscribed and controlled by rules that leave little doubt about how to behave.
2. Being part of a religious organisation may alleviate fears of social isolation and rejection.
3. Strong identification with a religious body can provide the perceived security of divine protection (2009, p.452).

The potential downside of a haven rooted in the physical church or meeting place with others of the religious community is that if no “bad” situations arise in these surroundings, someone might not know how to act if they do occur in a separate place. It is easy to avoid temptation if temptation is not present; it is only once one is faced with it that self-control must be truly exerted. If an alcoholic does not come across alcohol, a lesser degree of self-control is necessary than if an open bottle is in front of them. Religious places as a “haven” are highly unlikely to offer temptation but religious belief and identity itself can act as a consistent relief of stressors and this is transportable, existing outside both the walls of a church and also the interactions with others from the religious community. In other words, the mental benefits of

belonging to this community in a physical meeting point and with other people can be absorbed into one's mindset. An individual can hence carry around the coping tools given to them by religion, but outside of a religious community's tangible limits.

Despite the two somewhat extreme ends of the spectrum illustrated, religious communities may exhibit a variety of changeable or even conflicting behaviours and there is no easy way to predict how an individual within them may behave in return. The trajectory of any person on their journey through addiction and religion is unique and space must be made to appreciate the diversity of these experiences. The complex relationships between religion and health serve as a general starting point from which to progress to specific RBR and NRBR programs later on. The ideas illustrated about religious community are still true of non-religious communities: these can also hold negative stigmas surrounding addiction, offer sources of support to provide coping tools, lay down rules about correct ways to behave, and have authority figures who could both help and hinder addiction recovery. It is evident that religion can have both positive and negative effects on individual's physical and mental health.

The Relationships between Religion and Rehabilitation.

A history of religion as rehabilitation.

There is a history of religion being used as an antidote to addiction. One fundamental reason for this is the "mind over matter" idea. If a person is serving something "higher" than themselves or humanity in general, this acts as a powerful motivation in restraining actions seen as negative or sinful. Religion can thus be used as a tool in the process of combating addiction and could have the potential to prevent relapse. In some traditions, the use of alcohol or drugs in any instance is either frowned upon or forbidden. White and Whiters claim that the rise of Native American abstinence-based religious and cultural revitalisation movements in the 18th and 19th centuries, which call for a rejection of alcohol and a return to native tribal traditions, are a framework for personal recovery and cultural survival (2005, p.1). In the 18th century, Dr. Benjamin Rush, one of the Founding Fathers of America, was one of the first to notice that religious experience could serve as an antidote to alcoholism (White and Whiters, 2005, p.1). Alcoholics Anonymous started within the popular religious movement of the Oxford Group in America and Europe in the early 20th century and the Christian Alcoholic Rehabilitation Association was founded in 1967. The human rights activist Malcolm X brought Islam-based addiction recovery to African American communities in the 20th century. These are but a few examples of the intertwining of religion and rehabilitation. White and Whiters claim that faith-based recovery initiatives have often existed outside of, or on the fringe of, the mainstream system of addiction treatment, but such programs have recently received increased legitimisation through the Access to Recovery Program (ATR), implemented by President Bush, and through the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP) (2005, p.3).

The existence of such religiously-supported or oriented programs portrays the picture of religion as having a healing effect, ready to support those with addiction problems. However, despite this positivity, there is an adverse side to religion as rehabilitation. There is strong argument for a negative relationship between alcohol or drugs and religion, given that it is quite common for religious movements to have strongly prohibitive views on using either of these substances. Johnson refers to Calhoun's conclusion that numerous studies have reported inverse relationships between religiosity or spirituality and substance use, but programmatic research aimed at understandings these relationships is comparatively recent (2013, p.297). According to Johnson, in the early 1900s, there was a battle between those who viewed alcoholics as sinners and those who saw the problem as alcohol itself:

[T]he first perspective incorporated a specifically spiritual and individualistic perspective, and the latter secular view led to the great experiment of Prohibition. After Prohibition, alcoholism was thought of as a medical illness and spiritual disease. (2013, p.297).

It appears as if a stigma is easily attachable to the consumption of alcohol, whether this be in excess or not, the effects of which were outlined in the previous chapter.

White and Whiters claim that for both major and lesser-known religions, a common thread running through all religious frameworks is a rationale for restraint and radical abstinence: for example, the body as the temple of God in 1 Corinthians 3:16-17 (2005, p.4). However, there are instances of a positive relationship between religion and addictive substances. The fact that religious movements are often involved in rehabilitation programs shows that even if their faith condemns drug or alcohol use, they do not abandon those who use them to excess. A cynical perspective might argue that this involvement is in fact to gain more followers, taking advantage of those who are in a vulnerable position. In practice, though, some religions do not forbid the use of drugs or alcohol - some actively encourage it. Johnson writes that drugs have been used in religious ceremonies for thousands of years and some texts of world religions temperately "offer both celebrations of alcohol and warnings against excessive use" (2013, p.297).

A drink made from an Amazonian plant called ayahuasca has been used for spiritual purposes in South American shamanic traditions for at least a few centuries, though it is probable that it has been used for much longer previous to this.[6] The effects are an altering of one's consciousness and can be visionary and psychedelic - some people report healing effects as well.[7] Within this spiritual movement, the use of a mind-altering substance is clearly enabled by shamans, and ayahuasca ceremonies are watched over carefully by an experienced figure who is not partaking. It is, of course, possible that ayahuasca can become habitual if not addictive; it is considered a "drug" in that it is mind-altering. In this tradition, a positive relationship is between a drug and a spiritual movement is clearly demonstrated whereby it is used to access different levels of consciousness or other-worldliness. There is quite a cultural difference, however, when comparing the shamanic traditions and Christianity. The former focusses on channeling transcendental energies into the physical world and communicating with benevolent and malevolent spirits, unlike the latter: a doctrine-centred hierarchical tradition of an omnipotent being, which offers a system to make sense of how the universe came into being. Rather than get drawn into these differences, it is simply important to note that some faith movements do have positive relationships between religion and addictive substances, though these are not necessarily within this thesis' focus of Christianity. Johnson's figures in the previous chapter demonstrate the proscription of drugs and alcohol in many Christian denominations.

Typically, religious communities represent institutional sources of support and comfort and it is hence understandable why there has been a historical link between religion and rehabilitation. These sources include authorities who offer non-judgemental guidance and are always there to turn to; a supernatural power who is looking over you and who might have a divine plan which you do not understand; like-minded others who you see regularly and can build connections with; religious writings which provide advice, wisdom, and reassurance; the comfort of prayer; a building or meeting-place where one can go to for safety and escape from life's problems. This list is not exhaustive and does not apply to every religion or for all of its followers, but if these things are present then they will offer help to those in need. Apart from the

[6] http://www.ayahuasca-info.com/introduction/
[7] http://www.ayahuasca-info.com/introduction/

supernatural element, these sources of support and comfort can also be found in non-religious communities.

It is no surprise that both RBR and NRBR can be useful in treating drug and alcohol addictions. As society evolves and becomes more secular, it is expected that more "exclusively" NRBR programs will come about. In a sense, because of the interconnectedness of religion and society in general throughout history, all addiction treatments until the "secular" or "modern" age can be classed as inherently RBR. However, the importance of community in treating addiction is fundamental to this thesis and this can be found in both RBR and NRBR. Religion may have a long historical relationship with rehabilitation, but this is now not necessarily an exclusive one.

Conversion.

It is important to mention conversion because RBR sometimes uses it as a tool in order to provide a replacement for or motivation to stop addiction. Hood et al discuss sudden versus gradual conversion, stating that literature usually indicts the former as an expression of underlying pathology, while suggesting that the latter implies mental health and well-being (2013, p.448). The general position has been that, on average, those who convert suddenly tend to be emotionally unstable and are likely to relapse; research has fairly consistently shown that rapid conversion is associated with higher anxiety and poorer chronic adjustment than the gradual form (Hood et al, 2009, p.448). Hood et al conclude: "The rapid acquisition of a new religious faith is more likely than its gradual counterpart to reflect problems in coping with one's impulses and relations with others and the world," however, most large-scale studies demonstrate that conversions are constructive events and are infrequently manifestations of psychological disturbance (2009, p.448). These problems in coping with one's impulses and relations would obviously be prominent in cases of individuals with addictions. RBR which centres on conversion-based therapy provides a potential environment for sudden conversion, depending on the length of the program. The coping mechanisms gained from this could be unstable and offers a higher chance of relapse - though from Hood et al's claim, this is not certainly proven.

The concerns of sudden versus gradual conversion is related to the idea of legitimate (or valid) or illegitimate conversions. The division between these can sometimes be related to whether the faith movement one converts into is a "mainstream" or a "world" religion. These terms are complicated and problematic but the "main" religions often include or are limited to some of the following: Christianity, Judaism, Islam, Buddhism, Hinduism, Sikhism, and Jainism, though the practice of conversion into these religions varies. For some, conversion into these movements are inherently different from conversion into, for example, the New Age movement which has a much shorter historical tradition, originating in the 1960s in England. It draws on esoteric schools of thought, such as Theosophy, which is concerned with the mysteries of nature and divinity, and emphasises intuition and psychic powers.[8] The New Age movement is highly eclectic in its structure and practices, although common threads running throughout its factions are the prediction that a New Age of heightened spiritual consciousness and international peace would come and the belief that individuals could cause their own spiritual

[8] http://www.britannica.com/topic/theosophy

transformations.[9] The Holistic Health movement advocates alternative healing therapies as well as promoting spiritual healing.[10] The New Age community is “informal” in that it has no centralised authority or holy text[11] - which is perhaps what makes it seem fundamentally different to the “main” religions previously listed.

New Age practices such as astrology, healing crystals, Tarot cards, and channelling extraterrestrial beings[12] are thought by many to be unreliable and superstitious; in other words, these are not features of a “real” religion and could discredit the religions which are “real” by association. Without getting drawn too far into this discussion, it is unsurprising that it has drawn criticism from other religions which might include the attitude that conversions into this movement are illegitimate. One website claims that in the New Age movement, “Individuals are encouraged to "shop" for the beliefs and practices that they feel most comfortable with.”[13] This “shopping” seems to conflict with the classic idea of religious conversion which is more akin to Saul’s spiritual transformation on the road to Damascus which led him to be Paul the Apostle (though as a sudden conversion, the stability of this might be dubious for some). Shopping implies a practical, rational decision where one considers one’s choices - not a divinely-related, fundamental spiritual shift in one’s self. Pals describes a religious conversion as “something deep and fundamental, reshaping a person’s entire life from that moment forward” and regardless of whether it is sudden or gradual, “the key point in any conversion appears in the moment of self-surrender, the instant of ‘letting go’” (2014, p.203). This aligns more with Saul’s conversion than New Age shopping.

Any potential qualitative difference in conversions is difficult to measure because of the complex issues surrounding it but it is important to say that a factor in all conversions is the changing of one’s worldview in order to escape a present reality. Granqvist states that an insecure religious attachment can be formed where a god functions as a surrogate attachment figure for the individual; and this insecurity has been connected to fluctuations in religiosity such as conversion (2014, pp.781-782). According to Granqvist,

The research literature also suggests that, at least in parts of the Western world, insecurity and parental insensitivity are linked to religious syncretism (e.g., a combination of high levels of New Age spirituality on the one hand and theistic, organised religion on the other,) possibly suggesting extreme attempts at distress regulation using virtually any religious/spiritual mean available to the self. (Granqvist, 2014, p.282).

From his claims, it can be deduced that some vulnerable people may form a sudden and unhealthy attachment to a religious movement to gain emotion regulation tools and thus convert; some might be filling an emotional void. Halama and Halamova claim that conversion is an effort to resolve a problem resulting from stress (for example: depression, a sense of sin, confusion, disturbance of self-esteem, doubts, addictive behaviour) and an attempt to avoid the

[9] http://www.britannica.com/topic/New-Age-movement
[10] http://www.britannica.com/topic/New-Age-movement
[11] http://www.religioustolerance.org/newage.htm
[12] http://www.britannica.com/topic/New-Age-movement
[13] http://www.religioustolerance.org/newage.htm

emotional turmoil accompanying tension (2005, p.70). These ideas align with Hood et al's connection between high anxiety levels and rapid conversion. Theories such as these project the idea that people with emotional problems or needs are more psychologically inclined towards religious conversion in order to "fix" life stressors. This might be conscious or subconscious; a conscious decision relates to the "shopping" idea which implies a deliberate and rational choice to convert in order to change certain elements of one's life.

Conversions can be socially-oriented as well as an individual life choice. Halama and Halamova describe the "social drift model" which suggests that people convert "gradually, even inadvertently through the influence of social relationships which they develop with members of some religious group" (2005, p.71). For some, this could be deliberate, making a conscious choice to convert because of external social pressures or to "follow the crowd." Unfortunately, there is not space to discuss further the extent of how personal or premeditated a conversion is, or the extent of how one's reality changes, as it is not relevant to the conclusion ahead. What is significant is that some RBR programs use conversion as a tool (whether this is considered as legitimate outside of the specific movement or not) although the means of making this happen will vary.

As with any kind of psychological research, it should be noted that anyone who participates in questionnaires or interviews has a choice about how they answer. Everyone is capable of holding back the truth or putting particular emphasis on some aspects of their response. Studies depend on the participants being honest but ultimately the conclusions rest on the answers which are given, whether they are truthful or not. Where research is concerned with something as personal and intangible as religious belief, and especially religious conversion, this problem becomes even more prominent. Investigating conversion, where there is a "before" and "after" a significant event but only the "after" is investigated, it is possible that people obscure some "before" feelings in order to fit in with the "after" mindset.

For example: Person A has a minor drug or alcohol addiction, is not severely unhappy, has good relationships with others and their surrounding community, and has life-meaning and life-purpose as well as employment. Person A decides to seek help for their addiction because they are encouraged to by loved ones. Person A enters an RBR program, perhaps because they are religious anyway, and experiences either a religious conversion or re-conversion. Because of what they have learned during treatment, and newfound religious beliefs, Person A now thinks that their pre-rehabilitation self was a miserable sinner who had no life-meaning, life-purpose, or meaningful relationships. Halama and Halamova write that many studies on conversion and mental health suggest that conversion is followed by positive impacts:

There is a significant increase of well-being and positive emotions such as happiness, joy, calmness, release. Many converts also shift their sense of responsibility, quality of their relationships, self-esteem etc. Several researches have documented that impact of conversion includes such positive consequences as termination of drug use, decrease of psychotic symptoms and suicidal thoughts, less distress, less fear of death, greater purpose in life etc. (2005, p.73).

It naturally follows that if interviewed about the conversion, Person A would now project their "after" perspective onto their "before" self, seeing their levels of addiction, happiness, and meaningfulness from a different (more negative) angle. This might be especially true in the context of RBR programs where its success depends on the specific occurrence of conversion. This event is then imbued with a lot of meaning and pressure from money spent on treatment being "worth it" and optimism for prolapse depending on religious belief, amongst other reasons. Hence, emphasising the wonderful fact of its happening might heavily affect how an individual talks about it in an interview. This of course is not always true, but it is important to remember during the discussion of the RBR study in the next chapter, which involves conversion in its treatment.

Reintegration.

It is important to paint a fuller picture of the surrounding context of post-rehabilitation life, regardless of whether religion was involved. This involves the two categories of reintegration into "normal life" and changes in life-meaning or life-purpose, which will be discussed in turn. The former is something which could be measured by concrete matters, such as whether an individual has gained employment, as well as more intangible concepts, such as "feeling" a part of the community. This can be represented (to some extent) by partaking in community life. The latter is inherently more difficult to measure, but methods are in place to quantify life-meaning.

Reintegration into "normal" life after rehabilitation could be assessed by two things: employment and community life. Employment could also fall under the umbrella concept of community life but it can be separated and measured on its own terms. Rates of employment might help prove "successful" rehabilitation because it can show proof of prolapse, motivation to find a job, and responsibility enough to keep it. However, some caveats must be included in this assessment. The first of these is that employment rates in some cities or countries can be very low in general regardless of addiction problems, though inevitably these are often connected. Consequently, the standard employment rate of the subjects' communities must be taken into account because finding and keeping a job may not be a direct reflection on an individual's endeavour to penetrate the culturally subjective and fluctuating job market. This can also be on account of other factors such as an individual's previous education; which level of education they attained with what grades. Some jobs are simply unavailable for those who do not have higher education and increasingly, university degrees are required to climb the "career ladder" in some countries. Previous employment is also a significant factor: if an individual has been unable to acquire or keep jobs in the past, whether or not this was a consequence of addiction problems, this will automatically make finding a job post-rehabilitation more difficult.

Henceforth, place, previous education, and previous employment are part of a constellation of elements contributing to the likelihood of any individual gaining employment. Once addiction problems and treatment are added to this constellation, it becomes complicated separating the specific relationships between all of these factors. If someone attends addiction treatment, they may have to declare this to a potential employer which could then negatively affect their chance of getting the job. This will not be representative of the individual's attitude towards gaining employment. A practical difficulty in the academic discussion of this is the apparent lack of research in this particular area, especially relating to religion-based programs.

A question such as this also requires long-term investigation after the treatment has finished to give accurate results. Any kind of job search requires time for applications, interviews, and assessments and so results will not be apparent in a short-term period. Data collection over a prolonged period of time would give a more realistic overview of whether jobs are first acquired and then maintained over time.

Reintegration into community life is somewhat difficult to assess because it can be shown by many different factors, not all of which might prove "successful" rehabilitation. Those who exhibit these factors may still have addiction problems and those who do not exhibit them may successfully prolapse. These might include living independently, communication with friends and family, ongoing sources of support within the community, skills development or education, and some form of contribution to community life, for example, charity work or community support. Of course, this is not an exhaustive list but it sketches a picture of the ways in which an individual can be involved in their surroundings. This might be used as a measure of "successful" rehabilitation because it shows mutual support between a person and their physical and social environment, which is typically not shown when addiction is present.

The focus must briefly shift from America to India: this is where a very useful example of what reintegration into the community has been found. Kunphen is a centre in Dharamsala for substance dependence, HIV/AIDS, and human resource development (HRD). It is the first and only Tibetan-run non-government organisation providing programs focussing on treatment and care for alcohol and drug abuse as well as assistance in HRD and HIV/AIDS by promoting education and carrying out awareness campaigns in communities.[14] It is clear that this program focusses on awareness and prevention of addiction as well as treatment after addiction is present, but the latter will be more relevant to this discussion. The 'After-Care' phase of this program is...

designed to assess and evaluate whether addicts who have completed rehabilitation program are clean and ready enough to go back to their normal life. We have rented a house for this program and provide free accommodation, foods and other things needed to prepare our clients to join society with renewed hope and vigor. Since many addicts have nobody to look upon after the rehabilitation program, we send them for vocational trainings, such as Motor Mechanic, Bakery, Wood Crafting and also send them to learn English and computers, etc., according to their skills and capability. Our main goal is to build confidence and brace them up to meet challenges of life from a positive frame of mind. To put in a nutshell, we encourage them to live a happy and drug-free life... Apart from assisting our clients to get back to their normal life, we, as mentioned above, encourage and inspire them to be self-reliant by creating new possibilities. To help them in this regard, we send them to various vocational training centers in different parts of India where they learn skills that would help them craft a new beginning.[15]

Four types of treatment are used: advice regarding diet, advice regarding behaviour, prescribing traditional Tibetan herbal and 'modern' medicines, and performing surgery.[16] Reportedly, this

[14] http://www.kunphen.org/about/
[15] http://www.kunphen.org/about/
[16] http://users.skynet.be/keltic/kunphen.html

centre has received support from “many respected sources, including the Dalai Lama himself.”[17] In a nutshell, it aims “to help find employment and training for former addicts, to help them reintegrate into society. They also mediate with the addicts’ families to encourage re-acceptance.”[18] Kunphen’s goals describe the focus of this chapter. Put simply, reintegration into community life encompasses the skills or education required to lead to employment, and different sources of support or communication.

As of June 2011, Kunphen was successful in helping 125 people “get out of drug addiction” since its opening ten years previously, according to Tenzin Legphel, an employee of Kunphen for six years at the time.[19] This gives the impression of successful rehabilitation but Legphel’s phrasing is unclear and the number of people who entered the program without “getting out of” an addiction is unknown. However, Kunphen is not a case study to be analysed. Regardless of the success in practice of this organisation, Kunphen is relevant in theory because it provides a laudable indicator of what reintegration into the community really is, or should be.

There seems to be a lack of available academic research on this topic but a meta-analysis carried out by Wormith, Althouse, Simpson, Reitzel, Fagan, and Morgan is relevant. This particular research deals with sexual offenders as well as substance abuse offenders. The first is irrelevant to the discussion and where possible a distinction will be made between the two but sometimes the statistics will include both groups. In this study, “substance abuse offenders” are those who have been imprisoned for drug offenses and “rehabilitation” refers to a broad array of psychosocial programs and services. The offenses and the programs portrayed are hence unspecified and unnuanced, so it should be borne in mind that this research is representative neither of all those who suffer with drug addiction problems nor how they have been treated.

Wormith et al stated:

The Office of Justice Programs (2004) estimated that more than 630,000 offenders were released from federal and state custody in 2004. Because many of these offenders eventually relapse, public attention has focused on the issue of offender reentry, and researchers have suggested factors that must be addressed to enhance community reentry and reduce recidivism. (2007, pp.886-887).

The link between reintegration into the community and relapse is clear: if the former is assisted, the latter is less likely to happen. Although advances have been made in understanding of offender treatment and evidence for its effectiveness abounds, Wormith et al allow that critics remain suspicious about efforts to intervene in the lives of offenders (2007, p.882), though they do not go into further detail. It is possible to speculate that some believe people to have addictive personalities which cannot be changed, are forever confined by their socio-economic backgrounds, or that the individual is the only one who can get themselves over an addiction. If

[17] http://www.tibetrelieffund.co.uk/kunphen-hiv-and-drugs-awareness/
[18] http://www.tibetrelieffund.co.uk/kunphen-hiv-and-drugs-awareness/
[19]http://www.thetibetpost.com/en/news/exile/1799-drug-use-hivaids-alcohol-abuse-on-the-rise-amongst-youngsters

one holds any of these beliefs then it is possible to understand that they might think it futile to interfere in offenders' lives. However, these beliefs (though speculative) seem narrow-minded and deterministic. With the correct kind of support and treatment in a community, one does not know who might get over an addiction - even if it does not seem likely.

Regarding drug abuse specifically, Wormith et al claim that the most commonly used and thoroughly researched prison-based, psychosocial treatment is the therapeutic community (TC). Originally designed in response to the traditional medical approach to the treatment of mental health problems, these "open" communities stress consensus building and two-way communication between staff and patients and are founded on social learning theory (2007, p.882). In a nutshell, social learning theory is the idea that behaviour is learned through observing one's social environment and responding to it. Regarding addiction, this might involve observing that loved ones are unhappy if they see you drunk or high and subsequently either totally avoiding them or only seeing them when sober. Wormith et al claim that TC made for reductions of recidivism ranging between 5.3% and 6.9% and five-year outcome studies for prison-based programs in Delaware, California, and Texas found that offenders who completed both prison TC treatment and after-care treatment in the community showed "significant reductions in recidivism and relapse when compared with untreated controls" (2007, p.883). After-care treatment in the community proved critical in helping offenders make the transition from prison to the community and maintain TC gains, and reductions in recidivism and relapse were found to disappear three years after release for offenders who completed only the prison-based TC (2007, p.883). An evaluation of drug-abuse treatment programs within the Federal Bureau of Prisons found that inmates who had completed prison-based treatment and community-based aftercare were significantly less likely to relapse in drug use or recidivate than inmates in a comparison group, even after controlling for individual- and system-level selection factors (Wormith et al, 2007, p.883). These are positive results for NRBR when the focus lies on communication and after-care treatment is provided.

Though this meta-analysis had a "selective" approach (2007, p.880), and with some "questionable" conclusions (2007, p.883), the contribution towards a positive link between reintegration into the community and prolapse might still stand. Or, at least, it is clear that this kind of link is expected by psychologists and somewhat represented in practice. Wormith et al address the need for more research, such as whether investigating individuals' perceptions of their counselors affect the success of the treatment, or how different versions of a common program (like TC) vary in their effectiveness (2007, p.883). Given that there was not a large amount of research done into the relationship between reintegration into the community and relapse, it is clear that much more data needs to be collected before more concrete conclusions can be drawn. Whatever this relationship is, it is a meaningful one in the wider topic of this thesis.

Life-meaning.

Life-meaning is a somewhat narrower area of investigation than the constellation of elements which make up reintegration into the community and so necessitates a shorter discussion, though no less important. Various methods can be employed to measure or quantify the intangible concepts of "happiness," "life-meaning," and "life-purpose" and a significant amount of

research has been done into exploring these concepts for religious people in general. Life-meaning also seems to be the focus of much rehabilitation-based psychological research. It is predictable that during and after a significant life event such as rehabilitation, an individual's mindset and attitude towards life are likely to change in some way. This change might be temporary and fluctuate heavily, so it is important to monitor it regularly and over a long time period in order to gain a full insight into the relationship between rehabilitation and life-meaning.

Williamson and Hood investigated the spiritual transformation of substance abusers at the Lazarus Project, a residential year long Pentecostal-Charismatic program in the south of America. This program represents RBR in the next chapter and its specifics will be outlined then, but its references to life-meaning are more relevant to discuss here. Firstly, the term "spiritual transformation" must be clarified. It can be interpreted in many ways but Williamson and Hood link it directly with religious conversion, which they define as a sudden and/or gradual change in the self that results from a sacred encounter and involves a difference in quality of one's relationships both vertical (with God) and horizontal (with others) (2012, pp.613-614).

In the religious context of this study, the persistent and intense inner conflict that substance abusers encounter leads to a limit that is transcended only through the experience of surrendering all control to God – an act that initiates conversion; the subsequent change in self results in a new relation with God and with those who are important in one's existential world. The specific framing of these experiences in terms of God is what makes them not simply spiritual transformations, but religious conversions. (Williamson and Hood, 2012, p.614).

Here, Williamson and Hood reflect the aforementioned idea that belief in a higher power can offer a life-perspective which helps overcome physical cravings. They discuss the general ideas that religion-based rehabilitation programs see substance abuse as an attempt to fill a void and includes addicts in a religious community which enables them to encounter God and thus discover purpose and meaning in life (2012, p.615). The implication is that those with substance abuse problems function in a purposeless and meaningless void, which can be filled with the transformative tool of religion and addiction is thus replaced or obscured.

Inevitably, this invites the question of whether religious faith is an addiction or a crutch - a question which is not relevant to the conclusions of this thesis, but is part of the wider discussion which it rests in. The idea of religion acting as a crutch is Freudian: finding existential relief in the belief in a supernatural and powerful authoritarian figure who will look after you. This might also include the idea that this figure has a scheme which humans are incapable of fathoming - the knowledge that even though life stressors (such as addiction) may exist, there is a good and divine reason why they are happening to you, even if you do not understand it. The concept of an omnipotent being controlling events or "watching out" for you could be a defense mechanism against directly confronting difficult situations like addiction. If the tangible world has not provided comfort or reason enough to stop drinking alcohol or using drugs, it makes sense that some people might turn to something intangible. Religion as a crutch therefore somehow mediates between the problem (addiction) and the solution (prolapsing). It serves the practical and emotional purpose of helping someone get over an addiction and could thus be seen as a replacement addiction or habit, giving meaning to the lack of using drugs or alcohol and the loss

of their effects. For example, when an individual feels tempted to drink or use again, they might instead go to church or pray. This portrays “mind over matter” working when there is a supernatural element involved. This is not to claim that all relationships between religion and rehabilitation centre around this concept of a “crutch,” but it might be present for some individuals, whether this is conscious or not.

It is perhaps easy to speculate that however one defines “successful” rehabilitation, if an individual believes their treatment to have been a success, their life-meaning and general levels of happiness are more likely to be positive than if it was not perceived as a success. As time goes on, the maintenance of this life-meaning might heavily depend on the sources of support they are still receiving. Generally, it could be predicted that there will be a more positive relationship between life-meaning and prolapse than life-meaning and relapse. Over time, emotional states and sources of life-meaning are likely to stabilise if rehabilitation has been successful, though fluctuation must be allowed for. Both the body and the mind need time to adjust to life post-rehabilitation. As previously emphasised, meaningful insights into this journey will depend on regular data collection over a prolonged period of time.

In Williamson and Hood’s study, the survey at post-graduation assessment included items that reported on drug, alcohol, and tobacco use; probation and legal issues; employment; financial responsibility; marital status; current living conditions; quality of family/friend relationships; devotional time; church attendance; church ministry activity; mentor contact; physical exercise; and the Life Transformation Scale (2012, p.618). The specific results of these items are not relevant here, but it is important to note that the survey covers many practical and emotional aspects of life in general, as well as including religion-specific topics. It is similar to Kunphen in its holistic representation into the constellation of elements surrounding life during and after rehabilitation. These elements provide the surrounding context for the discussion ahead and are important to keep in mind throughout.

The Analysis of Studies.

In this section, three selected studies will be discussed. As mentioned in the introduction, they represent a rehabilitation spectrum of the non-religious extreme, the grey area in the middle, and the religious extreme. This is the order they will be analysed in.

Drug courts.

The NRBR of drug courts will function as the "other" to RBR in order to provide a meaningful comparison between each end of the spectrum. They are a secular form of treatment, devoid of religious features. Drug courts in America came into being in 1989. CASA provided the first major academic review and analysis of drug court research in 1998. At the time of writing they were implemented in around 275 jurisdictions around America and in this review, Belenko assessed 30 evaluations pertaining to 24 of them. In these drug courts,

[V]arious components of the criminal justice and substance abuse treatment systems work together to try and use the coercive power of the court to promote abstinence and prosocial behavior. (Belenko, 1998, p.4).

The drug court model usually entails the following: judicial supervision of structured community-based treatment; timely identification of defendants in need of treatment and referral to treatment as soon as possible after arrest; regular status hearings before the judicial officer to monitor treatment progress and program compliance; increasing defendant accountability through a series of graduated sanctions and rewards; mandatory periodic drug testing (Belenko, 1998, p.5). Drug courts aim to keep people out of prison for drug-related crimes, thus emphasising the criminality of drug use which is unsurprising given the previously outlined history of drugs in America.

Several different measures to calculate recidivism rates have been implemented in various drug court evaluations but the most common is to simply calculate the percentage of individuals rearrested after going through the drug court program (Belenko, 1998, p.12). This is a useful measure which can hint at whether relapse has occurred - but it can only hint and therefore provides inconclusive data. Some studies have calculated the average number of rearrests per client, or the length of time to the first rearrest (Belenko, 1998, p.12). The varied data makes it difficult to provide consistent conclusions. It is important to mention that for these calculations, recidivism and relapse are not the same thing and although the former gives some indication to the latter, relapse rates themselves are not shown. It is possible that any relapse noticed during drug court supervision would lead to arrest, in which case recidivism and relapse would be one and the same but we cannot know this for certain.

Another limitation of the available information is that the follow-up period varies by the study, although most have tried to include at least one year of follow-up information (Belenko, 1998, p.12). This is problematic given that long-term data is required to reach more certain conclusions. Belenko argues that more sophisticated recidivism analyses would adjust rearrest

rates for "time at risk" by discounting for any time spent in jail or prison, and would include a fixed follow-up period for all subjects, but no studies to date have done this (1998, p.12). He laments that there have been no completed drug court evaluations that have included a comprehensive analysis of costs and benefits which partly reflects the fact that calculating these long-term benefits and subtracting that from the costs of a drug court is an expensive and lengthy undertaking, requiring an impact evaluation with follow-up interviews and complex analyses of social and individual benefits (1998, p.11). Most studies compare only drug court graduates to a comparison sample, which tends to inflate the overall effect of the intervention, while a few make the more appropriate comparison between all drug court enrollees and the comparison sample (Belenko, 1998, p.12). A general problem is that for some studies, due to small drug courts or limited data collection periods, the sample sizes are fairly limited, making interpretation of the findings more difficult (Belenko, 1998, p.12). These drawbacks listed by Belenko strongly emphasise the lack of existing data and the need for more to be collected.

However, keeping these limitations in minds, some conclusions can still be reached from Belenko's investigation: he argued that a number of consistent findings emerge from available drug court evaluations. One of the results was that drug courts have been more successful than other forms of community supervision in closely monitoring the "drug offenders" and thus substantially reduced drug use and recidivism while offenders are in the program (Belenko, 1998, p.12). Based on more limited data and to a lesser but still significant extent, drug courts reduce recidivism for participants after they leave the program as well (Belenko, 1998, p.12). A fundamental process of drug courts is to closely monitor the participants and there is a sense of constant supervision, even though this is not a residential type of program. This regular monitoring helps to create a somewhat stable environment, or community, where any relapse or negative emotions or behaviour are likely to be noticed.

Drug courts thus exhibit some factors described in Hood et al's second and third relationships between religion and health: acting as a socialising force and protective agency. These function to promote "good" or prosocial behaviour rather than improve one's mental health, but there can be a strong and cyclical relationship between positive behaviour and positive psychological well-being. Hood et al's description of a "haven" may perhaps be excessive here, if one understands this to imply a positive emotional attachment, but it is possible that the consistent monitoring functions as a "safe place" which is synonymous with a haven. This naturally leads on to Hood et al's fourth relationship, where mental distress is alleviated through the therapeutic role of rehabilitation. Applying these relationships to drug courts clearly excludes the use of "religion" - but either "rehabilitation" or "community" could be fairly substituted to create the same kind of relationship. With either of these substitutions, the same effect as religion is produced for an individual. From the (limited) conclusions Belenko offers, a positive connection between NRBR and prolapse might be inferred, which would mean that the supervision that drug courts offer produces an environment which encourages self-control. It is also implied that an individual's resources for coping and emotion regulation have improved compared with the period of addiction.

Recidivism findings for studies that which tracked rearrests for all drug court participants were compared with comparison groups: for eight of the nine studies, post-program recidivism rates were lower for drug court participants (Belenko, 1998, p.17). The details of the comparison

groups vary: some are randomly selected offenders, some of whom were arrested before drug courts became implemented (Belenko, 1998, p.19). Though a small sample and not a direct comparison between RBR and NRBR, this still produces positive results for those who participated in the drug court system. Belenko claims that drug courts provide more comprehensive and closer supervision of the drug-using offender than other forms of community supervision (1998, p.21). He also writes that drug courts have been quite successful in spurring greater cooperation between the criminal justice system and the community (1998, p.21). Although this is not necessarily representative of the relationship between criminalised (ex-)drug users and the community, it might imply a more general movement which has the potential to ease reintegration for addicts after rehabilitation. This also falls under the positive relationship of a socialising un-religious force helping mental health.

Drug courts seem to create a unique kind of community that offers supervision and stability where individuals will be better equipped with tools for emotion regulation, self-control, and coping. Consequently, the environment built by drug courts fosters a good chance of prolapse without a religious factor. The community is perhaps the most important element in this rehabilitation although the motivation to not be rearrested will, of course, play a significant role. It is important to mention that while drug courts are non-religious and law-based in nature, those who are involved might be of any religious denomination. This includes both the individuals who are being monitored and the judicial officers and those working in the community; in other words, people on both side of the courts. This could make for any kind of overlap between all kinds of beliefs and it is possible that religious discussions would occur during the hearings and treatments involved in a drug court. However, this is not an official part of this system and any kind of religious discussion would be accidental and indirect from the perspective of the drug courts.

A study in Chicago.

Dennis, Foss, and Scott carried out an investigation into the relationship between the duration of abstinence (or prolapse) and other aspects of recovery from drug addiction. They used data collected annually over a period of eight years from 501 adults in Chicago who remained abstinent for at least a month after rehabilitation was completed. Dennis et al's questions for the study are as follows:

1. How do health, mental health, and coping vary by duration of abstinence?
2. How do illegal activity, incarceration, employment, and family income vary by duration of abstinence?
3. How do housing, clean and sober friends, recovery environment, self-efficacy to resist relapse, and social and spiritual support vary by duration of abstinence?
4. How does the likelihood of sustaining abstinence another year vary by the duration of abstinence? (2007, p.587).

All of these questions are related to the holistic approach of rehabilitation, as outlined in previous chapters, although the focus in this chapter remains on rates of relapse.

This study discovered the following results:

- Roughly a third of those who are abstinent for less than a year will remain abstinent permanently.

- Less than half of those abstinent for a full year will relapse.
- Less than 15% of those who remain abstinent for five years will relapse.
- Among people with five or more years of abstinence, there was still some risk of relapse.
- The odds of sustaining abstinence increased dramatically during the first three years and then levelled off. (Dennis et 2007, p.605).

This highlights the chances of relapse relational to how much time has passed since treatment occurred, but helps give a sense of quite positive statistics for prolapse in this sample. Dennis et al suggest that "initial abstinence and the initial time period do not fully represent the changes associated with long-term recovery" (2007, p.607). This places a limit on their results but nevertheless they reached conclusions which can be used in this discussion.

The specific types of treatment these subjects had are not stated and would have inevitably varied from each other in different programs. It is unclear whether some people experienced RBR and whether their chances of relapse were different to those who had NRBR, however, it could be assumed that individuals partook in both types of rehabilitation because both are present in Chicago. If this is true then successful rehabilitation does not necessarily depend on the tool of religion - other forms of treatment can also be helpful. It is possible that the "good" outcomes in Dennis et al's study came from RBR and the "bad" came from NRBR - or vice versa. However, given the lack of information on this in the study, this would be a hasty conclusion to jump to. The results must hence be taken as a whole, without attempting to create an uninformed RBR/NRBR division. It may be the types of specific treatment, like close monitoring and consistent support, that are present in both RBR and NRBR which cause positive outcomes - the Introduction chapter established the theory that extracting a purely religious element from rehabilitation would be difficult. Dennis et al write that abstinence is generally associated with being housed and having some friends, fewer problems in the recovery environment, and more personal, family, social, and spiritual support (2007, p.588). They also note that the general association between relapse and stress has also been found to be moderated by the extent of support one gets from self-perceived personal strengths, family, and social peers (2007, p.588). This holistic approach relates to the discussion in the previous chapter: successful rehabilitation is dependent on many subjective factors. Hood et al's positive relationships are exhibited in the Chicago study without the reliance on a religious lifestyle or on RBR: the emphasis lies on social and environmental supports in general.

Dennis et al identified four coping mechanisms which could be used to help treat addiction: logical analysis, seeking guidance and support, cognitive avoidance, and emotional discharge (2007, p.599). One of the conclusions from this study was that one to three years of abstinence are characterised by a slight increase in mental distress and reliance on several classic coping mechanisms but as the duration of abstinence increased (and the number of mental health problems eventually decreased), use of these coping mechanisms also decreased (2007, p.599). These coping mechanisms, which also involve emotional regulation and self-control, can all be found in religious and non-religious lifestyles and forms of rehabilitation. As an individual adapts to their abstinent lifestyle, the dependence on these mechanisms might decrease but they were important to start the journey of prolapsing. The mechanism of seeking guidance and support is part of creating a positive and stable

environment which lessens the chance of relapse. It is clear from this research that one's community and social surroundings are fundamental to rehabilitation being successful.

This study also found a rapid decrease in illegal activity and illegal income sustained across varying lengths of abstinence, which is somewhat predictable given that many of the crimes were drug-related (Dennis et al, 2007, p.604). This is part of a wider lifestyle away from high-risk and unstable environments which can act as triggers to drug-craving. Another conclusion read that following one year of abstinence, the number of days worked and legal income generated significantly increased and days with financial problems decreased; after three years of abstinence, there were also significant reductions in the percentage of families living below the poverty line, which indicates continued gains in financial status (Dennis et al, 2007, p.604). These findings are consistent with theories about desistance from crime that suggest people need to both stop deviant behaviours and engage in vocational activities (Dennis et al, 2007, p.605). Again, it appears that there are strong connections between a stable lifestyle, integration into the community, and prolapse. This may be due to the lack of stressful triggers or the fact that stability contributes to better coping mechanisms, and vice versa. Religion is not required to have this kind of lifestyle, though some might argue that religion contributes to a constant source of comfort and guidance which enables a more stable environment. However, this conclusion cannot be reached in general here: Dennis et al's research has found that it is community per se which has a strong influence on whether an individual relapses or prolapses. The positive relationships outlined by Hood et al are applicable here: the community can help with alleviating mental distress, act as a protective agency, and perform a therapeutic role in helping overcome addiction.

Dennis et al conclude that their study's strengths include a large sample size, long term follow-up, high follow-up rates, and a wide range of standardised measures as well as being one of the first to look at how the duration of abstinence predicts other aspects of recovery (2007, p.605). However, they recognise the limitations, one being that the analyses are fundamentally observational, comparing a retrospective classification of the duration of abstinence at the eighth year with other aspects of recovery during this year (2007, p.605). The follow-up data over a long period of time gives a useful insight into relapse not only once people have finished addiction treatment but also as they continue their lives and the treatment is no longer a fresh experience. It takes time to adjust to life after rehabilitation and find support systems outside of it. Employment may need to be gained or regained and meaningful relationships need to be made or renewed. All of these factors require time and effort, hence long term data must be gathered to give meaningful results. In a nutshell, the data from Dennis et al's study demonstrates that community and social environments are significant in predicting whether people relapse or prolapse, without necessarily relying on religion.

The Lazarus Project.

One of Jesus' most renowned miracles was to raise a man called Lazarus from the dead.[20] In medicine, the Lazarus syndrome or Lazarus phenomenon is the spontaneous and delayed return of blood circulation after failed attempts at resuscitation (Adhiyaman et al, 2007, p.552).

[20] *King James Version* of the Bible, Gospel of John, ch.XI.

Lazarus has become a positive symbol of resurrection and “the Lazarus effect” is a term widely understood as bringing something back from the dead. Drawing on this concept, the Lazarus Project is a year-long residential recovery program for substance abuse which is sponsored by a Pentecostal-Charismatic based Christian congregation in the south of America. This program demonstrates the RBR end of the rehabilitation spectrum.

Williamson and Hood Jr. have written several articles based on their research into this program. The Lazarus Project was appealing to Williamson and Hood Jr. because of its claim of a post-graduate success at rates of 80%, which is rare in the treatment of substance abuse (2012, p.611) - although what “success” means is unspecified. It could refer to 80% prolapsing or 80% being baptised. Despite the increase in number of rehabilitation centres to address the problem of addiction, general rates of post-treatment success range from 2-20%, although a few programs, like the Lazarus Project, have claimed success rates from 75-85% (Williamson and Hood Jr., 2012, p.614).

In one study conducted by Williamson and Hood Jr., 102 participants were involved and, though no information was taken regarding their religious background when they entered the program, interviews revealed that “most all had at least some experience with various Christian denominations in the past” (2012, p.615). Their study investigates not only the treatment outcomes but also the psychological and spiritual changes of the participants during and after the treatment. Its approach to treatment involves a highly structured program that includes Bible study, Christian discipleship training, counselling, job-training, and community service: “It strongly contends, however, that lasting freedom from addiction can come only by Christian conversion - one that is best supplemented by Spirit baptism” (Williamson and Hood Jr., 2012, p.611). Religious conversion is taken to be a form of spiritual transformation and to mean a sudden and/or gradual change in the self that results from a sacred encounter and involves a difference in quality of relationships both vertical (with the perceived God) and horizontal (with others) (Williamson and Hood Jr., 2012, pp.613-614).

Assessments of psychological (depression, self-esteem, psychopathology, personality markers) and religiosity (fundamentalism, religious orientation, spiritual well-being, mysticism) measures were conducted at the following points: T1. Induction into program; T2. Approximately six months into the program; T3. Graduation (at approximately 12 months); T4. 12 months post-graduation (2012, p.618). Results from T4 showed the following statistics:

- 67% had not experienced a relapse in drug use; among those who relapsed, 8% reported using 1-2 times; 8% disclosed using 3-6 times; and 17% admitted using 12 or more times.
- Concerning use of alcohol, 42% had not relapsed since graduation; 17% of those who had drunk did so less than once a month; 33% admitted to drinking 1-4 times a month; and 8% said that they drank 1-2 times a week.
- 67% reported that they had not used tobacco since graduation.
- 42% indicated that they read the Bible and prayed every day; 25% did so 4-6 days a week; and 33% reported 1-3 days a week.
- On the frequency of attending church or church-related activities each month, 42% attended 10 or more times; 17% attended 6-9 times; 25% attended 3-5 times; 8% attended 1-2 times; and 8% attended none.

- Most graduates also committed a number of hours to church ministry each month: 33% were involved 10 or more hours; 17% volunteered 6-9 hours; 8% gave 3-5 hours; 17% spent 1-2 hours; and 25% gave none.
- Mentoring is an important component of the Lazarus Project experience, in that each resident is matched with a proven Christian to receive nurturance, guidance, and support. When asked about how many contacts each month that graduates had with their mentors, 67% reported at least 4; 8% said 3; 8% indicated rarely; and 17% checked none. 25% had become mentors themselves and were maintaining 4 or more contact hours a month with their mentees.
- One item asked both at T3 and T4 investigated the degree to which the Lazarus Project had played a ‘‘significant role’’ in their spiritual change: 83% of graduates strongly agreed; 6% moderately agreed; and 8% slightly agreed. (2012, p.621).

Williamson and Hood Jr. admit that because of very little funding for the project, the part-time Lazarus Project counselor assisted in the administration of the testing protocol, which resulted in a few missed resident assessments, particularly early in the study, because she was acclimatising to keeping track of individual assessment times (2012, p.619). Despite this flaw, the results from this study are still overwhelmingly clear. There was an unusually high rate of prolapse, for both drugs and alcohol, in the year after graduation as well as a strong rate of regular religious behaviour both personally and for their wider religious community. As claimed by the participants themselves, the RBR contributed highly towards their spiritual change and naturally the RBR also helped with their addictions. Williamson and Hood Jr. conclude that the graduates...

do not view religion as a tool of manipulation for obtaining something, but as a well-spring that offers hope for transcendence beyond their impasse and for new direction in life without drugs. Faith-based programs tend to see such struggles with addiction as a failed attempt to deal with spiritual issues and thus emphasise religious conversion and the development of a spiritual relationship with God as the real answer. (2012, p.628).

In the religious context of this study, the persistent and intense inner conflict that substance abusers encounter leads to a limit that is transcended only through the experience of surrendering all control to God - an act that initiates conversion; the subsequent change in self results in a new relation with God and with those who are important in one’s existential world. The specific framing of these experiences in terms of God is what makes them not simply spiritual transformations, but religious conversions. (2012, p.614).

In this context, therefore, the “mind over matter” concept is absolute: the only way drug addiction can be cured is through religious conversion to a belief in a higher being. The participants in this study claimed themselves that religious faith gave them hope to overcome addiction, portraying the “mind over matter” theory. Although the concepts of emotion regulation, self-control, and coping are not specifically mentioned, it can be inferred that the religious community and its features gave the individuals these tools - without them, “mind over matter” is not possible. Hope alone is not enough to accomplish it; other mental facets must be exerted

too. The connection between religion and prolapse is very obviously positive from this study. The religious community is emphasised after graduation: spiritual surroundings and spiritual support continue to be present in a large way after the residential program has ended. This clearly illustrates Hood et al's second, third, and fourth relationships. Schermer's conclusion from extensive work with addicts is as follows:

I witnessed a significant healing of patients with substance misuse disorders and trauma [to] occur through means which, while they do not require a supernatural explanation, could only be described as spiritual, in the sense of a significant change in beliefs, attitudes and personality which involved higher consciousness and/or faith in God. (Williamson and Hood Jr., 2012, p.613).

This statement offers the same positive relationships Williamson and Hood Jr. found in the Lazarus Project: religion and its features can be used as tools to overcome addiction problems, as well as other traumatising events. An overwhelmingly positive relationship between religion and rehabilitation is shown in this study.

Conclusion and Further Research.

Results from the three studies.

In all the studies analysed in the previous chapter, there is a positive relationship between some sort of community and prolapse - although the type of community varies. The drug court study involved a "secular" law-centred community; the Chicago study showed a variety of communities including individuals' relationships, employment, and home; the Lazarus Project revolved around a religious community. It is perhaps clear that regardless of which community an individual functions in, it is simply the fact that they have a community to function in which contributes towards an addiction-free lifestyle. Naturally, it would have to be a community which offers sources of comfort and support (for example, loving relationships with reliable people or meeting with helpful guidance counsellors) and which has fewer opportunities for addiction-craving triggers (for example, high levels of criminal activity or socialising with others who have addiction problems). However, this kind of community does not necessarily depend on religious factors. It is therefore possible that it is the features of a beneficial community environment that is helpful for someone with an addiction, regardless of whether this is religion-based. The issue then becomes whether an individual has sources of support around them or not; not whether an individual has a religious lifestyle or not. It is possible that religious communities offer more sources of support in practice, but this does not negate other communities' potential or actual capacity for these as well.

The core concepts of coping, self-control, and emotion regulation are all (even if only implicitly) demonstrated when this beneficial community is present - or, in other words, when the positive relationships of Hood et al are demonstrated. Religion or community as a socialising force, helping people with life stress, as a haven or protective agency, and as performing a therapeutic role in alleviating problems have all been exhibited. The first and fifth relationships (religion as an expression of mental disorder and as a source of problems) have not been shown, although this may be more due to the angle of this thesis than lack of evidence in general research. Research does exist which demonstrates these relationships through a negative correlation between religion and health, and the conflict between this and the studies showing the opposite has not been clarified. Gall and Guirguis-Younger outline this conflict and refer to research which has found negative effects of religious coping mechanisms on well-being: one study by Richards and Folkman concluded that bereaved individuals who spoke of religion and spirituality in coping with the death of a loved one from AIDS reported more depression and anxiety and less positive states of mind compared with those who did not reference religion and spirituality (2013, p.252). This is just one example to demonstrate that a negative relationship between religion and health has also been found. This investigation was to find out if a kind of rehabilitation was more helpful than others but given the limited scope it necessarily had to take, this had to be approached through analysing which programs were helpful - not which were unhelpful. This means that positive relationships were more likely to be found than negative relationships; wider research has shown that both exist when discussing religion and health in general. However, the important conclusion remains that these positive relationships have been exhibited for both RBR and NRBR.

With all three studies, it is possible that cause and effect have been conflated, although this is more likely with the Lazarus Project because of its extraordinarily high success rates. This singular strong positive relationship between religion and prolapse means that it becomes easy to attribute similar effects (prolapse, life-purpose, high religiosity) in many individuals to specific causes (conversion, religious teaching) which they all experienced, when this might not be accurate. Any number of external and internal forces might be working on one person; it might not be as simple as pointing to a specific kind of rehabilitation and concluding that it is more useful than others. Successful rehabilitation is surely as subjective as the individuals who participate in any program. The causes (particular types of treatment, how regularly one meets with a counsellor, one's opinion of their counsellor, et cetera) and the effects (lessened drug-craving, more emotional stability, easier exertion of self-control, et cetera) are not necessarily easily linked together. In some, or even all, cases, successful rehabilitation might be illogical and unpredictable.

The two studies on drug courts and programs in Chicago showed that there is a positive relationship between prolapse and a stable and crime-free lifestyle. This conclusion is to be expected and would fit in with most predictions of post-rehabilitation life. However, it is important to note that these are only two studies and their limitations have been mentioned or will be discussed below. They may indicate the positive relationships of Hood et al, but it would be shortsighted to stop at these conclusions - in all areas of psychology and religion, it is of course more nuanced than that and all psychological studies are likely to be restricted or flawed in some way. This research reaches indications, not definite answers. As many questions are raised as they are answered. Despite these limitations, caveats, and reminders it remains a reliable that a positive relationship between prolapse and community exists - and of course this is true for a religious community as well. However, in order to gain clearer insights into this relationship, improvements which could have been made to the studies investigated could be carried out in further research.

Improvements on the studies and further research.

Limitations specific to each study were listed in the previous chapter, but there is one overarching improvement which could have been made for all of them: the continued collection of data from the participants. Research should be made for at least several years after a rehabilitation program has ended. Ideally, it would carry on for as long as is feasibly possible; even for the rest of their lives. This becomes complicated when one is talking about lifetimes of research because of the practicalities of keeping track of a lot of individuals and even those who are conducting the studies might need to hand the data down to someone who can carry it on after they are no longer able to do so. However, the point is clear: the psychological intricacies of addictions and religiosity also depend on evolving contexts, and can hence be highly changeable. It takes time for people to discover new rhythms of life without addiction, and often there are unstable periods where new support systems are being created and then maintained. In order to understand these journeys and their fluctuations meaningfully, data must be gathered regularly over a long period of time.

It would also be helpful to ascertain levels of the participants' religiosity (or lack thereof) both before they enter the rehabilitation program and afterwards. This can be measured by

methods such as the Religious Orientation Scale and would provide a quantitative way of comparing the “before” and “after” levels of participants’ faith, rather than depending on only the “after” results. In this way, a fuller picture of the possible effects of RBR is given, as well as NRBR to make a legitimate comparison. It is important to be careful conflating cause and effect but this picture might be more useful in highlighting any direct relationship rehabilitation has on religiosity. After rehabilitation has finished, levels of religiosity could continue to be measured to see if there has been a long-term effect of RBR or NRBR - although conversion-based RBR might show more drastic changes. This could also be carried out with levels of spirituality, as this has been sometimes put in a different category to religiosity.

A longitudinal study could include both regular rates of relapse and levels of religiosity and non-religiosity. What relationship, if any, exists between fluctuations in religion and fluctuations in relapse? For example, this could demonstrate that even if positive levels of religiosity vary over time, it consistently correlates positively with prolapse. This would need to include analysing sources of support in the community in order to gain a better insight into the “religion versus community” issue. In this way, more reliable data can be gathered concerning the relationship between religion and rehabilitation. These studies might also help understand the idea of religion as a crutch or addiction because levels of religiosity and relapse might even out and become more stable or consistent over time. Fluctuations in addictive behaviour, whether this is with alcohol, drugs, or religion, would hence be more obvious over a long-term investigation. This also allows individuals to gain more understanding of their own religious journey over time and their relationship with their addiction and faith. For example, over time they might realise that the inner void which they were trying to fill (unsuccessfully or unhealthily) with addiction has actually been filled with religion. Alternatively, this void could be filled with non-religious meaningfulness - for example, relationships, employment, or involvement in a secular community. To further this understanding, these studies could investigate the psychological processes of the core concepts of emotional regulation, coping, and self-control. Participants could be questioned on, for example: the intensity and regularity of their drug- or alcohol-craving; how strong their desire is to give in to this craving; whether they feel capable of coping with triggering situations (such as other people drinking or using around them); if this varies depending on whether any sources of comfort are present (whether this be other people who act as reassurance or in a specific context such as a church). Bringing together the issues of religiosity levels, relapse levels, meaningfulness, and the core concepts would give extremely helpful insights into the matter of rehabilitation.

As mentioned in the introduction, this area of study is remarkably lacking and much can be done to continue the investigation into comparing RBR and NRBR. A way to acquire psychological foci for these further studies is to realise which questions have been answered and which further questions have arisen from this investigation. One major issue which has arisen is how to disentangle facets of religiosity (or lack thereof) from its surrounding community. This also applies to the pros and cons of a religious community versus a secular or non-religious community. They can both provide the same functions shown in Hood et al’s relationships between religion and health, despite these being outlined for purely faith-based communities. Both offer aid to cope with life stress, a haven or protective agency or therapeutic role for mental problems, and a source for problems which can be hazardous to one’s health.

Communities can be strong positive or negative influences for those both in need of rehabilitation and also those having received it, whether they involve prominent religious elements or not. The roots of this issue lie so deep in society that it is perhaps not possible to get to the bottom of them: we are not aware of a society that has an entire absence of any religiosity or spirituality. Even in countries without a state (or official) religion, many laws are inspired, based on, or in keeping with older religious laws from times when state and religion were more outwardly intertwined. This is especially true of the Christian-based laws in America, which does not have a state religion despite the majority of the population adhering to Christian movements. How can we therefore make a proper comparison between religious and non-religious communities? Because of the community-based environment within which all rehabilitation functions, this is hence a problem for comparing RBR and NRBR.

There are two important elements to analyse when comparing predominantly religious and predominantly secular societies: stability and conservatism. It might be found that religious societies have more consistent but conservative attitudes towards alcohol and drug use, whereas secular societies are more liberal but changeable in their views. Conservative contexts are likely to negatively affect those in need of or participating in rehabilitation, whereas liberal communities might be more supportive and accommodating of addiction problems. This is pure speculation but these relationships affect which kind of treatment is available and which people are more likely to want to participate in. These aspects also need to be taken into account when assessing the relationship between religion or non-religion and the community. It is possible that meaningful answers cannot be found in the attempt to disentangle religion from the community and it is difficult to conceptualise how this might be done, but the attempt is necessary for this discussion.

It could prove fruitful to compare types of RBR amongst different religions and see if they have different results: for example, if monotheistic faiths or polytheistic faiths prove to aid more successful rehabilitation. This could lead to a more specific analysis between rehabilitation of different faiths (such as Scientology, Judaism, or Buddhism) and NRBR, rather than just Christianity. The difficulties for this include accounting for the countless varying traditions in one faith alone: Christianity has many denominations and each have their own approach to tackling addiction. This paves the way for many cross-comparisons to be done both within and without specific “umbrella” religions. This could also be investigated geographically: for example, comparing Christian RBR in America with Christian RBR in Europe, or particular European countries. Because Europe is seen as a relatively secular continent (though of course this varies between countries and regions - and things may not always be as they seem) it might be speculated that RBR is less common here, though that might not necessarily affect its effectiveness. In fact, RBR might be even more effective in places where it is less common because a more religiously fervent section of society would participate in it. This might prove for high rates of prolapse and therefore more “successful” rehabilitation.

The motivations behind religious or non-religious people choosing which rehabilitation program to attend (if they are not hospitalised and sectioned against their will) is another important factor to investigate. For example, if a Christian person with a drug addiction believed that they were committing a sin and would go to hell because of it, would they voluntarily go to an RBR centre? They might be afraid of religious condemnation - or they might think that this

kind of treatment is the only kind that can truly help them because it would understand their religious perspective. This leads to the problem of subjective religiosity: is it possible for people to find RBR centres with the same attitudes as them? This is true of NRBR as well because atheist or agnostic individuals may disagree with the outlooks taught in non-religious addiction treatment. It could be argued that in general it is important for people to encounter perspectives which challenge their own worldview. In rehabilitation one is especially vulnerable and this could mean that they would react negatively to this encounter; or it could be exactly what they need to help cope with their addiction. However, it might be predicted that those who are in need of this challenge are the ones who do not want it, and those who want it might not be helped by it. These considerations are important in understanding people's motivations, and the consequences thereof, for selecting rehabilitation centres.

Ellison and McFarland claim that many American sociologists and other observers have come to view the American religious landscape as "a marketplace in which individuals shop and choose their religion and in which religious groups compete for members and other resources" (2013, p.21). An individualistic approach to religion has largely characterised the West since the Enlightenment and there are many ways in which religions have overlapped and influenced each other. It is even seen as fashionable to incorporate typically Eastern traditions, such as yoga or meditation, into other religions, or even into atheistic and agnostic lives. This syncretistic way of life could play a role in how people decide which rehabilitation to enter: for example, would an atheist willingly partake in addiction treatment that was religion-based or even conversion-focussed if it was supposed to yield better results? Is this type of treatment likely to still work for them even if they do not belong or want to belong to that faith? Does the success of rehabilitation lie in the type of treatment received or the attitude and beliefs which one goes into the treatment with? Attitudes of participants could be assessed upon entering various RBR and NRBR programs to attempt to answer these questions. Places such as hospitals, doctors' surgeries, and guidance counselling centres could also help with these issues: those who work there could be questioned or even hand out questionnaires to people who come to them with addiction problems to understand their motivations towards and opinions of different types of rehabilitation.

Arnold, Avants, Margolin, and Marcotte carried out a study investigating HIV positive drug-users enrolled in an inner-city methadone maintenance program. It is presumed that this took place in America; Arnold et al write that eleven participants were white, five were African American, and five were Hispanic (2002, p.321). The two relevant aims of this study were: to explore perceived relationships among spirituality and abstinence, harm reduction, and health promotion, and to assess perceived helpfulness of a spirituality-based intervention for various aspects of recovery by sex, race, and HIV-serostatus (2002, 320). Some of the results from this study reflect the results from the Lazarus Project:

- Praying and belief in a higher power were most commonly cited as coping strategies in recovery from addiction: 19 of the 21 participants prayed or meditated at least once or twice a week, with 8 of those praying on a daily basis.
- Spirituality was conceived as a protector or helper to self in these, as group members asked for forgiveness or strength, and "many participants claimed that

it was due to their belief in God that they had achieved abstinence in the past or were currently clean" (Arnold et al, 2002, pp.322-323).

This study went one step further and also investigated participants' attitudes to the inclusion of spirituality in their treatment. Overall, they reported interest in having a spiritual or religious component to their addiction treatment, claiming that it would be helpful for reducing craving and HIV-risk behaviour, following medical recommendations, and increasing hopefulness (Arnold et al, 2002, p.324). Of course, it is possible that this helpfulness would not be realised in practice, but it is useful to know individuals' perspectives on the concept of RBR in general. Despite the very limited size of this study, it is a small plug in the vast hole of this area of research.

Religion as a rehabilitative tool, especially conversion, represents what is essentially a transformation of the self and the self's attitude. Sometimes this "mind over matter" will be enough to help an individual come to terms with addiction and improve their physical and mental health. However, this mind over matter concept can also be found in NRBR which leads to the question: is there a non-religious version of self-transformation that is similar to a religious or spiritual conversion? This is related to the ideas of changes in life-meaning discussed earlier. Arguably, any individual who goes through any kind of rehabilitation and experiences a change in life-meaning also experiences a transformation of the self. It could be interesting to investigate whether there is a difference between religious and non-religious self-transformation through addiction rehabilitation. This could be measured through sources of life-meaning and concepts of life-purpose, found in Schnell's Sources of Meaning and Meaning in Life questionnaire. It contains two separate scales to measure meaningfulness and crisis of meaning relating to 26 sources of meaning, thus enabling researchers to correlate the absence and presence of positive as well as negative experiences of meaning with other psychological variables (2009, p.484). This would give a well-rounded insight into life-meaning and is not directly related to religion, thus allowing for both religious and non-religious answers.

The possibilities mentioned are just a few of the many ways in which this topic of research could be furthered. Unfortunately, it is not possible to delve into more details of how this could be done, but the general issues which can be investigated have been mentioned. Answers to these issues would help understand the questions of this thesis.

Implications.

The implications for this kind of research are threefold: health-related, practical, and communal. The reasons stated in the Introduction for the importance of rehabilitation could be repeated here because the rationale behind this thesis illustrates these implications. As has been repeated, rehabilitation on the individual level is about improving both physical and psychological health of those who participate in it. The kind of treatment they receive for addiction problems is important for their lifelong health; it could be "make or break." People's lives hang in the balance and hence it is important that rehabilitative institutions are helpful for those entering them. Practically speaking, on a financial, governmental, and charitable level, the money and time invested into rehabilitation centres are thus of huge significance. Any psychological studies which find particular types of program to be more useful than others should be taken note of because they are evidence of successes and failures, whether this be in the treatments themselves or the outcomes of the program as a whole. On a communal level, it

is important that those in need of or coming out of rehabilitation feel supported by their environment and have opportunities within it to seek and receive the help they need. This improves the atmosphere of the community for everyone in it and eases reintegration.

Although these implications have only been mentioned briefly, their importance has been registered through previous chapters in this thesis. In amongst all of these three implications there are consequences for religion as well: if one type of rehabilitation is shown to be more helpful in treating addiction, what does this mean for the followers and authorities of that tradition? Should they reassess their approaches to addiction in general or should we insist on everyone maintaining their own beliefs, even if they have been shown to be antagonistic towards people's health? Of course, religious authorities and followers have every right to ignore any kind of psychological research, as do secular authorities and individuals. The implications for religion constitute another thesis in themselves, but these questions are relevant to raise here. Researching these issues further could go some way to improving rehabilitative and communal life for those with addiction problems, and the importance of this potential should not be diminished.

Bibliography.

Introduction.

Books.

Hood Jr, R. W., Hill, P. C., Spilka, B., *The Psychology of Religion: An Empirical Approach* (Guilford Press, 2009).

Chapters.

Ellison, C. G., McFarland, M. J., "The Social Context of Religion and Spirituality in the United States," in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 1* (American Psychological Association, 2013) pp.21-50.

Johnson, T. J., "Addiction and the Search for the Sacred: Religion, Spirituality, and the Origins and Treatment of Substance Use Disorders" in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 2* (American Psychological Association, 2013) pp.297-317.

McCullough, M. E., Carter, E. C., "Religion, Self-Control, and Self-Regulation: How and Why are they Related?" in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 1* (American Psychological Association, 2013) pp.123-138.

Reports.

Center for Behavioral Health Statistics and Quality, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (2015).

National Center on Addiction and Substance Abuse at Columbia University, *Guide for Policymakers* (2015).

United Nations Office on Drugs and Crime, *World Drug Report 2015* (New York, 2015).

World Health Organization, *Global Status Report on Alcohol and Health 2014* (Luxembourg, 2014).

Websites.

http://www.oxforddictionaries.com/definition/english/rehabilitate

http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

http://www.presidency.ucsb.edu/ws/?pid=3048

https://www.templeton.org/who-we-are/about-the-foundation/mission

Chapter I: The Relationships between Religion and Health.

Books.

Hood Jr, R. W., Hill, P. C., Spilka, B., *The Psychology of Religion: An Empirical Approach* (Guilford Press, 2009).

Chapters.

Johnson, T. J., "Addiction and the Search for the Sacred: Religion, Spirituality, and the Origins and Treatment of Substance Use Disorders" in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 2* (American Psychological Association, 2013) pp.297-317.

Marlatt, G. A., Witkiewitz, K., "Relapse Prevention for Drug and Alcohol Problems" in *Relapse Prevention, Second Edition: Maintenance Strategies in the Treatment of Addictive Behaviors* (Guildford Press, 2005) pp.1-44.

McCullough, M. E., Carter, E. C., "Religion, Self-Control, and Self-Regulation: How and Why are they Related?" in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 1* (American Psychological Association, 2013) pp.123-138.

Journals.

Redish, A. D., Jensen, S., Johnson, A., Kurth-Nelson, Z., *Reconciling reinforcement learning models with behavioral extinction and renewal: implications for addiction, relapse, and problem gambling*, Psychological Review (vol.114 no.3, 2007) pp.784-805.

Websites.

http://www.oxforddictionaries.com/definition/english/relapse

Chapter II: The Relationships between Religion and Rehabilitation.

Books.

Hood Jr, R. W., Hill, P. C., Spilka, B., *The Psychology of Religion: An Empirical Approach* (Guilford Press, 2009).

Pals, D., *Nine Theories of Religion* (Oxford University Press, 2014).

Chapters.

Johnson, T. J., “Addiction and the Search for the Sacred: Religion, Spirituality, and the Origins and Treatment of Substance Use Disorders” in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 2* (American Psychological Association, 2013) pp.297-317.

Journals.

Granqvist, P., *Mental Health and Religion from an Attachment Viewpoint: Overview with Implications for Future Research*, Mental Health, Religion & Culture (vol.17 no.8, 2014) pp.777-793.

Halama, P., Halamova, J., *Process of Religious Conversion in the Catholic Charismatic Movement*, Archive for the Psychology of Religion (vol.26 no.1, 2005) pp.69-91.

White, W., Whiters, D., *Faith-based Recovery: Its Historical Roots*, Counselor (vol.6 no.5, 2005) pp.58-62.

Williamson, W. P., Hood Jr., R. W., *The Lazarus Project: A Longitudinal Study of Spiritual Transformation among Substance Abusers*, Mental Health, Religion & Culture (vol.15 no.6, 2012) pp.611-635.

Wormith, J. S., Althouse, R., Simpson, M., Reitzel, L. R., Fagan, T. J., Morgan, R. D., *The Rehabilitation and Reintegration of Offenders*, Criminal Justice and Behavior (vol.34 no.7, July 2007) pp.879-892.

Websites.

http://www.ayahuasca-info.com/introduction/

http://www.britannica.com/topic/New-Age-movement

http://www.britannica.com/topic/theosophy

http://www.kunphen.org/about/

http://www.religioustolerance.org/newage.htm

http://www.thetibetpost.com/en/news/exile/1799-drug-use-hivaids-alcohol-abuse-on-the-rise-amongst-youngsters

http://www.tibetrelieffund.co.uk/kunphen-hiv-and-drugs-awareness/

http://users.skynet.be/keltic/kunphen.html

Chapter III: The Analysis of Studies.

Books.

Hood Jr, R. W., Hill, P. C., Spilka, B., *The Psychology of Religion: An Empirical Approach* (Guilford Press, 2009).

King James Version of the Bible.

Journals.

Adhiyaman, V., Adhiyaman, S., & Sundaram, R., "The Lazarus phenomenon" in *Journal of the Royal Society of Medicine* (vol.100 no.12, 2007) pp.552–557.

Dennis, M. L., Foss, M. A., Scott, C. K., *An 8-year Perspective on the Relationship between the Duration of Abstinence and Other Aspects of Recovery*, Evaluation Review (vol.31 no.6, 2007) pp.585-612.

Williamson, W. P., Hood Jr., R. W., *The Lazarus Project: A Longitudinal Study of Spiritual Transformation among Substance Abusers*, Mental Health, Religion & Culture (vol.15 no.6, 2012) pp.611-635.

Reports.

Belenko, S., *Research on Drug Courts: A Critical Review* in National Drug Court Institute Review (vol.1 no.1, June 1998) pp.1-42.

Chapter IV: Conclusion and Further Research.

Chapters.

Ellison, C. G., McFarland, M. J., "The Social Context of Religion and Spirituality in the United States," in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 1* (American Psychological Association, 2013) pp.21-50.

Gall, T. L., Guirguis-Younger, M., "Religious and Spiritual Coping: Current Theory and Research," in Pargament, K. (ed) *APA Handbook of Psychology, Religion, and Spirituality Volume 1* (American Psychological Association, 2013) pp.349-364.

Journals.

Arnold, R. M., Avants, S. K., Margolin, A., Marcotte, D., *Patient Attitudes Concerning the Inclusion of Spirituality into Addiction Treatment*, Journal of Substance Abuse Treatment (vol.23 no.2, 2002) pp.319-326.

Schnell, T., *The Sources of Meaning and Meaning in Life Questionnaire (SoMe): Relations to Demographics and Wellbeing*, The Journal of Positive Psychology (vol.4 no.6, 2009) pp.483-499.