Religious Addiction and The Family System: 
Implications for the Family Clinician

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This paper explores how a religious belief system could be considered an addiction in the same way alcohol and drugs are addictions. Various aspects of substance addiction are reviewed in terms of their implications for addiction as religious belief systems. A systems perspective of religious addictive families reveals that addictive families tend to have rigid communication patterns. In addition, religious addictive families tend to have an imbalance in the religious and secular rituals which may be expressed through family life cycle transition dysfunctions. Treatment issues of religious addicts are multifaceted and represent a number of interdependent factors. Clinicians must view the religious addiction within the context which may extend beyond the family. The clinician views the religious addiction as symptomatic behavior which develops similarly to other family dysfunctions. In addition to reducing stress in the family life cycle, the clinician also may want to strengthen secular family rituals.

The relationship of religious and substance addiction is multifaceted. For some researchers the lack of religion or spirituality causes substance addiction (Giannetti, 1987; Clinebell, 1963), while others view religion as a collective neurosis which is the root of many people's maladjustments (Freud, 1961).

The adaptive role and function of religion for individuals has been well documented in the extant literature from various disciplines (Allport, 1950; Berger, 1967; Tillich, 1952). The adaptive functions of religion include helping individuals adjust to both normal and unexpected change (Durkheim, 1961; O'Dea, 1970). Religion provides a sense of meaning to life (Frankl, 1962; Weber, 1922) and the discovery of "the self" in relationship to "ultimate reality" or God (Tillich, 1952). In addition to aiding individual adjustment and finding meaning in life, religion tends to justify the social conformity of individuals (Berger & Luckman, 1967; O'Dea, 1970; Parsons, 1960). An individual experiences the integration of personal meaning and social conformity by the participation in religious rituals (O'Dea, 1970).

While most religious expressions are adaptive, the purpose of this paper is to explore how religious belief systems might be nonadaptive or addictive. In other words, can religious belief systems be addictive in the same way as alcohol and drugs can be addictive? Although little research exists on the relation of religion and addiction, a body of literature exists on each independently. This paper will draw inferences on this relation of religion and addiction and discuss the implications for family therapists in treating such families.

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In order to accomplish this objective, "addiction," "belief systems," and "religion" must be understood and defined. In the context of this paper a belief system is defined as a logical set of premises or assumptions about the nature of reality. Continuing in this line of thought, religion is defined as a particular belief system concerned with understanding the meaning of life and one's personal identity, along with the need for transcendence (Berger, 1967). Addiction is defined as a person's attachment to a sensation, an object, a person, or the like, such as to lessen his/her appreciation of and ability to deal with other things in the environment or in himself/herself, with such attachments producing gratification for the individual (Peele & Brodsky, 1975).

Keeping these definitions in mind, religious addiction could be defined as a religious belief which lessens one's appreciation of and ability to deal with things in his/her environment or lessens the reliance on oneself. The term "religious addict" will refer to a person who meets these criteria. The caveat in the relation of religion and addiction is understanding how particular religious expressions may be considered addictive while other religious expressions do not have such an effect.

To understand how particular religious beliefs and practices can be addictive, key aspects of substance addiction will be discussed in terms of their addictive expression in a religious belief system. Second, a systems perspective of religious addiction in families will be discussed. Finally family treatment issues will be noted and a case example will be discussed.

**RELIGIOUS BELIEF SYSTEMS AS AN ADDICTION**

While this paper acknowledges that numerous theories of substance addiction have been elaborated, no one theory has adequately explained the complexities of substance addiction. Some theories view addiction as primarily a medical condition or chemical dependency arising from a biological predisposition, while other theories view it from psychological or sociocultural models (Armour, Polich, & Stambul, 1978). This paper is based on the assumption that substance addiction is determined by personality structure, traits, or beliefs which create an "addictive personality," constituting a psychological predisposition to develop an addiction. The following discussion outlines how religious addiction might be developed in the same way as a psychological addiction develops.

First, substance addiction has been linked to an escape from reason and painful experiences (Lenters, 1985). This addictive process is a numbness of the senses where the addict does not have to face consciously the painful existential questions of loss, disappointment, and ultimately death. Consequently, the addict slowly sinks into the existential void of nothingness that, paradoxically, is so desperately being avoided.

Religious belief systems can be used to easily escape from painful reality by relying on God to ease or lessen the burdens of life. In a similar way that the addict lacks confidence to deal with life adequately (Simmonds, 1977), the religious addict lacks confidence to face life squarely and uses the religious dogma to provide a shield to ward off this inadequacy (Peele & Brodsky, 1975). Although this escapism in religion may occur in any form, some religious belief systems tend to foster and encourage escapism. For example, fundamental Christianity asserts the need of an intimate, personal relationship with God. Generally, the focus is on unexplainable experiences rather than on a rational and critical exploration of experience (Glock, 1964; Simmonds, 1977). The healthy conversion experience of consolidating and forming a self-identity (Gordon, 1974) may be missing from the religious addict's feverish attempts to find solutions to life's problems.

Second, religious addicts are more likely to be found to have alcoholism (Simmonds, 1977). Studies by Lenters, Armstrong, & Suchmen (1950) found a relationship between alcoholism and religious beliefs. The dynamic between the alcoholic and the religion polarize the two, resulting in an "either/or" emphasis in determining the expression of the addiction in determinants.

Third, religious addicts are more likely to take more than one form of addictive behavior, including God credo, the act of taking religious belief as a choice (Simmonds, 1977).

Fourth, religious addicts are more likely to frequent religious beliefs and practices than addicted to a chemical response. As a result, even more religious addiction and spiritual addiction are fostered. For example, the religious belief systems of fundamental Christianity may be considered to as the need for the denial of any addiction and the denial of the fact that the particular acts of the Jesus Christ are an addiction (Simmonds, 1977).

Fifth, religious addiction is frequently viewed as a psychological or sociocultural phenomenon that is more frequently harmful than addictive. Religious dogma is used by religious addicts to provide a shield to ward off their inadequacies. Religious addiction has been found to occur in families through a carrier phenomenon in alcoholism (Simmonds, 1977).

Sixth, religious addiction is more frequent in particular religious beliefs and practices.
life's problems. This ritualization of conversion experience by fundamentalists has been found to fail to resocialize the convert toward psychologically healthier behaviors (Simmonds, 1977).

Second, substance addiction is related to a dependency on alcohol and drugs (Lenters, 1985). Religious beliefs have been associated with greater dependence on external resources (Black & London, 1966; Fisher, 1964; Goldsen, Rosenberg, Williams, & Suchman, 1960; Simmonds, 1977). Addictive religion, therefore, could be seen as an unhealthy dependency on religious dogma, or a personal relationship with God (Allport, 1950). The issue in dependency is not so much independency versus dependency, but between addictive dependency on an outside source and dependency on a dynamic religious experience (Lenters, 1985). While the healthy religious adherent would see a dynamic balance between independence and dependence, a religious addict would polarize them (Simmonds, 1977). For example, a religious addict would place more emphasis on the external hand of God in life situations than on one's individual choices in determining those life situations (Fisher, 1964).

Third, substance addiction has been described as an avoidance of taking moral responsibility for one's life (Lenters, 1985). The religious addict could be seen as failing to take moral responsibility for life decisions when he/she compulsively insists on giving God credit for achievements and successes. If God is responsible for every behavior, the religious addict neither accepts success nor failure as a consequence of freedom of choice (Simmonds, 1977). God is ultimately responsible for both good and evil.

Fourth, addiction is characterized as continuous and exchangeable, i.e., an addict frequently changes or substitutes one addiction for another (Lenters, 1985). A person addicted to one substance may, in "curing" that addiction, become addicted to another even more debilitating drug. In terms of religious addiction, it would seem logical that addictive religious belief systems would be appealing to persons who have other addictions. For example, in the late 1960s, former hippies were converting to fundamental Christianity in large numbers. This turning to Christianity was referred to as the "Jesus Movement" (Simmonds, 1977). Researchers of the Jesus Movement have concluded that this switching to religion by former hippies was simply replacing one addiction for another (Peele & Brodsky, 1975; Simmonds, 1977). Since many adherents of the Jesus Movement appeared to be searching for meaning and security, the conversion to Jesus was only a different context to search for such meaning and security (Simmonds, 1977).

Fifth, a major aspect of addiction is denial, i.e., refusing to admit one's addictive behavior and, consequently, forming rigid and non-critical cognitive patterns (Clinebell, 1963). Denial becomes the basis of the addict's self-system. The denial of alcoholism gives a false sense of control over one's life and relationships (Denzin, 1987). In religious addiction, one subsumes one's knowledge under the umbrella of a larger structure which may represent the particular beliefs of a charismatic leader (Simmonds, 1977; Peele & Brodsky, 1975). As Allport (1950) noted for unhealthy religion, the religious addict would be able to rationalize or moralize any questionable behavior through a belief system. Holding on to these beliefs in the face of circumstances or situations where relying on faith in God would be more appropriate, the religious addict never comes to grips with real experience (Simmonds, 1977). In the same way that the alcoholic denies the need for help (Denzin, 1987), the religious addict refuses to surrender his/her limited belief system (Simmonds, 1977).

Sixth, substance addiction is related to the disintegration of relationships, particularly the family (Lenters, 1985). In religious addiction, there frequently can be
a discontinuity between the generations (Markowitz, 1983). This discontinuity was quite apparent in the Jesus Movement where adolescents practiced a traditional form of religion that seemed to punctuate their separateness and alienation from their families rather than usher them into dialogue with family members (Markowitz, 1983). In families where one member tends to be a religious addict and other members are not, it can be assumed that a barrier exists in that family to reduce cohesion and unity.

In summary, religious addiction can be viewed as an individual's attempt to deal with painful life experiences by escaping through supernatural means. Addictive religion could be related to an unhealthy reliance on religious dogma rather than taking responsibility for one's decisions. There is a tendency for the religious addict to have previous addictions and to have replaced them with religion. The religious addict is uncritical of his/her belief system and intolerable of those who question it. Finally, there is discontinuity in the religious addict's family relationships. Generations may be divided by these beliefs and the family may suffer from lack of cohesion.

A SYSTEMS PERSPECTIVE OF ADDICTIVE FAMILIES

Belief systems are usually associated with the internal life of the individual and, consequently, are viewed primarily in the literature as intrapsychic phenomena. The underdevelopment of individual or intrapsychic processes in a systems perspective impedes the development of the function and role of belief systems in the family.

An individual belief system such as a religious belief system is a belief about the nature of reality in the context in which it occurs (Minuchin, 1974). A belief system is governed by rules which are expressed through the family communication process (Steier, Stanton, & Todd, 1982), which is concerned with both maintaining the system and maintaining the dysfunction as well. The communication process has been researched in families of alcoholics (Steinglass, Weiner, & Mendolson, 1971) and drug addicts (Klagsbrun & Davis, 1977; Stanton et al., 1978). Families with a member addicted to drugs have been characterized as having a communication system that is both dysfunctional and maintains the dysfunction (Stanton et al., 1978).

The addicted family might be characterized as being overly concerned with stability which results in rigid organization of communication patterns or pathological homeostasis (Steier et al., 1982). Research in the area of communication in addictive families has focused on two dimensions -- who speaks for whom and who allies with whom. It would be assumed that a more rigid pattern exists in addictive families in these two dimensions. A recent finding is that while addictive families display a more rigid communication pattern than normal families, the rigidity for a given dimension may vary (Steier et al., 1982). For example, some families may be rigid on the category of who speaks for whom but not on who allies with whom, while other families may function in an opposite manner.

Recently, more focus has been placed on understanding the shared identity in the family through a greater analysis of family rituals, i.e., the family's repetitive behaviors which are acted out in a systematic fashion over time (Wolin & Bennett, 1984). Family rituals help establish family identity through understanding the roles, establishing the boundaries within and without the family, and defining the rules. As such, the family ritual is designed to maintain and perpetuate a family's paradigm or system of shared belief, which shapes its interactional style with the outside world (Reiss, 1981).
Cultural anthropologists have focused on the religious ritual to the exclusion of secular rituals (Boas, 1911; Greetz, 1973; Malinowski, 1955). These anthropologists believe that the sacred or magical, usually expressed as myth, underlies all rituals. The enactment of the ritual also has a cohesive function for the participants binding them together as a group. Rituals consist of certain group activities which defined both the role of the deity and the role of humans (Malinowski, 1955). The sacred ritual allowed primitive man a chance to control frightening and unexplainable reality (Greetz, 1973).

More recently attention has been paid to secular rituals, or rituals which regulate and educate its members about their behavior. Family celebrations such as holidays promote both the nuclear family unit and the external family and social network. Each family has unique traditions which reoccur and provide regularity in the family. These traditions include visits with extended families, family reunions, vacations, anniversaries, and birthdays. Daily life and activities are organized through a third type of ritual referred to as family interactions. These activities include regular mealtime, bedtime for children, friends visiting in the home, and weekends (Wolin & Bennett, 1984).

Rituals are related to an understanding of pathology in the family in that those families that become stuck in certain patterns are generally inflexible and do not adjust to changes well (Wolin & Bennett, 1984). Early married couples form rituals that must be added to, changed, or discarded when a child is born. Parenting behaviors create a completely new set of rituals which also must be revised and adapted as children move through stages of development (Roberts, 1987). Some periods demand more ritual participation than others, but they must be flexible, particularly as the family moves through the normal life cycle and also experiences unexpected changes, such as change in family income, divorce, remarriage, death or interment of the older generation (Wolin & Bennett, 1984). While it is true that many religious rituals become secular events, it appears likely that certain rituals are needed for religious expression and different rituals are needed for secular events. Whether religious and secular rituals are seen as two polar ends of the same continuum (Yinger, 1963) or as separate constructs, it seems reasonable that imbalance in rituals can occur in families.

This paper assumes that functional families are balanced in secular and religious rituals. Dysfunctional families are skewed toward either the secular or the religious end of the continuum. Religious addiction could be explained from this perspective as resulting from a skew in the family toward the religious end of the ritual continuum. This skew may take place as a result of failure to adjust to normal changes in the family life cycle. It also could result from and be perpetuated by a rigid and dysfunctional communication system. Religious addiction may be viewed as an attempted solution to stress in the system. As the stress increases in the family, one or more members move toward the religious end of the continuum to reduce stress. The increase in the religious ritual would decrease other more functional rituals. In systems terms, the attempted solution has become the problem (Haley, 1980).

IMPLICATIONS FOR THE CLINICIAN

Religious addiction for the most part has gone untreated by family therapists (Schwartz & Kaslow, 1979). The prevailing attitude has been to see religious addiction in terms of other systems problems. For example, when a 19 year old adolescent leaves home to join a cult, the family therapist may reframe this behavior as part of the life cycle stage of leaving home. When presented with a cult phenomenon, parents either have ambivalence toward taking a firm stand (Markowitz, 1983), or because of guilt, they turn against their spouse. The involvement of the adolescent in the cult experience can
exaggerate inactive conflicts in the marital relationship. The families with adolescents belonging to a religious cult adapt poorly to change and the transition to adult life for the adolescent is extremely difficult (Markowitz, 1983).

No doubt the family life cycle stage of launching is occurring in these families with adolescent cult members and provides a plausible explanation for the family's dysfunction. Other events, occurring simultaneously perhaps, characterized as religious and secular rituals, may influence such behaviors in families. The religious or spiritual rituals of these families may have been underdeveloped and the adolescent cult member's behavior may be an exaggerated attempt to meet this need.

Treatment Issues

This paper assumes that treatment issues of religious addicts are multifaceted and represent a number of interdependent factors. A single theory for understanding these individuals would be insufficient to explain the dynamics of these various forms. Instead of developing a particular treatment modality for religious addiction, this paper will discuss treatment issues based on family systems theory and the preceding discussion of the development of religious addiction.

First, and perhaps most importantly, the clinician must view the religious addiction in a familial or social context. The familial context acknowledges that even belief systems are communicative and not developed in isolation. While the context may not extend beyond the family in some dysfunction, in religious addiction the context may be broader than the family and include friends, church or body of believers, and community. The need to change that larger context while remaining within the same relationship boundaries, however, is often the goal of treatment. The therapist should aid the religious addict in altering this larger social network and differentiating emotionally from it.

Second, the function the religious addiction serves in this social context should be addressed. Does it bind together the participants in a whole or cohesive unit? Does it serve a homeostatic function? Is the increase in religious fervor predictable in the family setting? These are interesting questions and are generated from the systems concept of homeostasis (Minuchin, 1974). The assumption is that a religious addiction could serve a homeostatic function to balance the system against other threats to the stability of the family.

Third, religious addiction in the family could be seen as a metaphor for a dysfunctional system. It is important for the therapist to determine what the family is avoiding through the religious obsession. It can be assumed that the religious ritual has decreased other rituals necessary for functional families. Research with alcoholics indicates that when secular rituals are operational, there is less intergenerational transmission of alcohol addiction (Wolin & Bennett, 1984). If people tend to compensate for felt deprivations either through secular or religious means (Glock, 1964), religious addiction represents an attempt by a member or members of a family to adapt to a dysfunctional system. As a result, it can be expected that religious addiction in families would interfere with the development of appropriate secular rituals.

Fourth, not only can religious addiction be a metaphor for the family's dysfunction, it is seldom the presenting problem. Usually another problem, such as marital communications or a noncompliant child, is the presenting problem. Since it is rarely the presenting problem, it is understandable how therapists have ignored religious addictions in families.
Fifth, religious addiction like other forms of family dysfunction could be related to
transitions in the family life cycle. For example, it can be expected that as families fail
to adjust to a particular lifecycle stage, a religious addiction by one member or the whole
family, may be likely to form. This response to stress through a religious addiction
would be similar to the development of other forms of family dysfunction, including
schizophrenia.

Case Example

The Jones family consists of a husband, a wife, and two children, a boy 17 and
a girl 11. Mr. and Mrs. Jones are both employed and work different shifts.
Mr. Jones works during the evening and Mrs. Jones works during the day.
This difference in schedules means that family activities are infrequent, and
Mrs. Jones must make much of the family decisions alone. The Joneses
consulted with a therapist because their 17 year old son, Dane, was refusing
to do chores at home. This “attitude” problem also was witnessed at school
in that his grades had plummeted from A’s to barely passing. His sister was
non-symptomatic and appeared to be a normal adjusted child. Mr. Jones was
very angry and disappointed at his son and reminded him frequently of their
close relationship in the past, such as going on fishing and camping trips. Mr.
Jones also lamented his son’s new activities, such as his involvement in rock
music and adolescent hero worship of rock stars. Mrs. Jones sided with her
son against her husband on these matters, believing that her husband was too
tight and harsh. While no family member had been religious in the early years
of marriage, Mr. Jones had recently joined a church which was devoted to
Biblical teachings. He had been a heavy drinker before his conversion. His
attempts at involving his wife and children in his religious activities were met
first with passive resistance in that they attended church with him to appease
him. Later, neither his wife nor his children would attend church with him
which increased his religious zeal. Mr. Jones began reading his Bible to both
his wife and his son to support his religious view of family relationships. The
son’s response was to increase non-compliant behavior in school and at home.
When Mrs. Jones admitted to a recent affair, Mr. Jones reacted little
outwardly and claimed to forgive and forget. Only when he became angry at
his wife about other matters, particularly her support of Dane rather than
him, did he mention her affair.

Treatment with this family would involve a number of issues. First, on the surface
this case appears to be a typical family with a non-compliant adolescent teenager. With
some probing into the dynamics, however, a more complicated picture of family
dysfunction emerges. For example, Mr. Jones had a history of alcohol abuse as a young
adult and continued to drink throughout the marriage until he was converted, when he
renounced his former behavior and began “living for God.” Shortly after his conversion,
Dane began experimenting with drugs and alcohol and doing poorly in school. Part of
Mr. Jones’ religious fervor is to prevent Dane from following in his footsteps. Perhaps
Mr. Jones is reliving some of his past in his own family of origin through his son’s poor
adjustment to adolescence.

Secondly, family rituals are disrupted in this family. While father and son enjoyed
fishing and camping in the past, these secular rituals have disappeared as Mr. Jones has
become more religious. The work schedule prevented the sharing of many family rituals
as well. One focus in treatment of this family is the development of secular rituals
which are meaningful for family functioning. For example, the therapist could bring

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father and son together through suggesting they go on a weekend camping trip or any activity that they would find meaningful.

Third, it is clear that this family is struggling with the issue of cohesiveness and identifying itself as a family unit. This lack of identity and confusion of family roles may explain why young Dane is doing poorly in school, Mrs. Jones is having an affair, and Mr. Jones is into religion. This confusion of family identity and role completion may be related to poor adjustment to the adolescent life cycle stage. The parents adjusted appropriately at early periods despite their work schedules, but they are not able to adjust at the present stage. The therapist could redirect energies in this family toward changing roles and responsibilities. For example, changing work schedules, or assigning Mr. Jones more parental responsibilities, might reduce the tension Mrs. Jones experiences in being responsible for most of the parenting decisions.

Fourth, Mr. and Mrs. Jones have many underlying conflicts in their spousal roles. Mr. Jones uses religion to justify his position and decisions while Mrs. Jones reacts by forming a coalition with the son. Her affair is further evidence of intrusion in the marital dyad. The therapist should encourage the parents to make joint decisions which both can reinforce. In addition, the therapist should explore more deeply the unresolved feelings Mr. Jones has about his wife's infidelity.

CONCLUSION AND SUMMARY

In conclusion, this paper is an attempt to understand how religious beliefs may be considered an addiction. The religious addict is one who has a decreased ability to deal with things in his/her environment and a decreased appreciation of or reliance on oneself. A religious belief system may be seen as addictive if it is used as an escape from painful reality by an unhealthy dependency on God as an external source of support. This excessive dependency on God results in failure to take personal responsibility for one's actions and decisions. Religious addiction also may be related to substituting one addiction for another. Denial for the religious addict results from a narrowing of reality to include only the limited beliefs allowed by the religious dogma. In religious addiction there is frequently disruption in family relationships.

In the family system, religious addiction can be understood as resulting from an imbalance in secular and religious rituals. This skew toward the religious end of the continuum may result from an attempt to reduce stress in the system as a consequence of normal changes in the family life cycle. This attempted solution through the religious ritual takes on a homeostatic function, reducing secular occurrence of more functional rituals.

Therapists working with families with a religious addiction problem must attempt to determine the role and function of the religious addiction within the family system. The religious addiction is viewed as a metaphor for a dysfunctional system. Treatment would focus on strengthening or creating more functional rituals. This maneuver would tend to create a structural change which would reorganize the system at a more functional level.

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