

Hawaii and Christian Religious Addiction

A Survey of Attitudes toward Healthy Spirituality and Religious Addiction within Christianity

by

James Slobodzien

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Christian Religious Addiction

A Survey of Attitudes Toward Healthy Spirituality
and Religious Addiction Within Christianity

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A Clinical Research Project submitted to the faculty of the
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Honolulu, Hawaii
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We, the Dissertation Committee, have read this paper and have found it to be acceptable in content and quality. It meets the requirements for the Doctoral Dissertation at the American School of Professional Psychology, Hawaii Campus.

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DEDICATION

To my parents, whose unconditional love, unwaivering guidance, and living example gave me the eyes to see the true meaning of healthy spirituality. Their continual support and understanding has given me the encouragement and perseverance to complete this project.

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Abstract

A literature review was conducted on the relatively newly recognized phenomenon of religious addiction within Christianity. The symptoms, beliefs, and stages of religious addiction along with the characteristics of religiously addictive organizations are also considered. In addition a religious attitudes inventory was designed to assess general spirituality, religious addictive beliefs, religious addictive symptoms, and church leadership practices. The author surveyed ministers, psychologists, psychiatrists, and the general public to assess the relationship between religious addiction and church leadership. More specifically, the purpose of this survey was to attempt to determine if religious addictive beliefs and symptoms are more positively correlated with churches structured upon a self-selected (authoritarian hierarchial) style of leadership versus an elected (collegial) style of church leadership. In the latter, power and authority is equally vested in each of a number of elected church leaders.

Inventories were sent to 452 ministers, 175 psychologists, 74 psychiatrists, and 431 members of the general public. Usable responses (Total N=320) were received from 126 ministers (28%), 116 psychologists (66%), 8 psychiatrists (11%), and 78 members of the general public (18%). The subjects were asked to rate how spiritually healthy or unhealthy 33 items

involving religious beliefs, symptoms, and church leadership practices are, according to a Likert type 5-point scale ranging from Very Healthy to Very Unhealthy. Standard demographic variables were also assessed to include church membership, religious affiliation, and church service attendance variables.

All six hypotheses tested were statistically validated at significant ($p < 0.05$) levels. The Self-selected Minister group indicated that significantly more religiously addictive- beliefs, symptoms, and church leadership practices were spiritually healthy, compared to the Elected Minister, Psychologist, and Public groups. A factor analysis of the 33 survey items of the Religious Attitudes Inventory extracted 6 factors which suggested commonalities with it's 4 scales.

The results of this survey suggest the possibility of a positive correlation between the self-selected minister group and their responses to religious addictive beliefs and symptoms. Further study of a prospective nature with larger samples is necessary to define this relationship more clearly. Additional research with onsite observation and assessments is necessary to adequately verify the possible link between religious addiction and church leadership practices. Future research must replicate this study with different samples to determine whether results obtained in the present survey generalize to similar groups.

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Introduction

Surveys show that religion and spirituality play a central role in the lives of most of the population in human experience. Gallup (1989) found that 53% of the U.S. population considers religion to be very important in their life, and another 31% considered it fairly important (p. 176). The religious and spiritual dimensions of culture were found to be among the most important factors that structure human experience, beliefs, values, behavior, and illness (Browning et al., 1990; James, 1961; Krippner and Welch, 1992).

Yet, theory, research, and training in psychiatry and psychology have largely ignored or over-pathologized the religious and spiritual dimensions of life. Traditionally, much of psychological theory has downplayed or dismissed patients' religious experiences and orientations (Sleek 1994, p. 8). A study of articles published in four psychiatric journals during a recent 5-year period showed that only 2.5% (59 of 2348) included religious variables (Larson et al., 1986, p. 329). Similarly, in a survey of members of the American Psychological Association, 83% reported that discussions of religion in training occurred

rarely or never (Shafranske and Maloney, 1990, p. 72). Religion and religious belief are basically neglected in psychology textbooks, in spite of the prominent role that religion plays in many people's lives (Kirkpatrick & Spilka, 1989).

A 1984 survey of religious preferences of academicians found psychologists to be among the least religious. 50% of the psychologists in this study responded that they had no current religious preference, compared with only about 10% for the general population ("Politics," 1991, p. 86). Bergen and Jensen (1990) summarized prior research on the religiosity of psychotherapists. They said that, "Data from previous surveys indicated that therapists were less committed to traditional values, beliefs, and religious affiliations than the normal population at large" (p. 3). Another survey found clinical psychologists to be the least religious of the major psychotherapy provider groups (Jones, 1994, p. 184). Similarly, the religious issues and faith of clients are frequently not dealt with by nonreligious psychotherapists (Lovinger, 1984). Anderson and Young (1988) observed that "all clinicians inevitably face

the challenge of treating patients with religious troubles and preoccupations" (p. 813). Many psychologists, academic and applied, do not relate to religion as such; they maintain a stance of neutrality or silence toward it (Jones, 1994). Thus, many psychologists and psychiatrists may be operating outside the boundaries of their professional training, which raises clinical and ethical concerns.

Paul Holland, Ph.D. an ordained minister, recently led a discussion on religion's role in psychotherapy during the Mid-Winter Convention of APA's divisions 29 (Psychotherapy), 42 (Independent Practice) and 43 (Family Psychology). He stated that, "Ignoring a person's religious views as a central issue in their therapy is remiss...Even if the therapist doesn't believe, to downplay the faith and concepts that are already there is destructive" (Sleek 1994, p. 8).

Some religious problems involve conflicts over questions of faith and doctrine. These should be, and generally are, handled by clergy. They are usually dealt within a church setting by a religious counselor who typically does not have training in psychotherapy (Young and Griffith, 1989).

In a change intended to encourage mental health professionals to view patients' religious experience more seriously, the new DSM-IV includes a new entry entitled "Religious or Spiritual Problem" (Steinfels 1994). This new diagnostic category was proposed for the DSM-IV as "Psychoreligious Problems Not Attributable to Mental Disorder," to delineate those distressing experiences of a religious or spiritual nature that are the focus of psychiatric diagnosis or treatment, but are not attributable to a mental disorder (Lukoff, Lu, and Turner, 1992, p. 677). These problems would involve conflicts that concern a person's religious life and beliefs.

One type of psychoreligious problem involves patients who intensify their adherence to religious practices and orthodoxy. The interface between obsessional ideation and religious commitment has always been obscure. This obscurity is often reflected in the confusion experienced by the psychotherapist in attempting to work with a patient who has developed an intense religious commitment (Halperin, 1983).

Addictive disorders have been studied from various academic and professional disciplines such as medicine,

pharmacology and the social and behavioral sciences. Yet, few studies have articulated an understanding of addiction from a religious perspective despite the decidedly religious basis and success of both Alcoholics and Narcotics Anonymous in the treatment of addiction (Giannetti, 1987).

This study reviews the literature on the relatively new phenomenon of religious addiction. The clinical signs and symptoms, along with possible progressive stages of religious addiction will be considered. Factors related to the dynamics of religious addiction within dysfunctional religious organizations, and spiritually abusive belief systems will be reviewed. Additionally, a religious attitudes inventory will be designed to survey the manifestations of religious addiction and healthy spirituality within Christianity in the State of Hawaii.

Statement of the Problem

Researchers report that some individuals have problems that concern their religion. Members of the American Psychological Association reported that at least one in six of their clients presented issues that involve religion or spirituality (Shafranske and Maloney, 1990). In another study, 29% of psychologists agreed that religious issues are important in the treatment of all or many of their clients (Bergin and Jensen, 1990, p. 3). Psychotherapy can sometimes be effective in treating religious problems. Robinson (1986) noted, "Some patients have troublesome conflicts about religion that could probably be resolved through the process of psychotherapy" (p.22).

Religious problems can be as various and complex as mental health problems. One type of psychoreligious problem involves patients who intensify their adherence to religious practices and orthodoxy (Lukoff, Lu, and Turner 1992, p. 677). Generally when people speak of addictive diseases they imply a medical problem. In the past few years the term addiction has been used to characterize behaviors that go beyond chemicals. Dr. Robert Lefever (1988) views addiction as a "family

disease" involving self-denial and caretaking, domination, and submission (p. ix). Gerald May (1988) states that addiction is a "state of compulsion, obsession, or preoccupation that enslaves a person's will and desire" (p.14). Shaef (1987) defines addiction as "any process over which we are powerless" (p. 18). She divides addictions into two categories: substance addictions -alcohol, drugs, nicotine, food) and process addictions -money-accumulation, gambling, sex, work, worry, and religion.

Research in the area of religious addiction is deficient, however there were a few older related studies found in the literature. Simmonds (1977) reports that there is some evidence to indicate that "religious people in general tend to exhibit dependency on some external source of gratification" (p. 114). Black and London (1966) found a high positive correlation between the variables of obedience to parents and country and indices of religious belief such as church attendance, belief in God and prayer (p. 39). Goldsen, et al. (1960) showed that people who were more religious consistently showed tendencies toward greater social conformity than did the

nonreligious, a finding consistent with the notion that religious people seek external approval. These results are supported by Fisher (1964 p. 784), who reported that a measure of social approval and religion were strongly associated. Religious people show dependence not only on social values, but also on other external agents. Duke (1964, p. 227) found that church attendance indicated more responsiveness to the effects of a placebo. In a study of 50 alcoholics, it was found that those who were dependent on alcohol were more likely to have had a religious background (Walters, 1957, p. 405).

The few research studies aforementioned seem to suggest that religious people develop a dependency on religious practices for social approval. Since religious people seem to be describable in terms of relatively high levels of dependence, it seems useful to borrow a concept suggested by Peele and Brodsky (1975)- that of "addiction." According to these writers addiction is "a person's attachment to a sensation, an object, or another person... such as to lessen his appreciation of and ability to deal with other things in his environment, or in himself, so that

he has become increasingly dependent on that experience as his only source of gratification" (p. 168).

There are a variety of definitions for the concept of religious addiction. Arterburn and Felton (1992) state that "when a person is excessively devoted to something or surrenders compulsively and habitually to something, that pathological and physiological dependency on a substance, relationship, or behavior results in addiction" (p. 104). They indicate that, "like any other addiction, the practice of religion becomes central to every other aspect of life...all relationships evolve from the religion, and the dependency on the religious practice and its members removes the need for a dependency on God...the religion and those who practice it then become the central power for the addict who no longer is in touch with God" (p. 117).

Spirituality can also have pathological aspects to it. Vaughan (1991) reports that "the shadow side to a healthy search for wholeness can be called addiction to spirituality" (p. 105). He indicates that this can be found among people who use spirituality as a solution to problems they are unwilling to face. Van-Kaam

(1987) presents a viewpoint of addiction as a quasi religious or falsified religious presence. He reports that "an understanding of the relationship between religious presence and addiction allows potential dangers of receptivity to be identified in order to realize the real value of true religious presence and the shame of its counterfeit, addiction" (p. 243). McKenzie (1991) discusses addiction as an unauthentic form of spiritual existence. He says that, "addiction is born of the human desire for transcendence which is often perverted or misplaced by societies that encourage their members to seek ultimate meaning in dimensions that have no regard for the transcendent" (p. 325). Heise (1991, p. 11) explores the fundamentalist Christian's focus on perfectionism, and it's possible contribution to an increase in dysfunctional individuals, family systems, and addictions.

Until recently, research in this area has primarily focused on religious cults. Estimates of the number of cults range from several hundred to several thousand, with a total membership up to three million (Allen and Metoyer, 1988, p. 38; Melton, 1986).

According to Margaret Singer, Ph.D., a psychologist specializing in cult phenomena, "the word cult describes a power structure, ...what really sets a cult apart is that one person has proclaimed himself to have some special knowledge, and if he can convince others to let him be in charge, he will share that knowledge" (Collins & Frantz, 1994, p. 30). The Jim Jones People's Temple mass suicide has been documented in the news, and more recently David Koresh's Branch Davidian Christian cult. Cults, both destructive and benign, have been with us in various guises since time immemorial. Many psychologists and psychiatrists have become knowledgeable about destructive cults in the course of their work with patients affected by the problem.

Within the past few years, however, traditional Church members have faced their compulsive behavior and harmful beliefs. Doucette (1992) reports that "many people are waking up because they have seen their religious leaders fall. Some researchers believe that the magnitude of the tragedy of religious addiction and abuse was revealed by the TV evangelist scandals documented in the news media which involved: Jim and

Tammy Bakker; Jimmy Swaggart; and Oral Roberts (Brand 1987, p. 82; Woodward 1987, p. 68; and Kaufman 1988, p. 37). These personal confessions have exposed not only how these supposed men of God had betrayed people's trust, but how many of those who had been abused, betrayed, and bankrupted never seemed to question what was happening and continued to support these individuals.

Booth (1991) states that "the Bakker, Swaggart, and Roberts scandals created a national intervention that served to interrupt the progress of this unhealthy phenomenon" (p. 38). What had previously been viewed as fanaticism or zealotry increasingly began to be called religious addiction and religious abuse. Booth (1991) defines religious addiction as "using God, a church, or a belief system as an escape from reality, or as a weapon against ourselves or others in an attempt to find or elevate a sense of self-worth or well-being" (p. 38).

Other researchers use the terms spiritual and psychological abuse to describe the characteristics of religious addiction. Enroth (1992) says that his book "Churches That Abuse is about people who have been

abused psychologically and spiritually in churches and other Christian organizations" (p. 29). He reports that "unlike physical abuse that often results in bruised bodies, spiritual and pastoral abuse leaves scars on the psyche and soul...the perversion of power that we see in abusive churches disrupts and divides families, fosters unhealthy dependence of members on the leadership, and creates, ultimately, spiritual confusion in the lives of victims" (p. 29). The scandals involving TV evangelists created a national intervention by bringing religious addiction and abuse too close to home to be ignored. Those scandals spurred people to act and call for change.

What are the factors that result in the phenomenon of religious addiction? What is adaptive and what is damaging within a religious environment. What are the symptoms that manifest when one is victimized by an abusive religious leader or an addictive belief system? This literature review will attempt to answer these questions and others related to the development, assessment, symptomatology, and beliefs of religious addiction.

Purpose

To date, the slowly growing literature and the professional conventions devoted to understanding and treating the cult devotee have been primarily descriptive rather than prescriptive (Clark, 1979, p. 279; Conway and Siegelman, 1978; Deutsch, 1975, p. 166; Etemad, 1979; Galanter and Buckley, 1978; Galanter, Rabkin & Rabkin 1979, p. 165; Goldberge and Goldberg, 1982, p. 165; Levine, 1978, p. 75; Lifton, 1961; Maleson, 1981, p. 925; & Pattison, 1980, p. 275).

Despite the growing research concerning religious cults, research specifically concerning religious addiction among members of traditional Christian Churches is lacking. Clark (1983) reports that, "we are reticent, as a culture, to criticize anything called religion" (p. 279). The aim of this literature review was to: 1) help mental health professionals improve diagnostic assessments when religious addiction and other psychoreligious problems are involved; 2) reduce iatrogenic harm from the misdiagnosis of religious addiction and psychoreligious problems; 3) improve the treatment of such problems by stimulating clinical research; and 4) encourage clinical training

centers to address the religious and spiritual dimensions of human existence.

A religious attitudes inventory was given to a sample of ministers, psychiatrists, psychologists, and a group from the general public all within the State of Hawaii. The purpose of this survey was to attempt to determine if beliefs and symptoms identified as related to religious addiction are more positively correlated with churches structured upon an authoritarian-hierarchical style of leadership versus a collegial model in which power and authority is vested equally in each of a number of elected church leaders.

Limitations

Limitations encountered in the study include:

1. The sample population surveyed (N=320) in this study was limited to three groups within the State of Hawaii: ministers, psychologists, and a group from the general public. This relatively small population sample represents a modest limitation to the reliability and generalizability of the results.

2. Defensiveness concerning the disclosure of psychoreligious characteristics of subjects may have been a factor which was unable to be determined in