

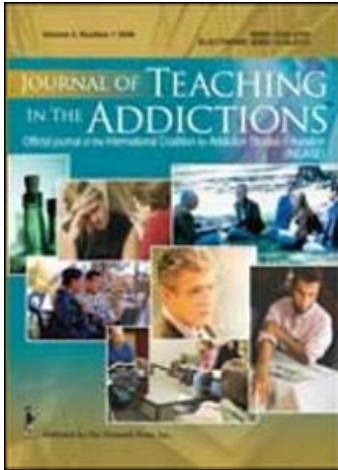
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### Beyond the Disease Model: Reframing the Etiology of Alcoholism From a Spiritual Perspective

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## **Beyond the Disease Model: Reframing the Etiology of Alcoholism From a Spiritual Perspective**

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*The disease model of alcoholism, which has gained prominence since the mid-20th century as the major etiological model of alcoholism, suffers from several limitations including its overemphasis on biological factors at the expense of other psychosocial factors, in addition to its lack of consistency with a holistic, social work person-in-environment perspective. The increased interest in spirituality among social work and other helping professionals calls on educators and practitioners to be at the forefront of efforts to develop new holistic conceptualizations of alcoholism that can incorporate spirituality. Using transpersonal theory as a conceptual framework, a spiritual etiological model of alcoholism is presented that complements the strengths of the disease model by allowing for the inclusion of biological determinants of alcoholism, providing a complementary way to understand alcoholism that can be taught to students and utilized by practitioners.*

**KEYWORDS** *alcoholism, disease model, social work, spirituality, transpersonal*

Mankind has a history with alcohol that dates back thousands of years (Burns, 2004; Peterson, Nisenholz, & Robinson, 2003). Societies appeared to be of two minds in terms of their relationship with alcohol, as drunkenness was considered an evil in the Bible, yet wine was considered a gift from God (Royce, 1985). Although many societies and religious sects condoned the use of alcohol, the misuse of alcohol to the point of drunkenness was condemned (Royce, 1985). People who were not able to control their use of

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alcohol were typically considered immoral, sinful, or weak-willed. The social sanctions these people experienced were severe at times, especially for women (Covington, 2000).

Prior to World War I this “moral model” of alcoholism was predominant. The subsequent rise of addictions studies in the 1930s provided an alternative perspective that suggested psychological or physiological factors might be more responsible for the malady than poor moral character (Morgan, 1999). According to Morgan:

The emergence of this “amoral” perspective regarding addiction was influenced by a number of factors, including (a) the growing ascendancy of psychoanalysis and psychological theories of motivation, (b) the influence of pioneering researchers and new discoveries in medicine and physiology, (c) the apparent success of the newly-founded Alcoholics Anonymous, and (d) the support and cooperation of a number of leading religious figures of the time. (p. 4)

During this time the social work profession began to become more involved in the treatment of alcoholism. In her seminal work on social diagnosis, Richmond (1917) characterized inebriety (or what we might call alcoholism today) as a disease that required a medical diagnosis and a comprehensive treatment approach. Social workers have subsequently become more involved in research, administration, policymaking, and program development domains (Straussner, 2001) in addition to treatment provision. In recognition of the increasingly important role that social workers will continue to play in the alcoholism field, the National Association of Social Workers (2005) began offering a specialty practice section on alcohol, tobacco, and other drugs, where social workers can access information on screening and assessment, counseling, referrals, case management, research, education, and advocacy.

Alcoholism will continue to be a serious problem with which social work and other practitioners are confronted, either as a primary problem or as a contributing factor in such issues as child abuse and neglect, domestic violence, mental health, and homelessness (Bliss & Pecukonis, 2009). Therefore, educators will need to continue to play a critical role in preparing social work students for the realities of working with individuals and families who are negatively affected by this age-old malady.

## ETIOLOGY OF ALCOHOLISM

Social workers and other writers often debate the etiology of alcoholism. Among the more prominent conceptualizations are (a) symptom of a psychiatric illness, (b) moral weakness, (c) lack of willpower, and (d) disease

(N. S. Miller, 1991). Yet, despite the enormous social costs of alcoholism, little consensus exists on what causes it and how it should be treated. Siegler, Osmond, and Newell (1968) noted that the diversity of definitions of alcoholism creates hazards, as “we are not simply faced here with the problem of comparing the evidence offered within one field for more than one theory, but with discussing different theories, each of which comes from a different discipline or profession” (p. 571). The complex nature of this situation makes comparing diverse viewpoints difficult.

Another difficulty lies in the ideological struggle for dominance that competing etiological models can have. Gregoire (1995) noted that although arguments exist between those who support the disease model and those who support the social learning model, the debate between the two camps results in a rejection by each camp of knowledge about alcoholism that does not fit within the favored ideological framework of that camp. For example, proponents of the disease model tend to ignore studies that indicate some problem drinkers can return to controlled drinking, whereas supporters of the social learning model tend to downplay studies that indicate only a small portion of problem drinkers are able to return to controlled drinking. Gregoire also criticized how this ideological struggle actually limits our understanding of alcoholism and suggested a broader etiological view of alcoholism as “far more than the curse of a bad genetic code, or the result of unfortunate maladaptive learning, alcoholism is better understood as a problem of body, mind, and spirit, and an impediment to the resolution of existential dilemmas” (p. 340).

### DISEASE MODEL OF ALCOHOLISM

Among the competing etiological models of alcoholism, the disease model has gained more prominence than others. W. R. Miller and Kurtz (1994) noted there are four core assumptions that underlie this model:

1. Alcoholism is a unitary disease entity that is qualitatively distinct and discontinuous from normality. As with pregnancy, there are no gray areas; one either is or is not alcoholic.
2. The causes of alcoholism are solely biological, rooted in heredity and physiology. Behavioral, family, and personality disturbances are merely symptoms of the underlying physical abnormality in how the body reacts to alcohol.
3. The definitive symptom of developed alcoholism is an inability to control consumption after the first drink. This is an inexorable reaction to the chemical ethanol, resulting from the physical abnormality.
4. This condition is irreversible and cannot be cured, only palliated.

Despite the widespread acceptance of the disease model, it does suffer from limitations. First, in examining the benefits of accepting the disease

concept of alcoholism, Hill (1985) noted that this perspective can reduce the stigma associated with being an alcoholic and helps to encourage persons to utilize treatment. However, the author also noted there are other implications about this conceptualization of alcoholism, including questions about the validity of the long-term nature of physical dependence and the one-sided emphasis of medical providers on the physical problems associated with alcoholism at the expense of psychosocial problems.

Second, “some consensus exists that social, environmental, and cultural influences play a role in etiology” (Polcin, 1997, p. 299), although less clear is whether these factors, which can be associated in the development of alcohol use problems, are implicated in the actual development of alcohol dependence. For example, Zucker and Gomberg (1986) wrote, “the factors connected with beginning a pattern of problem use are not necessarily the same as those pharmacological and behavioral characteristics that contribute to the maintenance of the alcohol use pattern or to the later build-up of a habitual problem involving alcohol abuse or dependency” (p. 783).

Third, Bride and Nackerud (2002) used Kuhn’s model of scientific progress to challenge the dominance of the disease model in the United States due to its inability to explain anomalies that contradict its tenets. According to the authors, “perhaps the most persistent anomaly of the disease paradigm is the repeated finding, in violation of the entrenched expectations of irreversibility and loss of control, that persons diagnosed as alcoholic can sometimes return to normal, controlled patterns of drinking” (p. 131).

Fourth, from a social work perspective, the disease model and its emphasis on the biological determinants of alcoholism and accompanying medically based treatment interventions is at odds with a holistic, person-in-environment perspective that also emphasizes psychosocial and spiritual aspects of alcoholism. Hesselbrock, Hesselbrock, and Epstein (1999) added support to the validity of this assertion by noting how the interactional relationships among biological, psychological, social, and environmental factors affect the risk for alcohol abuse or dependence. The authors suggested that new etiological models will continue to be developed given the interactions among these factors. Additionally, Okundaye, Smith, and Lawrence-Webb (2001) contrasted medically based practice models that follow the disease model with strengths-based practice models that characterize a social work perspective. The former have a “focus on disease, dysfunction, deficits, and limitations,” whereas the latter emphasize “health, functionality, opportunities and capabilities” (p. 70).

The challenge then, is to develop new etiological models of alcoholism that can complement the strengths of the disease model, yet be more consistent with a holistic, strengths-based, person-in-environment perspective. In addition, given that the etiological debate as to whether alcoholism is truly a disease or not might not ever be satisfactorily resolved, social work and other helping professions also need to develop new ways to view

alcoholism that facilitate diagnosis and treatment. This is critical, as “the search for underlying causes of alcoholism and drug addiction has delayed the growth of their diagnoses and treatment, often the emphasis and the debate are directed toward the etiology before the criteria for addictions are established” (N. S. Miller & Gold, 1990, p. 29).

An illustrative example of social work innovation in this regard is the work of Matto (2004), who developed a new conceptual model of addiction and recovery called the acculturation model. Although more a practice model than an etiological model, Matto’s model does use a social work ecological framework for understanding the sociocultural factors involved in the transition from addiction to recovery.

## SOCIAL WORK AND SPIRITUALITY

Although social workers will continue to be in high demand for work in the alcoholism field, one area that has been neglected in social work education and training has been the role of spirituality in alcoholism treatment and recovery (Okundaye et al., 2001). This neglect might be a function of the lack of inclusion of spirituality as a whole by social work programs (Dudley & Helfgott, 1990). Fortunately, this exclusion has begun to change as there has been an increased interest in spirituality among social work educators and practitioners (Canda & Furman, 1999; Carroll, 1997). For example, the Council on Social Work Education validated the need for the inclusion of spirituality and religion in social work practice with its publication of *Spirituality and Religion in Social Work Practice: Decision Cases With Teaching Notes* (Scales et al., 2002). The text, written for social work educators, is comprised of numerous cases followed by a teaching note for each that includes a case synopsis, suggested learning outcomes, discussion questions, and other materials the instructor can use.

However, this movement toward further legitimizing spirituality in social work education has been hampered due to confusion in differentiating spirituality and religion and a lack of consistency in how spirituality has been conceptualized. For example, in a study on spirituality and severity of alcohol dependence, Bliss (2005) found that the terms *spirituality* and *religion* were often used interchangeably. In addition, there was a lack of consensus on how spirituality was conceptualized, including questions about whether it was a holistic, unifying aspect of human functioning or just one dimension of human functioning on par with psychological, biological, and social dimensions of human development.

Carroll (1998) helped to provide some clarity in this matter in her discussion of the differentiation between spirituality and religion and in her examination of social work conceptualizations of spirituality. First, Carroll wrote that “spirituality refers to one’s basic nature and the process of finding

meaning and purpose whereas religion involves a set of organized, institutionalized beliefs and social functions as a means of spiritual expression and experience” (p. 2). Second, Carroll discussed the work of Canda in conceptualizing spirituality either broadly as the wholeness of being human (spirituality-as-essence) or narrowly as a component of human experience (spirituality-as-one-dimension). In practice, these two conceptualizations are not necessarily mutually exclusive, but should be viewed as being interrelated and complementary (Carroll, 1998).

## SPIRITUAL ETIOLOGICAL MODEL OF ALCOHOLISM

The lack of consensus on conceptualizations of spirituality highlights the need for the use of theory to help provide a starting point for creating a common ground that social workers and other practitioners can operate from as they increasingly incorporate spirituality in their holistic work with individuals, families, groups, and communities. In terms of conceptualizing the etiology of alcoholism from a spiritual perspective, one theoretical framework that can be used is transpersonal theory.

Transpersonal theory offers a unique perspective on human development in that it emphasizes the spiritual aspects of human functioning (Wilber, 1981, 1986). A transpersonal perspective posits human development is spiritual in nature and evolves toward higher states of consciousness, transcendence of egocentric perspectives, and the attainment of higher levels of human potential (Lajoie & Shapiro, 1992). Additionally, the theory provides an integrative framework for describing this process as biological, psychological, social, and cultural aspects of human functioning are incorporated into a holistic framework (Robbins, Chatterjee, & Canda, 1998). This is a critical aspect of the theory as it allows for the inclusion of biological determinants of alcoholism emphasized by the disease model in addition to psychosocial factors that are emphasized by other etiological models. Spirituality, then, can be considered the framework that integrates all of these components into a unified whole.

Whereas contemporary etiological models of alcoholism suggest the malady can be the result of willful bad behavior, disturbed psychiatric functioning, genetic predispositions or vulnerabilities, or poor coping responses (W. R. Miller & Kurtz, 1994), a transpersonal perspective suggests that pathologies such as alcoholism can be seen as a disruption of the innate spiritual evolution of each person. Within this framework then, alcoholism is considered a disturbance of the psyche or soul (Cowley, 1993) or a symptom of a spiritual disease (Doweiko, 1999).

This novel way of reframing the etiology of alcoholism might be more on target than initially thought. First, Ringwald (2002), in referencing Royce (1995), wrote “that while alcohol cannot touch the spirit directly, it does

knock out the brain's ability to serve as the sensory instrument of the soul. The result is spiritual dysfunction or disease" (p. 13). However, Ringwald noted that although spirituality and alcoholism might go hand in hand, it might not be possible to determine which comes first.

Additionally, although numerous types of treatment approaches have been developed to address the biological, psychological, and social aspects of alcoholism, the nature of the spiritual approach of Alcoholics Anonymous (AA) and resulting demonstration of its early effectiveness for many people who were considered hopeless alcoholics, led researchers such as Tiebout (1944, 1961) to study how and why AA worked. Nace (2005) noted that involvement in AA is associated with several outcomes measures and stated the mechanisms that are thought to be responsible for the effectiveness of AA might also include the spiritual themes of release, gratitude, humility, tolerance, and forgiveness. The author suggested, "possibly, for some, the program may be a secular expression of the Christian concept of grace—an unmerited gift from God" (p. 596).

This raises the intriguing question of how the spiritually based focus of AA can be so effective for addressing a primarily biologically based disease as the disease model holds. Perhaps AA stumbled on an important spiritual etiological component of alcoholism that the disease model overlooked. Yet, as intriguing as this notion might be, little research has been conducted to examine its validity. This could be due to the dominance of psychoanalytic and behavioral theoretical perspectives in psychological thought and practice during the first part of the 20th century (Richards & Bergin, 1997) and resistance to the spiritual dimension of alcoholism by positivistic perspectives that consider research on spirituality to be nonscientific due to its mystical nature (Chapman, 1996).

However, criticisms of this spiritual approach to the etiology of alcoholism are not necessarily without validity. For example, transpersonal conceptualizations of alcoholism do not differentiate whether alcoholism is a cause or effect of the spiritual disturbance of the individual. Clearly it seems that it could be both. Also, these conceptualizations problematically tend to minimize the biological aspects of the etiology of alcoholism as a substantial research literature supports the role of biology in the development of alcoholism (Moak & Anton, 1999).

Despite these limitations, researchers and practitioners have begun to incorporate transpersonal concepts into recovery from alcoholism. For example, Whitfield (1984a, 1984b, 1984c) contributed to early discussions on spirituality and alcoholism with his three-part series on framing stress management and spirituality during alcoholism recovery from a transpersonal perspective. Nixon (2001) discussed how Wilber's transpersonal model of spiritual development can be used as a framework to guide alcoholism treatment. Moxley and Washington (2001) suggested how social workers can use a transpersonal framework for framing substance abuse recovery.



Interestingly, AA (2000, 2001), which predates the formal emergence of transpersonal theory in the 1960s by a few decades, incorporates transpersonal concepts of reduced egocentrism, higher levels of functioning, increased awareness, and improved relationships with self, others, and a Higher Power into its suggested program of recovery. Although AA explains the etiology of alcoholism as being a threefold illness (physical, mental, and spiritual), its strong emphasis on spirituality in the recovery from alcoholism suggests the role of spirituality cannot be discounted in examining the etiology of alcoholism. Ringwald (2002) supported this notion by stating “if the solution is spiritual, so too was the malady, at least in part” (p. 13).

## COMPARISON BETWEEN DISEASE AND SPIRITUAL MODELS

The construction of models method developed by Siegler et al. (1968) provides a means for comparing diverse points of view such as the disease model of alcoholism and the proposed spiritual etiological model of alcoholism. According to the authors:

A model must be able to provide a course of action for every situation which arises in connection with the disputed ailment, whether for professional people, patients, their families or the general public. The dimensions, then, are a series of problems, situations or questions which will require answers or decisions in connection with the ailment. In the case of alcoholism, the model must define it, indicate how it arose, and show how the behavior of alcoholics is to be explained. Some sort of treatment must be proposed, a prediction must be made about the outcome, and, if there is a treatment facility, its function must be stated. There must be some basis for choosing appropriate people to work with alcoholics. If suicide occurs, it must be accounted for. The rights and duties of all the participants in situation which arise must be related. (p. 572)

Table 1 provides a comparison of the disease model (as primarily conceptualized by Siegler et al., 1968) and the spiritual etiological model. Although the dimensions from the construction of models method provide the main bases for this comparison, a dimension that compares the degree of consistency each model has with a holistic, social work perspective has been included.

A comparison between the two models highlights important differences. First, the disease model is predominately biological, emphasizing the role of genetics and physical abnormalities in the etiology and course of alcoholism. In contrast, the spiritual model, although noting the biological component of alcoholism, places the predominant etiological emphasis on a disruption of the innate process of spiritual development. Second, the disease model “medicalizes” the treatment of alcoholism by emphasizing the

**TABLE 1** Comparison Between Disease and Spiritual Etiological Models of Alcoholism

Dimension	Disease Model	Spiritual Model
Definition	Alcoholism is an incurable, progressive, often fatal disease that gets worse if left untreated.	Alcoholism is a primarily spiritually based disease that also has biopsychosocial components. Alcoholism gets progressively worse if left untreated. This manifests in increasing negative consequences in many domains of life functioning including a corruption of the afflicted person's spiritual development.
Etiology	Alcoholics tend to have a genetic predisposition toward developing alcoholism. Psychosocial factors are symptoms of the underlying physical abnormality of how the body reacts to alcohol. This physiologic, genetic vulnerability is at the root of the etiology of alcoholism.	Alcoholism results from a disruption of the innate spiritual development of the person. As such, it can be seen as a symptom of a deeper spiritual malady. Biological, psychological, and social factors are embedded within the overarching and integrative framework of the spiritual developmental process.
Behavior	The physical abnormality the body experiences from the ingestion of alcohol drives behavior that tends to become more centered on getting more alcohol due to the insistence of craving and the desire to avoid aversive withdrawal symptoms. The life of the alcoholic can become more unmanageable in social, familial, legal, health, and occupational life areas as the alcoholism progresses, yet some people, termed "functional alcoholics," are able to function relatively well in social and occupational domains.	Alcoholism is a form of spiritual insanity. As the alcoholic's life becomes more centered on the use of alcohol, he or she becomes increasingly spiritually bankrupt. This can be characterized by (a) degradation in relationships with self, others, and God/Higher Power; (b) impaired spiritual health; (c) reduced sense of meaning and purpose in life; (d) decreased awareness; and (e) failure to attain fullest human potential.
Treatment	Medical care is often needed to manage detoxification. Cognitive-behavioral therapy, relapse prevention planning, family therapy, and support groups play important roles in the treatment process. Most people need treatment to assist them in abstaining from alcohol, although some are able to quit on their own.	Although medical care might be needed to manage the detoxification from alcohol, the primary treatment focus addresses the damage done to the person's spirituality. Nontraditional forms of therapy such as meditation, guided imagery, and prayer can be very beneficial. Spiritually based support groups such as Alcoholics Anonymous are very helpful in this regard as spiritual growth, a lifetime endeavor, is considered to be at the heart of recovery from alcoholism.
Prognosis	Alcoholism cannot be cured. Total abstinence can ultimately lead to improved functioning, but the prognosis is poor if the alcoholism continues unabated. Once a person becomes an alcoholic, he or she can never return to controlled drinking.	The prognosis is poor for persons whose alcoholism is left untreated as their spirituality will continue to deteriorate. Paradoxically, this crisis can also lead to the mobilization of spiritual resources and motivate the person to seek help. Persons who enter treatment and take advantage of support groups that emphasize spirituality can ultimately lead spiritually whole and satisfying lives. Interestingly, some members of AA talk about how they eventually came to see their alcoholism as one of the best things to happen to them because it led them to embrace a spiritual way of living.

Function of the hospital	Hospitals provide a safe place to medically manage the detoxification from alcohol and to manage any other physiological problems. Many treatment programs were once hospital-based, but the fiscal constraints of managed care have necessitated the increased use of nonhospital treatment sites.	Hospitals are only needed to medically manage the detoxification from alcohol of persons with severe alcoholism. The clinical, sterile environment of the hospital can actually be a hindrance to facilitating a holistic, spiritual approach to treatment.
Personnel	Specially trained persons are required for treating alcoholics including doctors, nurses, addiction counselors, and social workers. Untrained volunteers such as those in support groups like Alcoholics Anonymous can serve as adjuncts to these trained personnel.	Specially trained personnel such as doctors, nurses, addictions counselors, and social workers can be helpful in facilitating the recovery from alcoholism, but their usefulness is minimized when their focus on spirituality is limited. Laypersons in recovery such as sober members of Alcoholics Anonymous can be more effective in some circumstances than highly trained personnel by serving as role models and sources of social support. Qualities of caring, compassion, empathy, and hope are generally more important than specific professional expertise, although there are circumstances when specific professional expertise is required, such as when clients have cooccurring psychiatric disorders that require medication or when clients exhibit suicidal ideation or attempts. The sense of alienation, meaninglessness, and despair that results from the damage done to the alcoholic's spirituality can lead to suicidal ideation or attempts. Therefore, persons new to treatment might be at a higher risk to attempt suicide, especially as they become aware of the extensive damage done to their lives by alcoholism along with the prospect that repair of this damage will be long term in nature.
Suicide	Suicide is a risk for alcoholics. Doctors or psychiatrists must be able to assess the risk for suicide and avoid giving the alcoholic medications such as tranquilizers and painkillers that could be used for the purpose of suicide. Some people consider alcoholism to be a form of passive or involuntary suicide in that death from traffic accidents, interpersonal violence, and alcohol-related health problems such as cirrhosis can be caused by alcoholism. Alcoholics have the right to be treated just as others who have diseases have the right to be treated. They also have the responsibility to cooperate with treatment.	
Rights and duties of alcoholics		Alcoholics have the right to treatment and recovery just as persons with other serious illnesses have. Alcoholics also have the duty to take responsibility for their recovery and avail themselves of the resources that are available to them. Although alcoholics are not considered responsible for the development of their alcoholism, they are considered responsible for their recoveries. As such, there is a strong focus on personal responsibility and accountability in the recovery process.

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(Continued)

**TABLE 1** (*Continued*)

Dimension	Disease Model	Spiritual Model
Rights and duties of families	The families of alcoholics have the right to receive treatment, although they can be seen as suffering less than the alcoholic. In actual practice, treatment programs might offer limited services to families if they offer any at all. Families need to cooperate with medical care and avoid "enabling" the alcoholic.	Families are negatively affected by the spiritual insanity of alcoholism and have the same right to treatment as the alcoholic does. Families have the responsibility to nurture their own spirituality regardless of what the alcoholic does. They also have the responsibility to refrain from "enabling" the alcoholic.
Rights and duties of society	Although society has the obligation to treat persons with alcoholism as it would persons with other chronic diseases, society does have the right to be spared from the social costs of alcoholism. This can include incarcerating alcoholics who commit crimes while under the influence of alcohol. The use of driving while intoxicated diversion programs that mandate treatment in lieu of incarceration is an example of this social policy.	Although society has the right not to suffer from the damages done by alcoholism, it does have the responsibility to provide the resources and support to facilitate the recovery from alcoholism. From a transpersonal perspective, alcoholism in an individual is part of a larger societal problem with alcoholism, as what happens on an individual level also occurs on a societal level. In effect, society needs to recover from alcoholism, too.
History of the model	The disease model received official sanction from the American Medical Association in 1956, but its roots extend to the writings of Declaration of Independence signatory Benjamin Rush in Colonial America. Alcoholics Anonymous, founded in 1935, played a major role in fostering the notion that alcoholism was an illness rather than a moral failing. For example, whereas the disease model emphasizes the biological determinants of alcoholism, AA emphasizes the threefold nature of the illness (mind, body, and spirit).	This model is greatly influenced by the success of the spiritually based program of recovery of Alcoholics Anonymous, but the notion that the etiology of alcoholism is primarily spiritual in nature rather than biological is new. This perspective might be disputed by proponents of the disease model, who will cite extensive research supporting the biological determinants of alcoholism.
Consistency with social work perspective	The disease model is not consistent with the person-in-environment perspective of social work as it emphasizes the biological determinants of alcoholism at the expense of psychosocial and spiritual factors. In addition, the disease model adheres more to a deficit-based perspective rather than the strengths-based perspective favored by social work. Finally, primary responsibility for treatment outcomes is placed more in the hands of expert professionals rather than being attributed to the person who is attempting to recover from alcoholism.	The spiritual etiological model is consistent with the person-in-environment, strengths-based perspective of social work. In addition, the model explicitly encompasses all biopsychosocial aspects of human functioning within an integrative, holistic spiritual framework. Finally, primary responsibility for treatment outcomes is seen as resting in the person with the alcoholism rather than in the hands of experts, whose roles instead are to provide a supportive and caring environment that helps a person to facilitate his or her own spiritual development.

role of medical and health care professionals. In contrast, the spiritual model places a greater emphasis on holistic treatment provided by nonmedical and laypersons, although medical personnel can play supporting, and at times, necessary roles. Third, the disease model is at odds with a holistic, social work perspective as it overly emphasizes the role of biology in the etiology and treatment of alcoholism at the expense of other psychosocial factors. In addition, the disease model is much more “deficit based” with its emphasis on “disease.” In contrast, the spiritual model is consistent with a holistic, strengths-based perspective.

## DISCUSSION

Despite the differences between the two etiological models, the spiritual model should not be considered a “better” etiological model of alcoholism, as subjective arguments about the superiority of one model over another are futile given that no one model can fully explain the complex nature of the malady (Gregoire, 1995). Whitfield (1985) wrote that alcoholism is probably a multifactorial problem, with an “X” factor among other possible contributory factors including amount of alcohol use, ethnicity, socioeconomic status, psychological functioning, family dynamics, occupational status, genetics, and spirituality. This conceptualization suggests that there is an unexplained, and perhaps unexplainable, factor in the etiology of alcoholism that no one etiological model can account for, including the spiritual model.

Utilizing a spiritual etiological perspective, though, has important assessment and treatment implications for social workers and other practitioners. Social workers are increasingly recognizing the importance of assessing spirituality in their work with clients, but less clear is how well they have been prepared to engage in this due to the minimal training on spirituality and religion they might have received in their graduate education (Hodge, 2006b). One way to address this void in social work education is through the incorporation of a transpersonal perspective in practice classes (Cowley & Derezotes, 1994). Accomplishing this should not prove difficult, as social work educators have already demonstrated the ability to creatively adapt curricula in other domains by including diverse themes such as religion (Hemert & Clark, 1994) and women’s issues (Carter & Coudrouglou, 1994).

Adding spirituality-focused content to graduate practice courses can then become the foundation on which social workers can learn how to engage in spiritual assessment with their clients. Students will then have a basis for understanding how to appropriately use currently available spiritual assessment tools and instruments. For example, Hodge (2006b) provided a review of questions the Joint Commission on Accreditation of Healthcare Organizations recommends for operationalizing an assessment of spirituality

that social workers can use. A more comprehensive resource is provided by Hodge (2003), whose practice-oriented handbook includes a set of instruments for spiritual assessment, spiritual life maps, spiritual genograms, and more.

Even as social workers are increasingly using spiritual interventions, few guidelines exist for their use due to the lack of training social workers receive in spirituality and religion (Hodge, 2006a). Sheehan and Owen (1999) noted that the multifaceted nature of alcoholism necessitates a treatment approach that addresses the consequences of the disease that can affect the biological, psychosocial, mental health, and intrapersonal dimensions of an individual's life. Treating alcoholism from a spiritual perspective would involve explicitly addressing the following transpersonal domains in client functioning: (a) increasing awareness; (b) reducing degree of egocentrism; (c) improving relationships with self, others, and God or Higher Power; (d) attaining higher levels of functioning; and (e) exploring meaning and purpose in life in addition to more traditional domains in human functioning.

Among the treatment modalities that are commonly used within the disease perspective are peer support groups, motivation enhancement strategies, behavioral and cognitive strategies, and medications (Allen & Litten, 1999). Providing treatment from a spiritual perspective would necessitate a different practice stance that also includes the use of other nonconventional treatment approaches. Hutton (1994) examined how transpersonal psychotherapists differ attitudinally toward spirituality from other practitioners with an emphasis on how this affects the types of psychotherapy techniques used. Boorstein (2000) provided a discussion of tools he uses to facilitate a transpersonal approach in therapy, including spiritual bibliography, meditation, holotropic breathwork, past-life regression hypnosis, yoga, visualization, and psychodrama. In a review of the literature, Hodge (2006a) found that spiritually modified cognitive therapy has been used successfully in treating various mood, anxiety, and psychotic problems. Given the prevalence of these problems as cooccurring disorders in populations with addictive disorders, this spirituality-based therapy might also be effective in treating alcoholism, although more research is needed in this domain.

Among the professional disciplines that address addictive disorders, social work might be the one best suited to use a spiritual etiological model of alcoholism. Canda and Furman (1999) noted the increased interest in spirituality among social work educators and practitioners. Given the prominent historical role of social workers in the treatment of alcoholism (Straussner, 2001), the social work profession is well positioned to be at the forefront of developing new conceptualizations of alcoholism that include spirituality. In addition, social work educators are being called on to examine how social problems such as alcoholism need to be viewed from a transpersonal framework, as the individual and social problems that

confront social work reside in the spiritual dimension of human functioning (Cowley, 1993). Reframing the etiology of alcoholism from a spiritual perspective is not meant to replace the disease model, but this new conceptualization builds on the strengths of the disease model while providing a framework that is more consistent with a holistic, strengths-based, social work perspective.

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