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Article

Tackling Addiction: A Case for Drug Policy Reform Based on Science and Christian Ethics

Daniel J. Mallinson

Debates over the efficacy and morality of drug prohibition in the United States are presently driven by changes in politics, economics, and science. Groups mobilize against mass incarceration and for marijuana. States face tight budgets and pressure for funding expanded prison systems. An important question for this issue on addiction science is how to translate the science, as well as Christian ethics, into evidence-based drug policy that can have an impact in this political environment. The science presented in this theme issue highlights the physiological complexity of addiction. This article presents a four-dimensional view of addiction: moral, biological, social, and spiritual. The intent is to offer policy options for both government and the church that build upon a Christian ethical view and addiction science. Churches are already on the front lines of fighting addiction. When examining the intertwining of faith and science, we must be cognizant of the way in which the two can inform public policy.

According to the Centers for Disease Control and Prevention, approximately 91 Americans die per day from opioids.[1] The four-fold increase in opioid deaths from 1999 to 2015 resulted in over one-half million deaths in total. At the same time, commentators increasingly admit that the War on Drugs is largely failing in its overarching goal of reducing drug abuse.[2]

Churches find themselves at the front lines of offering addiction treatment through variations on Alcoholics Anonymous.[3] Prominent pastors and Christian publications, such as *Christianity Today*, increasingly promote a reframing of addiction as a disease that has a moral dimension, as opposed to simply a moral failing. In fact, a 2016 article by Matthew Loftus presented four dimensions of addiction: moral, biological, social, and spiritual.[4] Within this model, redemption through the Gospel and community through the church represent important elements of addressing drug addiction, alongside the biological and psychological realities of addiction.

In this article, I argue for moving toward the four-dimensional model through drug policy reform and a mindset among Christians regarding addiction that moves beyond a focus on the moral dimension. I begin by briefly discussing what the Bible says about the spiritual dimension of wanting, and contrasting the existentialist and evangelical/Pentecostal views and approaches to addressing addiction. These two views have influenced Christian approaches to addiction intervention over the last two hundred years.[5] I will then address the scientific ideas of wanting that emerge from Judith Toronchuk's article.[6] Next, I will address how the dominant framing of drug addicts as deviants during the war on drugs era, does not lend itself to addressing Loftus's four dimensions of addiction. This is followed by a discussion of what an evidence-based

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approach to treating drug addiction might look like. Such an approach will necessarily involve both public and private efforts to reach those struggling with addiction. Moreover, this approach will require a rethinking of the past thirty years of drug policy in the United States. In fact, this rethinking is already occurring in state and local governments.

The Fall, Our Wanting, and Addiction

As humans, we were created with a deep longing, or wanting. First and foremost, God created us with a wanting for him; a deep longing for vertical relationship. But that was not all. We were also created with a desire for horizontal relationship. We see it in the second chapter of Genesis:

> The Lord God said, "It is not good for the man to be alone. I will make a helper suitable for him." (Gen. 2:18)[7]

The work of naming the animals did not satisfy. Only when Adam saw bone of his bone and flesh of his flesh was his horizontal relational wanting satisfied. Of course, wanting quickly became twisted:

> When the woman saw that the fruit of the tree was good for food and pleasing to the eye, and also desirable for gaining wisdom, she took some and ate it. She also gave some to her husband, who was with her, and he ate it. (Gen. 3:6)

The fruit of the tree of knowledge was *desirable* because it offered God-like wisdom. Alas, the fruit also yielded death and separation.

Sin thus separates humanity from God, leading to estrangement in this important vertical relationship. Moreover, the story of the Fall illustrates estrangement in our longing for horizontal relationship: "Your desire will be for your husband, and he will rule over you" (Gen. 3:16).

There are several competing views on the meaning of this passage. I will not attempt to reconcile or adjudicate them here, but instead I wish to point out that many of the interpretations represent a desire that is difficult to fulfill, either for headship, worth, or physical/psychological pleasure.[8] Thus, human wanting is present and active from the beginning of creation, but, at the Fall, humans no longer correctly orient the fulfillment of that wanting through relationship to God and fellow humans; instead, they turn inward to selfish desires.

In an existentialist view, addiction arises from this estrangement from God, which can cause anxiety, "and we seek to sooth our anxiety in inappropriate ways."[9] Saint Augustine of Hippo wrote that "You [God] stir man to take pleasure in praising you, because you have made us for yourself, and our heart is restless until it rests in you."[10]

Further, Blaise Pascal argues:

> What is it, then, that this desire and this inability proclaim to us, but that there was once in man a true happiness of which there now remain to him only the mark and empty trace, which he in vain tries to fill from all his surroundings, seeking from things absent the help he does not obtain in things present? But these are all inadequate, because the infinite abyss can only be filled by an infinite and immutable object, that is to say, only by God Himself.[11]

C.S. Lewis presents the longing thusly:

> All the things that have ever deeply possessed your soul have been but hints of it—tantalizing glimpses, promises never quite fulfilled, echoes that died away just as they caught your ear. But if it should really become manifest—if there ever came an echo that did not die away but swelled into the sound itself—you would know it. Beyond all possibility of doubt you would say "Here at last is the thing I was made for." We cannot tell each other about it. It is the secret signature of each soul, *the incommunicable and unappeasable want*, the thing we desired before we met our wives or made our friends or chose our work, and which we shall still desire on our deathbeds, when the mind no longer knows wife or friend or work. While we are, this is. If we lose this, we lose all. … *All that you are, sins apart, is destined, if you will let God have His good way, to utter satisfaction.* … But God will look to every soul like its first love because He is its first love.[12]

These notions of restlessness, craving, and unappeasable want are popularly translated today as humanity's "God-shaped hole." Humankind's efforts to find meaning and to fulfill wanting apart from God result in a wide range of idolatries, of which drug and alcohol abuse is only one.[13]

Of course, there is no shortage of discussion in the remainder of scripture, beyond the Creation account,

regarding the ramifications of a selfish fulfillment of wanting. Micah 6, Hosea 13, and Ezekiel 7 remind us of the deeper lack of satisfaction that comes when we seek to satisfy ourselves only with the pleasures of the world. James writes that "for where you have envy and selfish ambition, there you find disorder and every evil practice" (James 3:16). Paul writes in Ephesians 2:3: "All of us also lived among them at one time, gratifying the cravings of our flesh and following its desires and thoughts. Like the rest, we were by nature deserving of wrath." Furthermore, as Paul writes in 1 Corinthians 10:13: "No temptation has overtaken you except what is common to mankind." Paul goes on to write that "God is faithful; he will not let you be tempted beyond what you can bear. But when you are tempted, he will also provide a way out so that you can endure it." In response to this temptation, Paul exhorts the Corinthians to "flee from idolatry" (1 Cor. 10:14). Again, alcohol and drug use is but one idol that humans use in an attempt to fill their "God-shaped hole."

Pastor and Chancellor of Bethlehem College and Seminary John Piper offers a recent attempt to positively harness the human longing for God that is adapted from hedonism, which Piper calls "Christian Hedonism."[14] He argues that God created us to seek joy, and that true joy is found only in God. Further, this joy offers a certain transcendence from the pain experienced in life, and our satisfaction in him brings God glory. Such Christian hedonistic joy is not simply a product of conversion, but grows as our faith deepens.

The existential view stands in contrast to the Protestant evangelical and Pentecostal views that addiction is a sin, a moral failing, which can be cured through religious conversion.[15] Relationship with God is necessary for fulfilling humanity's need for psychological and spiritual meaning, but this comes not only from conversion (justification), but also through increasing surrender to God during sanctification. Paul and Augustine both wrote about the divides in the self and will of fallen humanity. Paul's personal admonition as a wretched man in Romans 7 displays a self that is torn between the law of the mind (i.e., reason) and the law of sin. In *Confessions*, Augustine writes, from personal experiences, about his divided will. His perverse will manifests in scenes of anger, idleness, lust, and theft for the sake of tasting the forbidden. The book chronicles Augustine's journey as he is first governed by his perverse will, then discovers what would become Catholicism's view regarding the provision of reason by which to overcome the will, and finally finds the necessity of God's grace for submitting his will to him. Mitchell Kalpakgian writes,

> As Augustine's autobiography reveals, the will can receive God's grace, assert will power, change the course of a person's life, conquer evil, cooperate with God's Divine Providence, and love as God loves.[16]

Overcoming the perverse will and submitting to God, however, are not merely a result of conversion, but also the continually working out and maturing of one's faith. As this theme issue highlights, viewing addiction simply as a moral failing, or a sinful act of agency, ignores physiological and psychological dimensions that often require additional support and time to address.

The Science of Wanting

C.S. Lewis claims in *The Problem of Pain* that the Fall transitioned us from being subject to the laws of the spiritual to the laws of nature. Toronchuk's lead article in this collection provides a useful overview of how science has identified the natural pathways for our feelings of "wanting." I will not reproduce all of her points here, but I do wish to highlight a few that establish a foundation for developing an evidence-based policy response to addiction.

Dopamine is an important component of our natural reward, pleasure, and motivation system. As Toronchuk states, "Dopamine release in NAc [nucleus accumbens] produces 'wanting' rather than 'liking' by focusing attention on the stimuli already associated with reward."[17] There are a plethora of natural ways to increase dopamine release or receptor availability, including sex, certain foods, exercise, meditation and prayer, massage, sunshine, and more.[18] Many drugs either directly or indirectly affect the ways in which dopamine operates in the brain. Drug abuse thus results in a dysregulation of the brain's built-in reward system.[19] There is evidence that drug abuse not only floods the system with dopamine, but that it also reduces normal dopamine function, thus increasing feelings of need or wanting.[20] It is important to note, however, that there is growing scientific support for the idea that behavioral addictions also alter the brain's reward system,

though perhaps not as strongly as pharmacology.[21] The battle of wills is still relevant, but we must recognize that drugs and habits weaken a person's agency to make decisions.

This is an important point of discussion, particularly as we move to focusing on the appropriate policy response for addressing drug addiction. As Christians, we understand that many, if not all, of our personal wantings are for physical things that represent mere shadows of the true object of our obsession: God. We all have idols in our lives that we pursue with an obsession that should be reserved for our Creator. But as a civil society, only some of the wantings that we pursue are criminalized. Although from a Christian perspective they are all moral failings, we are learning from a scientific perspective that there are physiological pathways in our bodies that facilitate and reinforce such failings. Granted, there are moral failings that necessarily require criminalization (e.g., child pornography), but is imprisonment the most effective avenue for addressing drug addiction, and to what extent does that policy response inflict injustices that should also be of concern to Christians? It is to these questions that I now turn. After addressing the historical approach of mass incarceration for executing the War on Drugs, I will consider what evidence-based policy would look like for drug abuse, including how some state and local governments are experimenting with related policies.

The War on Drugs and Mass Incarceration

The abuse of drugs was not always socially constructed as a moral failing. In fact, the case of opium use in the 1800s is instructive regarding the modern War on Drugs and emerging efforts to combat opioid addiction. Through much of the nineteenth century, addiction was viewed as a pharmacological property of opium.[22] Thus, resulting public policy efforts centered on regulation of supply and use. As opium addiction became increasingly viewed like alcohol abuse and mental illness, as a "habitual intemperance as a type or result of mental illness," the theory of addiction shifted from pharmacological effect to a "disease of the will."[23] In fact, postmillennialist missionaries to China were active in trying to "purify" the continent from the use of opium.[24] When the definition of a social problem (i.e., its framing) shifts, the required solution inevitably shifts with it.[25] In this case, the social (i.e., policy) response shifts from targeting the drug and its effects to targeting the individual and their moral failings.[26] Drug addicts are thus socially constructed as deviants, resulting in weak political power, an oversubscription of societal burdens, and an undersubscription of societal benefits.[27]

While drug regulation in the United States dates to the early twentieth century, the modern war on drugs commenced under the Nixon administration[28] and via the 1970 Controlled Substances Act, which introduced the current five-tier drug schedule. Granted, this was preceded and legitimized by the Single Convention on Narcotic Drugs of 1961 international treaty, aimed to prevent the production and trafficking of drugs.[29] The US war on drugs increased in fervor, however, under the Reagan, Bush, and Clinton administrations as substantial federal resources were conferred on state and local law enforcement for the purpose of addressing drug crime. Anne Schneider and Helen Ingram argue that the common societal response to deviant groups is to avoid them.[30] In the case of drug addiction, such avoidance occurs through the criminal justice system and the imprisonment of distributors and users.

The incarceration of drug offenders is part of, though not the totality of, the story of the increase in incarceration in the United States. From 1978 to 2014, the US experienced an over 400 percent increase in its incarcerated population, leaving the country with the largest prison population of any country in the world.[31] Within the last five to ten years, state and local governments throughout the US began reconsidering an incarceration-based approach to drug addiction, particularly as imprisonment failed to reduce rates of addiction. Arrests for drugs, however, mask the whole story, as 74 percent of all inmates in one state sample exhibited lifetime substance abuse or dependence disorders, as classified by the DSM-IV.[32] This means that many offenders who are in prison for violent or property crimes also struggle with drug addiction. Thus, the prevalence of drug addiction in the vast criminal justice system is itself staggering.

Prison is a remarkably poor environment for combatting drug addiction. Take Toronchuk's three evidence-based treatment methods:

> Treatments *that provide individuals the slow release of dopamine associated with social support* rather than supraphysiologic bursting, do seem to show the greatest promise. *In particular, the various 12-step programs that utilize continued social support can be combined with medical treatments and cognitive therapy*.[33]

Prisons are notoriously bad environments for all three evidence-based approaches: medical treatment, social support, and therapy. In fact, the early Quaker penitential model, which served as the inspiration for our modern prison system, proscribed isolation for the purpose of reflecting on sins. While the modern prison system remains an isolating experience, there have been efforts to incorporate the three approaches above. For instance, prisons are not known for producing positive health outcomes.[34] Furthermore, there is not enough drug treatment capacity in prisons.[35] However, when available, residential drug treatment programs appear effective.[36] There is also evidence that prosocial support mechanisms, such as education and family reunion programs, increase the likelihood of effective reentry and decreased recidivism. Alas, such programs are not available at all prisons or to the entire prison population within individual institutions.[37] In fact, "less than 20 percent of [federal] inmates with drug abuse or dependence receive treatment."[38] Without such social supports, prisoners instead face a negative social prison culture and a process referred to as prisonization, which does not result in positive long-term outcomes for inmates.[39] Finally, cognitive behavioral therapy shows promise for reducing recidivism, but it is also not always available to inmates, especially in overcrowded prisons.[40] Having established that, as currently structured, prisons in the United States does not utilize the evidence-based methods highlighted above, I now turn to presenting a different model that does.

An Evidence-Based Policy for Addressing Four Dimensions of Drug Addiction

This section will build upon the four dimensions of addiction—moral, social, biological, and spiritual—presented by Loftus in *Christianity Today*.[41] I use this as a framework for presenting alternative methods to mass incarceration for treating drug addiction. When possible, I also highlight the evidence that supports these alternatives and I give examples of governments that are implementing such programs. Importantly, this is not a purely public policy. The church also plays a key role in addressing the four dimensions. Indeed, many churches are already on the front lines of fighting the spreading opioid epidemic in communities across the United States.[42]

The Moral Dimension

While there is growing recognition of the physiological pathways of addiction, controversy remains among Christians as to whether addiction is a moral failing or a disease. The moral failure framing relies on God's commands regarding drunkenness, which surface across both the Old and New Testaments.[43] Christians cannot thus ignore the moral dimension of addiction. But, to view it solely as a moral failing misses the other important dimensions, and any policy response emergent from that single frame is unlikely to bring true healing. Clearly, science and the Christian ethic need to be merged. Christians should emphasize the need for us to protect our minds (Prov. 23:29–35), guard our bodies as temples (1 Cor. 6:19–20), and avoid the self-imprisonment of overindulgence (2 Pet. 2:17–22). But as this theme issue highlights, shaming and warning are not enough. The physiological pathways of addiction remove some of the agency required to "Just Say No."[44] How then can public policy maintain a moral dimension by warning citizens about the dangers of addiction?

For over three decades, the United States has educated young people about the pitfalls of drug addiction in primary and secondary schools. The Drug Abuse Resistance Education (DARE) program is perhaps the most publicly recognizable effort. While DARE's effectiveness came into question by the late 1990s, recent research highlights some of the more effective elements of drug abuse prevention education programs.[45] It is important to recognize that effectiveness of different techniques varies depending on students' developmental level.[46] In terms of generally effective elements, one systematic review offers the following seven evidence-based quality criteria:

1. Effects of program must be proven
2. Interactive delivery
3. Social influence model is superior
4. "Focus on norms, commitment not to use, and intentions not to use"

5. Include community interventions
6. Use of peer leaders
7. Inclusion of broader life and social skills[47]

One of the challenges in widely implementing such evidence-based approaches, however, is the decentralized nature of school curriculum decisions. States make such decisions, and they vary greatly in terms of the fidelity of their standards to recommended content and pedagogical practice.[48] Further, we know from political science that controversial curriculum is not taught equally across classrooms, as it is influenced by local public opinion and variation in teacher knowledge.[49] One policy response to the moral dimension is thus to encourage states to move toward scientifically assessed models of drug education.

Something that we must also wrestle with in the moral dimension is whether to continue domestic prohibition and international interdiction. The United States has spent a substantial sum of money in both efforts, with questionable results.[50] In addition, strict drug control policies can amplify suffering by preventing palliative care and the treatment of pain.[51] The question is how to retain a moral position on the issue of drug addiction while recognizing that criminalizing and incarcerating individuals with drug abuse and drug dependence is ineffective. Full prohibition has not worked, but full legalization removes any moral dimension to the problem.

Decriminalization for some drugs offers a potential middle ground for Christians. For example, Portugal in 2001 decriminalized the use of all drugs. This means that the country still jails and/or fines dealers and traffickers, but those found guilty of possession receive treatment instead of prison. In the first five years, Portugal saw reductions in overdose deaths, diseases related to drug use such as Hepatitis C, and prison crowding, while not experiencing increases in use.[52] State and local governments in the US are experimenting with decriminalization and treatment instead of incarceration. There is evidence that treatment can be less expensive, and certainly more effective, than imprisonment for those addicted to drugs.[53] The key for effective decriminalization, however, is a widespread and consistent approach, such as that of Portugal. Some states experimented with limited decriminalization of marijuana in the 1970s, but this approach demonstrated limited effects beyond a positive financial impact.[54] Decriminalization, as opposed to full legalization, with required treatment provides a policy option that retains the moral dimension, while also addressing the other three dimensions of the problem.

The Biological Dimension

Several treatments for drug addiction demonstrate effectiveness at helping addicts recover inhibition and critical thinking pathways that are altered by drugs. Though their use may be controversial, medications like methadone, buprenorphine (Suboxone), topiramate, and naltrexone demonstrate effectiveness in treating opioid and alcohol addiction.[55] Such drugs alleviate withdrawal symptoms and, over time, the brain repairs the reward, impulse control, and critical thinking pathways altered by drugs.[56] Medications like naltrexone also show promise in treating other chemical and behavioral addictions.[57] While still in the early phases of scientific assessment, brain stimulation of the prefrontal cortex (i.e., the brain's inhibition center) demonstrates promise in treating addiction, particularly for drugs such as cocaine that have no alternative pharmacological treatment.[58]

For Christians, a more complicated recent finding is that states with medicinal marijuana programs appear to experience declines in opioid overdose mortality.[59] While there are important criticisms of current research methodology[60] and additional research explicating such a relationship is necessary, the underlying theory carries face validity. Essentially, the expectation is that medical marijuana can be prescribed as an alternative pain management tool to opioids. As Toronchuck notes in her article, marijuana is less addictive than opioids. Additionally, there is little scientific evidence of a broad gateway effect for marijuana.[61] Thus, marijuana offers a compelling alternative to opioids for pain management.

The challenge for the church, however, is that marijuana is often demonized in concert with other illicit drugs. In fact, marijuana holds a somewhat unique place in the history of American drug prohibition and American culture. Its nativist roots were shared by opium prohibition, but marijuana experienced pivotal episodes in American popular culture. Such events include the publication of *Assassin of Youth*,[62] production of *Reefer Madness*, hippies, appearances in multiple musical genres, Bill Clinton not inhal-

ing, and Barack Obama inhaling frequently because "that was the point."[63] Throughout this history, marijuana's place in popular culture evolved from hysteria to acceptance. Catholic and Protestant churches remain active advocates against marijuana, including recent state efforts to legalize medicinal and/or recreational marijuana. In 2016, for example, the Archdiocese of Boston provided almost $1 million in the fight against Question 4, which legalized recreational marijuana in Massachusetts.[64] The question is where the church should stand if regulated medicinal marijuana use provides an alternative to more addictive, and deadly, opioids.

Some Christian thinkers are open to the use of medicinal marijuana, while still maintaining a prohibitionist stance toward recreational marijuana.[65] This may in fact be the appropriate middle ground that incorporates the moral concerns of Christianity toward overindulgence, while also recognizing the potential for saving lives and relieving human suffering. Approving medicinal marijuana (including removal from Schedule 1 of the Controlled Substances Act), while also decriminalizing other illicit drugs and consequently shifting resources into treatment instead of imprisonment, offers a more compassionate and more effective response than prison with sparse access to treatment.

Recognizing the brain disease model is necessary for Christians and public policy; bioethicists, however, raise important concerns regarding viewing the brain disease model in isolation. Namely, it can result in a shift from a moral definition of "otherness" to a disease definition of "otherness" that still results in individual and collective efforts to isolate those addicted to drugs.[66] Such isolation, regardless of whether it results from a singular focus on the moral or biological dimension, ignores the social dimension of addiction.

The Social Dimension

Carla Meurk and colleagues argue that focusing only on the brain disease model ignores the "we" of our social existence.[67] Johann Hari, author of *Chasing the Scream,* summarizes this dimension succinctly when he says, "The opposite of addiction isn't sobriety, it is connection."[68] Addiction and recovery each have important social elements. In terms of addiction, social experience during development (e.g., maternal separation) and the social context of drug use interact with underlying individual differences to explain addiction proclivity.[69] In terms of recovery, 12-step programs and cognitive behavioral therapy demonstrate long-term positive effects, while family therapy and group counseling show the largest positive benefits for adolescents.[70] The state of Delaware piloted an effective community addiction treatment program within its prisons.[71] It is further apparent that social attachment is a key to increasing resilience against addiction and rewiring the brain pathways that relate to addiction; however, this presumes a healthy social environment.[72] An unhealthy social environment, for example, social relationships with those who are users, otherwise reinforces dependence. As far as public policy is concerned, this research points us toward the most effective forms of treatment in a decriminalized environment.

The social dimension is also a key avenue of engagement for the church. As Lindsay Stokes writes for *Christianity Today*,

> If the Christian church has anything to offer those hurting from opioid addictions, it is connection: connection to a community, connection to resources, and most critically, connection to a God who saves.[73]

The church is already operating on the front lines of addiction, broadly speaking, and the opioid crisis, in particular, as churches are homes to both 12-step programs and Narcan (naloxone) availability.[74] Thus, the church plays an important role in offering community for the purpose of combating addiction. Community and relationship are deeply embedded in Christianity's views of humanity and God. The Trinity offers a model for human relationships, as the Father, Son, and Holy Spirit exist in (sacrificial) relationship with each other.[75] Moreover, humans were created to be in communion with God and one another. Finally, the early church is often pointed to as an example of Christian community (Acts 2:42–47). Members of the church held property in common, supported each other's needs, regularly broke bread together, and worshiped God corporately. Thus, the church should always offer a supportive community to fellow men and women struggling with addiction.

The challenge for the church is to make connections between week-night 12-step groups and Sunday mornings. Believing in a higher power is a cornerstone of Alcoholics Anonymous (AA) and its derivatives, but participants tend to express a vague

notion of spirituality. As Barbara Gilliam reminded the American Association of Christian Counselors, church attendance in America is on the decline, but AA attendance is increasing.[76] The church needs to address the disjuncture between offering a space for an "honest and transparent community" (i.e., AA) and building such community within the rest of the church.[77] There is no shortage of writing or evidence that both Christians and non-Christians today are more skeptical of institutionalized churches.[78] Given that the church is the bride of Christ, it is true, as Pope Francis and other Protestant writers have claimed, that one cannot dichotomize the two.[79] It is also clear, however, that the church has work to do in developing the types of authentic community necessary to merge the social and spiritual dimensions of addiction recovery.

The Spiritual Dimension

In the existentialist view presented above, only Christ/God can fill Pascal's "God-shaped vacuum." Specifically, it is salvation through Christ that allows us to become a new creation and bridge the estrangement with God, though while we remain in a physical body we are not fully healed, nor does the tension between spirit and flesh fully subside.[80] Jesus talks of being the bread of life (John 6:35). In his Sermon on the Plain in Luke 6:17–49, Christ tells his apostles that "blessed are you who hunger now, for you will be satisfied." Further, he tells the Samaritan woman at the well in John 4:13–14 that those who drink of the well from which she drew water will become thirsty again, but those who drink of his living water will never be thirsty. These appear to be metaphysical promises of future fulfillment, but Paul also writes of present contentment that comes from Christ (Phil. 4:10–13) and tells Timothy that godliness paired with contentment is of great gain (1 Tim. 6:6–10), as contrasted to a pursuit of money (i.e., worldly satisfaction/gain). Thus, we will receive fulfillment in Christ, but, as Augustine suggests, this occurs through ongoing submission to God. It is a process, not a moment.

The physiological and psychological aspects of addiction illustrate the dissatisfaction that emerges from dependence on worldly pleasures. Repeated usage of drugs does not lead to more euphoria; instead, it undermines the reward center of the brain, making an addict not so much long for a high, but for relief from the pain of withdrawal.[81] Thus, in addition to biological and psychological support, spiritual healing is necessary for addressing the idols in our lives. The need for submission to a higher power and continual support and healing was recognized by the creators of AA. In fact, the program is a combination of social support, spirituality, religiousness, life meaning, and 12-step programs that support long-term recovery.[82] In his extended discussion of the different models of alcoholism, addiction psychiatrist Christopher Cook argues for a theological model of addiction that builds on the notion of the divided will, but still recognizes the biological (psychological) dimension of addiction.[83] One reviewer describes the book's view as: "Cook reckons that theology can be an important corrective to the tendency toward reductionism and determinism in contemporary discourse, with their consequence of nihilism in treatment."[84] In addition to the moral, biological, and social dimensions, churches play a vital role in offering spiritual raiment that is essential to addiction recovery.

Conclusion

Drug addiction is a multifaceted problem that cannot be reduced to a single dimension. Effective treatment requires attention to all four of the hereinpresented dimensions: moral, biological, social, and spiritual. Of course, the state can only go so far in legislating these dimensions. Public policy responses to drug addiction can address the moral, biological, and social aspects of addiction by establishing appropriate consequences and restorative supports for the addicted. However, the church is a necessary partner in providing social support and spiritual redemption through the person and work of Jesus Christ. Even secular 12-step programs, like AA, recognize the importance of relying on a higher power. Christians offer a higher power that heals the broken and finds the lost. Likewise, the church must recognize the multiple dimensions of addiction. Reducing the problem to a moral failing and assuming addicts have full agency in making choices results in marginalization, punishment, and isolation.[85] Christ calls us to recognize the plank in our own eye before removing the speck in our brother's.[86] C.S. Lewis reminds us of the danger facing the self-righteous:

> The dangers of apparent self-sufficiency explain why Our Lord regards the vices of the feckless and dissipated so much more leniently than the vices that lead to worldly success. Prostitutes are in no

> danger of finding their present life so satisfactory that they cannot turn to God: the proud, the avaricious, the self-righteous, are in that danger.[87]

Drug addiction is not a special class of sin. It requires personal and social restoration, like any sin. Thus, the church, in light of Christian social ethic and science, should be a force in establishing a restorative addiction care and criminal justice system, more broadly.

Notes

[1]Centers for Disease Control and Prevention, "Understanding the Epidemic," https://www.cdc.gov/drugoverdose/epidemic/index.html.

[2]For example, see George P. Shultz and Pedro Aspe, "The Failed War on Drugs," *The New York Times* (2017), https://www.nytimes.com/2017/12/31/opinion/failed-war-on-drugs.html.

[3]AA itself is said to have Christian roots. Specifically, its practices are viewed as Jesuit; this idea is often credited to the involvement of Jesuit Priest Father Ed Dowling who was the first sponsor of AA co-founder Bill Wilson.

[4]Matthew Loftus, "Is Addiction a Disease? Yes and Much More," *Christianity Today* 60, no. 10 (2016): 41.

[5]Jason Pittman and Scott W. Taylor, "Christianity and the Treatment of Addiction: An Ecological Approach for Social Workers," in *Christianity and Social Work: Readings on the Integration of Christian Faith and Social Work Practice*, ed. Beryl Hugen and T. Laine Scales (Botsford, CT: North American Association of Christians in Social Work, 2002).

[6]Judith A. Toronchuk, "Addiction: Diseased Brain, Divided Will, or Restless Heart?," *Perspectives on Science and Christian Faith* 70, no. 4 (2018): 218–31.

[7]All references to the Bible are drawn from the NIV translation.

[8]Wendy Alsup, "Her Desire Will Be for Her Husband," (2010), http://theologyforwomen.org/2010/04/her-desire-will-be-for-her-husband.html; Susan T. Foh, "What Is the Woman's Desire?," *Westminster Theological Journal* 37 (1974–75): 376–83.

[9]Pittman and Taylor, "Christianity and the Treatment of Addiction"; Mark Kline Taylor, ed., *Paul Tillich: Theologian of the Boundaries* (Minneapolis, MN: Fortress Press, 1991); Howard John Clinebell, *Understanding and Counseling Persons with Alcohol, Drug, and Behavioral Addictions* (New York: Abingdon Press, 1998).

[10]Augustine of Hippo, *Confessions*, trans. Henry Chadwick (Oxford: Oxford University Press, 1991), 3.

[11]Blaise Pascal, *Pensées*, trans. W. F. Trotter (South Australia: University of Adelaide, 2014), 7.425, https://ebooks.adelaide.edu.au/p/pascal/blaise/p27pe/index.html.

[12]C. S. Lewis, *The Problem of Pain* (New York: Macmillan, 1962), 146–47. Emphasis added.

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