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Does the biopsychosocial-spiritual model of addiction apply in an Islamic context? A qualitative study of Jordanian addicts in treatment

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ABSTRACT

Background: There is a dearth of research in the published literature on substance use and addiction in the Middle East and Islamic countries. This study was the first to explore whether the biopsychosocial-spiritual model of addiction was relevant to an addicted treatment population in Jordan, an Islamic country.
Methods: A qualitative study design using semi-structured, face-to-face interviews were conducted with a sample of 25 males in addiction treatment. The sample was drawn from a cohort of in-patients at a treatment centre in Amman, Jordan who had already participated in a quantitative survey. A purposive sample was selected to ensure the inclusion of a range of characteristics that might affect their experience of developing addiction and its consequences, i.e., age, marital status and educational level. Interviews were transcribed and thematic analysis conducted using verbatim quotes to illustrate themes. Themes were mapped onto the biopsychosocial-spiritual model of addiction.
Results: This study found addiction was associated with a range of health (physical and psychological), social and spiritual factors. Unpleasant physical withdrawal effects, psychological symptoms, such as anxiety and suicide attempts, were experienced. There was breakdown in marital and family relations, loss of employment, involvement in crime and neglect of religious practices, resulting in social isolation.
Conclusion: This study found that, despite some differences in emphasis, the biopsychosocial, spiritual model of addiction fit wel,l particularly given the relative importance of religion in Islamic culture. Spirituality was not explored and further study of spirituality versus religious practice in this culture is recommended.

1. Introduction

1.1. Substance use, Islam and the Jordanian context

Substance use and addiction is a worldwide phenomenon. In some countries and societies, the establishment decides which substances are acceptable Society is thus a key factor in determining whether or not a substance is considered harmful (Wanigaratne et al., 2007). The definitions of addiction and diagnostic criteria applied in Western countries may be problematic when applied internationally, but at the same time it is recognized that problematic substance use and addiction is observed across the world, in people from different cultural and religious backgrounds (Nasir and Abul-Haq, 2008). Although Islamic countries are associated with less substance use as the Islamic religion is considered protective (UNODC, 2011), there is still problematic substance use (Sloan, 2014; Adib, 2014). Good epidemiological data from this region is rare. A global review of the prevalence of injecting drug use found little data from the Middle Eastern Countries (Mathers et al., 2008). Some prevalence data on alcohol is available via the World Health Organisation (WHO) listing the rate of problematic alcohol use in the adult population in Jordan to be higher than other Eastern European Regions (0.4% compared to 0.3%) (WHO, 2015). Data on drug seizures found Jordan recorded an increase in amphetamine seizures in 2008–2009 and ranked fifth in the world after Saudi Arabia, USA, China and Mexico. Approximately 29 million captagon (amphetamine and theophylline) tablets were seized in 2009 (USDS, 2011).

Jordan is a small country in the Eastern Mediterranean region (population: 7.6 million). Unlike other countries in the region it has no oil and is classified by the World Bank as a lower middle income country. However, it is a relatively well educated society

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Table 1
Demographic profile of participants.

Ref	Age	Marital Status	Employment	Educational level	Substance
2	23	Single	Employee	Primary	Alcohol
11	37	Divorced	Unemployed	Primary	Alcohol
31	52	Divorced	Unemployed	Primary	poly substance
84	24	Single	Unemployed	Secondary	alcohol
94	38	Divorced	Unemployed	Secondary	Heroin
142	42	Divorced	Employee	Primary	Alcohol
143	29	Married	Employee	Secondary	Heroin
201	33	Divorced	Employee	Primary	poly substance
202	35	Single	Unemployed	Secondary	Alcohol
203	40	Divorced	Employee	University	Poly sub
210	34	Divorced	Unemployed	Secondary	Alcohol
212	26	Single	Unemployed	Primary	Heroin
218	23	Single	Unemployed	Primary	Poly substance
220	39	Married	Unemployed	Primary	Alcohol
224	44	Divorced	Unemployed	Primary	Heroin
225	30	Single	Own business	Secondary	Alcohol
226	35	Married	Unemployed	Primary	Poly-substance
230	31	Single	Unemployed	Secondary	Alcohol
231	25	Divorced	Unemployed	Primary	Alcohol
238	39	Single	Unemployed	Primary	Poly substance
242	47	Married	Unemployed	Secondary	Alcohol
245	34	Married	Unemployed	Secondary	Alcohol
234	45	Divorced	Unemployed	Secondary	Alcohol
223	41	Divorced	Employee	Secondary	Alcohol
140	40	Single	Unemployed	Secondary	Alcohol

with a literacy rate of 92% (DOS, 2011). In Jordan, as in other Islamic countries, drug and alcohol use is forbidden. No distinction is made between alcohol and psychoactive substance as both are considered 'intoxicants'. Ali (2014) explored Islam's perspective of drug addiction, noting shame and guilt as key factors. The Quran states in several verses that intoxicants are forbidden. In Surah Baqarah, for example: "*They ask you regarding wine and gambling. Say, in both of them is major sin, and there is some benefit for men, but the sin of them is far greater than benefit*".

The common psychoactive substances used recreationally in Jordan are alcohol, cannabis, opiates, stimulants, benzodiazepines and other sedatives and analgesics (Weiss et al., 1999) including both legal and illegal substances.

1.2. Models of addiction

The concept and descriptions of addiction, particularly alcoholism, have evolved in western medical literature since early writings by Trotter (1804), cited by Vale and Edwards (2011).

The "biopsychosocial disease model" emerged in America in the 1970s and brought the three domains of biological, social and psychological together (Engel, 1977; Schwartz, 1982). This model is a conceptual framework that implicates numerous biological, psychological and social factors as playing a part in the development of addiction. Consequently, it is considered that all three domains must be considered in treatment. They are "*all more or less equally relevant, in all cases, at all times*" (Ghaemi, 2009). An appreciation of the model has been stated "*We all love the biopsychosocial model in psychiatry because it gives us a warm inclusive glow and the knowledge that almost every aspect of practice can be incorporated within it*" (Tyrer, 2009).

In addition, evidence of a spiritual/religious dimension as an important protective factor in the development of and recovery from addiction has resulted in a spiritual dimension being added to the biopsychosocial model (Miller, 1998; Morgan, 1999; West, 2006). Religion is an important aspect of Islamic societies but it is not known whether this conceptualisation of addiction fits with Islamic culture. No previous study of the biopsychosocial-spiritual model of addiction in an Islamic context was identified in the literature.

The aim of this study was to explore the characteristics of addicts in treatment in Jordan, their addiction journey and its consequences and to consider whether the biopsychosocial-spiritual model of addiction applies to an Islamic context.

2. Method

2.1. Study sample

The population selected for the study was a clinical population receiving treatment in Amman, Jordan. The sampling frame was a cohort of those attending a treatment centre in Amman, Jordan between 2008 and 2009. A purposive sample was drawn from this cohort of 250 men who had already participated in a quantitative survey (Al Ghaferi, 2013). A range of characteristics that might affect their experience of addiction and its consequences, i.e., age, marital status and educational level were included. The treatment centre only treated males.

The first contact with potential participants was by their physician who gave them an information sheet. Written consent was sought by their physician or the researcher.

2.2. Data collection

A topic guide (semi-structured interview) was developed which covered a participant's experience of developing addiction and subsequently seeking treatment. The topic guide was framed within the biopsychosocial-spiritual model of addiction and covered development of dependence and consequences of substance use. The first five interviews were considered a pilot, but no changes were required so these were included in the analysis.

The interviews were all conducted in Arabic, by the lead author (HA). Data collection continued until data saturation had been achieved (i.e., no new themes arose). Interviews were conducted from July 2008 to August 2009.

2.3. Data management and analysis

Interviews were transcribed in Arabic and checked for accuracy. Transcriptions were translated into English for analysis. For a sam-