Addiction Research

WHEN THE SOUL FALLS ILL: Existential Distress, Moral Injury, and Loss of Meaning as Transdiagnostic Drivers of Addictive Behaviors and Recovery

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ABSTRACT

Addiction science has developed powerful models of reinforcement learning, cue reactivity, neuroadaptation, and impaired control. However, in clinical consultations, families, and in the private silence of relapse, many people describe something even more basic than craving: the loss of an inner home. They say "I feel empty", "I can't stand being with myself", or "I have betrayed who I am". Sometimes they choose a simple and devastating phrase: "my soul is ill". This narrative review treats that expression as clinically meaningful, not metaphysical. We translate "illness of the soul" into five operational psychological dimensions directly relevant to addictive vulnerability and recovery: coherence (value–action alignment), dignity (moral worth protected from humiliation), care (self-compassion, boundaries, and prosocial concern), truth (contact with inner experience and reality), and purpose (meaning and direction). We integrate evidence from negative reinforcement and self-medication models, self-determination theory, research on shame and self-stigma, psychological flexibility and experiential avoidance (ACT), compassion-focused approaches, and the emerging literature on moral injury. From this synthesis we propose the Meaning–Dignity Disconnection Model of Addiction (MDDMA), a clinically usable and empirically testable loop in which loss of meaning and injuries to dignity intensify shame, avoidance, and isolation, increasing reliance on substances or compulsive behaviors as rapid regulation strategies. We argue that recovery becomes more durable when treatment complements symptom reduction with restoration of meaning, moral repair, rebuilding of dignity, and reconnection with caring relationships. Beyond individual therapy, the model has implementation implications: programs that protect dignity, avoid humiliation, and offer reintegration pathways after slips may reduce dropout and relapse by preventing shame-driven secrecy. We conclude with testable hypotheses, a measurement map, and practical guidance for clinicians and programs seeking to protect dignity and strengthen long-term recovery capital.

Keywords

Addiction, Craving, Relapse, Meaning in life, Moral injury, Shame, Self-stigma, Self-compassion, Experiential avoidance, ACT, Recovery capital, Dignity, Eudaimonic well-being, Psychological flexibility.

Highlights

- Many people describe relapse risk as the inability to remain with themselves without anesthesia.
- "Illness of the soul" can be operationalized in five measurable dimensions: coherence, dignity, care, truth, and purpose.
- Shame, humiliation, and moral injury may act as existential triggers of craving and avoidance.
- Durable recovery improves when abstinence is connected to meaning, dignity, and a credible future narrative.
- The MDDMA framework is compatible with evidence-based practice and generates testable hypotheses.

Introduction

There is a recurring clinical moment that rarely appears in diagnostic manuals. The person has stopped—or almost—and the old relief has disappeared. The room falls silent. Then they say, not always in tears but with a disconcerting honesty: "now I have to live with myself". That sentence is not poetry; it is a diagnostic clue. It marks the point at which addiction stops being only a substance or habit problem. It becomes an encounter with the self:

sometimes with a self that feels empty, ashamed, fragmented, or morally injured.

Terminological note. In this article, "soul" is used as a phenomenological and clinical—not religious—term to name a set of human experiences that are observable and measurable. If the reader or patient prefers another language, it can be replaced by "inner home", "psychological integrity", or "identity coherence" without loss of precision. The focus of the manuscript is not metaphysics, but mechanisms: coherence, dignity, care, truth, and purpose.

A brief personal–clinical observation (why it matters)

Across years of work in leadership and human development, one pattern repeats: people can tolerate pain when it has meaning, but they collapse when pain is experienced as useless and humiliating. In addictions this becomes dramatic. Someone may endure detoxification, craving, and insomnia and relapse after a contemptuous phrase. Another holds on for weeks and falls after a silent emptiness on a Sunday afternoon. These are not "random failures": they are signs that meaning and dignity are not decorative. They are structural.

This is why this article speaks in two registers. It uses academic language because a journal requires it. But it preserves lived language because clinical work needs it. The goal is not to romanticize suffering: it is to reduce relapse by naming the real triggers.

Public conversation still imagines addiction as the pursuit of pleasure. In practice, many addictions are the pursuit of relief: relief from anxiety, dysphoria, loneliness, intrusive memories, ruthless self-criticism, and existential distress. When relief is the reinforcer, the "reward" can be negative reinforcement—removing pain—more than pleasure. The clinical question is not only "what is being relieved", but "what kind of pain is being anesthetized". For a substantial portion of people, the pain is not only affective: it is existential. It is the collapse of meaning, an injury to dignity, a betrayal of values, and a growing difficulty remaining present with one's own inner life.

People do not speak in constructs: they speak in the language of survival. And sometimes, in the language of the soul. Academia is uncomfortable with that word because of its religious or metaphysical connotations. But the experience it condenses is neither vague nor irrelevant. It is a compact label for processes studied for decades: value incongruence, shame and self-stigma, moral emotions, moral injury, experiential avoidance, dissociation, and disconnection from caring relationships. If we discard the language, we risk discarding the core.

Objective and contribution

Objective. We build a bridge: we propose that what many patients call "soul illness" can be translated into a small set of psychological dimensions that (a) are consistent with evidence-based models, (b) are measurable, (c) illuminate relapse mechanisms, and (d) provide

actionable targets for treatment and program design.

In addition, we propose that these five dimensions function as early indicators of vulnerability: when they drop, relapse risk increases even if the person maintains apparent abstinence. Therefore, the model is useful not only for treatment, but also for prevention and for quality evaluation of programs, by offering observable criteria of "inner health" that precede use events.

Methods: Narrative Review Approach

This is a narrative review with an integrative and clinical orientation. We synthesize evidence across: (1) negative reinforcement and self-medication models; (2) self-determination theory and needs frustration; (3) shame, humiliation, and self-stigma; (4) psychological flexibility and experiential avoidance (ACT); (5) compassion-focused and self-compassion approaches; and (6) moral injury and moral repair.

Minimum process transparency. The search was carried out iteratively (initial search, backward and forward citation chaining, and a final refinement by clinical relevance). Systematic reviews/ meta-analyses were prioritized when available, and highly cited theoretical texts were added to support definitions and conceptual bridges.

Given the scope of the journal and the purpose of the paper, we prioritize conceptual coherence, clinical utility, and testable propositions rather than exhaustive PRISMA-style coverage. References are used to anchor each dimension in established empirical literatures.

In-text citations note: The conceptual and clinical synthesis in this review is grounded in core literatures on self-efficacy, self-determination, meaning-centered approaches, compassion, acceptance and commitment processes, antireward and relapse prevention models, stigma and shame, craving, and neurobiological advances in addiction [1-15].

Conceptual Background: Why "Meaning" And "Dignity" Matter in Addiction

Negative reinforcement, self-medication, and existential distress

Many addictive patterns are maintained by relief rather than pleasure. Substance use or compulsive behaviors reduce aversive states (anxiety, shame, emptiness, loneliness, traumatic activation). This aligns with negative reinforcement and self-medication frameworks, and suggests that understanding the aversive state being reduced is essential.

Existential distress is not just "sadness". It involves meaning collapse, hopelessness, identity fragmentation, and moral pain. These states can amplify craving through urgency to escape.

Self-determination theory and needs frustration

When autonomy, competence, and relatedness are chronically frustrated, motivation becomes controlled, shame increases, and

people seek short-term regulation. Addictions can function as a substitute route to perceived autonomy ("I choose"), competence ("I can cope"), or relatedness ("I belong")—but at high cost.

Shame, humiliation, and self-stigma
Shame is a moral emotion tied to the self ("I am bad"), often fueled by humiliation and social rejection. Self-stigma converts social stigma into inner identity, increasing secrecy, isolation, and avoidance. Shame-driven secrecy is a major relapse amplifier: when the person cannot tell the truth about risk or slips, the relapse loop accelerates.

Psychological flexibility and experiential avoidance (ACT)
Experiential avoidance—efforts to escape or control unwanted inner experiences—predicts many addictive patterns. Psychological flexibility (openness, present-moment contact, values-based action) is associated with better outcomes. This aligns directly with the "truth" and "coherence" dimensions proposed here.

Compassion-focused approaches and moral repair
Compassion reduces shame and self-attack, supports reintegration after slips, and strengthens sustained behavior change. Moral repair—acknowledging wrongdoing, making amends, rebuilding trust and identity—relates to dignity and coherence, and intersects with the moral injury literature.

From "Soul Illness" To Five Operational Dimensions
We propose five dimensions that together capture what many people call "soul illness" in addiction contexts. They are conceptual, but also operational and measurable.

Coherence (value–action alignment)
Coherence refers to living in accordance with one's values and identity. When coherence drops, people experience a "double life", self-betrayal, and fragile commitments. Coherence loss fuels shame and destabilizes recovery narratives.

Dignity (protected moral worth)
Dignity is the sense of moral worth that can be injured by humiliation, contempt, violence, exclusion, or self-degradation. Dignity injury is not merely low self-esteem: it is moral pain. In addiction, dignity injury often triggers "I give up" moments and secrecy.

Care (self-compassion, boundaries, prosocial concern)
Care includes self-compassion, the ability to set boundaries, and a prosocial orientation that reconnects the person with human belonging. Care counteracts self-attack and supports sustained effort after setbacks.

Truth (contact with inner experience and reality)
Truth refers to honest contact with internal experience (emotions, cravings, triggers) and external reality (consequences, relationships). It opposes denial, dissociation, and secrecy. Truth is a clinical mechanism: when truth increases, relapse loops weaken because help-seeking and co-regulation become possible.

Purpose (meaning and direction)
Purpose involves meaning, direction, and a future narrative. When purpose collapses, abstinence can feel like an empty life. Rebuilding purpose is not grandiosity; it can start with micro-purpose and realistic contribution.

The Meaning–Dignity Disconnection Model of Addiction (MDDMA)
The core loop
We propose that addiction risk escalates when meaning and dignity are disconnected, producing shame, avoidance, and isolation. Substances or compulsive behaviors then function as rapid regulation strategies. The relief reinforces the loop, while consequences further injure dignity and coherence, deepening shame and secrecy.

Testable hypotheses
H1: Drops in purpose and dignity precede increases in craving and avoidance within individuals.
H2: Shame and self-stigma mediate the effect of dignity injuries on relapse risk.
H3: Psychological flexibility moderates the impact of existential distress on craving.
H4: Interventions that increase truth-telling (reducing secrecy) predict better retention and lower relapse.
H5: Programs with reintegration protocols after slips show reduced dropout and improved outcomes compared to
punitive models.

Table 1: Pragmatic map of the five dimensions.

Dimension	Operational focus	Example measures (as applicable)	Brief clinical question
Coherence	Value–action alignment; integrity; authenticity	VLQ/values-based living measures; self-congruence scales	"Where are you not living your values this week?"
Dignity	Exposure to humiliation; self-stigma; injury to moral worth	Measures of internalized stigma; humiliation scales; moral injury screening (civilian adaptation)	"Where are you treated—or do you treat yourself—as 'less than'?"
Care	Self-compassion; safe support; recovery capital	Self-Compassion Scale (SCS); recovery capital measures; social support scales	"What act of care can you do for yourself today?"
Truth	Psychological flexibility; emotional contact; dissociation risk	AAQ-II/flexibility measures; dissociation screening when appropriate	"What emotion are you avoiding right now, and where do you feel it in your body?"
Purpose	Meaning presence/search; credible future narrative	Meaning in Life Questionnaire (MLQ); life purpose measures	"What is your 'why' for recovery this month, even if it is small?"

Measurement Map and Practical Operationalization
Suggested measures and clinical questions
Each dimension can be mapped to existing measures and brief clinical questions (Table 1). The goal is pragmatic: not to add burden, but to create a shared language that reduces moralization and increases alliance.

Study design notes (how to test the model in 12 weeks)
A pragmatic way to test MDDMA is an intensive longitudinal design over 12 weeks in outpatient or residential treatment. Weekly measures can include: craving, use (if any), meaning (presence/search), self-stigma/shame, psychological flexibility, belonging, and recovery capital. Analyses can focus on:

(a) mediation: does craving decrease when meaning increases via reduced shame and reduced avoidance?

(b) moderation: does self-compassion buffer the impact of shame on relapse?

(c) multilevel models: do within-person week-to-week variations predict relapse better than baseline levels?

(d) program effects: compare centers with explicit reintegration-after-slip protocols versus punitive centers.

At the micro-temporal level, ecological momentary assessment (EMA) can capture daily changes in shame and meaning that precede craving spikes. This brings the model closer to real mechanisms: not only who will relapse, but when and after which micro-events.

A map of outcomes: beyond abstinence (what to measure)
Sustainable recovery is not reduced to "zero use". To evaluate MDDMA it is advisable to incorporate indicators of life rebuilding: relational quality, work/education reintegration, self-efficacy, eudaimonic well-being, subjective sense of dignity and coherence. These indicators may be sensitive to dignity-oriented interventions even if consumption takes longer to stabilize. In other words: the first observable change may be "less secrecy and more truth", before "zero relapses". And that change may be the most valuable early predictor.

Implications for Measurement and Evaluation
The five dimensions can be used as a quality lens for programs. Programs do not only "treat addictions"; they also inadvertently manufacture shame or manufacture dignity through language, policies, and reintegration practices.

Table 2 as a shared clinical decision tool (shared decision-making)
A benefit of mapping dimensions is that it enables a non-defensive clinical conversation. Instead of "you must stop", the clinician can say: "I see your dignity is injured and that is why the urge to anesthetize appears; let's protect dignity and build meaning". This language reduces shame, increases alliance, and supports commitment. It also enables prioritization: if the lowest dimension is truth (due to dissociation/trauma), the initial intervention may not be purpose-building but stabilization and internal safety.

Table 2: Six-step clinical pathway (duplicate as in the Spanish source).

Step	Clinical focus (what to assess/name)	Action (what to do in practice)
1) Meaning rupture	Where meaning collapses; what is experienced as emptiness, uselessness, or hopelessness	Evoke a recovery "why"; anchor a meaningful future; clarify values
2) Dignity wound	Humiliation, dehumanization, self-contempt, injury to moral worth	Dignity-protective language; anti-stigma work; rebuild self-respect through commitments
3) Shame narrative	The internal story after a slip ("I'm a failure")	Differentiate guilt vs toxic shame; compassionate reframe; relapse learning plan
4) Avoidance pattern	What is being escaped internally (emotions, memories, moral pain)	ACT skills: acceptance, defusion, willingness; expand distress tolerance
5) Values micro-actions	Small actions that restore coherence (value–action alignment)	Weekly micro-commitments; coherence tracking; self-efficacy via small wins
6) Moral repair plan	When moral injury is present: harms, amends, restitution, reintegration	Amends plan; repair relationships; re-commit values; reintegration rituals/supports

Table 3: Pragmatic map of the five dimensions.

Dimension	Operational focus	Example measures (as applicable)	Brief clinical question
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Dignity	Exposure to humiliation; self-stigma; injury to moral worth	Measures of internalized stigma; humiliation scales; moral injury screening (civilian adaptation)	"Where are you treated—or do you treat yourself—as 'less than'?"
Care	Self-compassion; safe support; recovery capital	Self-Compassion Scale (SCS); recovery capital measures; social support scales	"What act of care can you do for yourself today?"
Truth	Psychological flexibility; emotional contact; dissociation risk	AAQ-II/flexibility measures; dissociation screening when appropriate	"What emotion are you avoiding right now, and where do you feel it in your body?"
Purpose	Meaning presence/search; credible future narrative	Meaning in Life Questionnaire (MLQ); life purpose measures	"What is your 'why' for recovery this month, even if it is small?"

Clinical Implications: Interventions that Fit the Model
Coherence interventions
Values clarification, commitment contracts, "micro-integrity" plans, and learning plans after slips.

Dignity interventions
Humiliation reduction, anti-stigma language, moral repair, narrative reconstruction, restorative practices, and boundaries against contempt.

Care interventions
Self-compassion training, compassionate imagery, relational safety, prosocial contribution, and healthy limits.

Truth interventions
Relapse prevention as truth-protection: early disclosure, accountability partners, crisis plans, and non-punitive reporting cultures.

Purpose interventions
Meaning-making, values-based projects, micro-purpose, realistic contribution, and future narrative building.

Early signals of existential risk (brief list)
Many relapse prevention plans include "high-risk situations" (bars, friends, availability). MDDMA adds existential signals useful for early detection:

- Persistent "I don't feel like anything" (purpose collapse).
- "I'm worthless" or "I'm trash" (injured dignity/self-stigma).
- Avoiding looking at people or answering messages (shame and secrecy).
- Increased self-criticism after small mistakes (shame cascade).
- Compulsive distraction seeking (experiential avoidance).
- Fantasies of "disappearing" or "not feeling" (existential anesthesia).

When these signals appear, the priority intervention is not to argue "willpower", but to activate care, truth, and belonging: contact a safe person, rest, grounding, and a micro-action of dignity.

Rapid intervention checklist (24 hours)
In high-rotation services, a 24-hour list can save processes:

1. Is there physical safety? (medical risk, overdose, withdrawal).
2. Is there a safe person activatable today? (call, group, therapist).
3. What emotion is central? (name it and locate it in the body).
4. What is the trigger: humiliation, emptiness, moral conflict, loneliness?
5. What micro-action of dignity will be done before sleep?
6. What truth commitment will be kept tomorrow? (tell someone).

This checklist is simple, but it targets the core: it cuts secrecy, reduces avoidance, and restores minimal coherence.

Discussion
MDDMA does not replace neurobiological or behavioral models; it complements them by naming the existential and moral layer that many patients describe and that frequently drives relapse. The model is compatible with evidence-based practice: it integrates reinforcement mechanisms, self-determination needs, shame and stigma, ACT processes, compassion and moral repair.

An operational synthesis (the model in one sentence)
Addiction is maintained when immediate relief feels more bearable than living in a self without meaning and without dignity. Recovery consolidates when the self becomes inhabitable again: coherent, dignified, cared for, truthful, and oriented toward purpose.

Three frequent errors in programs (and their correction)
Error 1: confusing "control" with "change". Programs centered on surveillance and punishment may achieve temporary obedience but often increase shame and secrecy. Correction: replace control with responsibility with dignity, clear rules, and reintegration after slips.

Error 2: treating relapse as "betrayal" instead of "signal". When relapse is interpreted as disloyalty, the patient learns to hide. Correction: post-slip protocols that reward truth and fast learning, not perfection.

Error 3: reducing treatment to "stopping the substance". If meaning remains broken, sober life is experienced as empty. Correction: include purpose, bonds, and coherence rebuilding as explicit treatment goals.

Table 4: Low dimension → typical presentation → fitting interventions.

Low dimension	Typical presentation	Fitting interventions (examples)
Coherence	Dissonance, "double life," impulsive self-betrayal, fragile commitments	Values clarification; commitment contracts; micro-integrity; learning plans after lapses
Dignity	Self-contempt, humiliation triggers, secrecy, "I don't deserve to recover"	Anti-stigma work; protective language; boundaries; moral repair; reintegration supports
Care	Harsh self-demand, poor self-care, burnout, relapse as self-punishment	Self-compassion; compassionate imagery; restorative routines; safe support network
Truth	Denial, dissociation, emotional confusion, avoidance of inner contact	ACT defusion; emotion labeling; grounding; trauma-informed pacing; honest disclosure plans
Purpose	Emptiness, boredom, "what's the point?", weak future	Meaning-centered interviewing; future narrative; pathways of contribution/service; identity reconstruction

Table 5: Six-step clinical pathway.

Step	Clinical focus (what to assess/name)	Action (what to do in practice)
1) Meaning rupture	Where meaning collapses; what is experienced as emptiness, uselessness, or hopelessness	Evoke a recovery "why"; anchor a meaningful future; clarify values
2) Dignity wound	Humiliation, dehumanization, self-contempt, injury to moral worth	Dignity-protective language; anti-stigma work; rebuild self-respect through commitments
3) Shame narrative	The internal story after a slip ("I'm a failure")	Differentiate guilt vs toxic shame; compassionate reframe; relapse learning plan
4) Avoidance pattern	What is being escaped internally (emotions, memories, moral pain)	ACT skills: acceptance, defusion, willingness; expand distress tolerance
5) Values micro-actions	Small actions that restore coherence (value–action alignment)	Weekly micro-commitments; coherence tracking; self-efficacy via small wins
6) Moral repair plan	When moral injury is present: harms, amends, restitution, reintegration	Amends plan; repair relationships; re-commit values; reintegration rituals/supports

A framework for clinical interviews (10 minutes)

For time-limited teams, we propose a short script:

1) "What hurts inside that no one sees?" (existential pain)
2) "Where do you feel you have lost dignity?" (humiliation/self-stigma)
3) "What emotion are you trying not to feel?" (avoidance)
4) "What value is being left out of your life?" (coherence)
5) "Who is a safe person for you?" (belonging)
6) "What small purpose would you like to recover?" (direction)
7) "What micro-action will you do in 24 hours?" (action)

This format turns the model into practice and reduces moralization.

The "truth" dimension as intervention: less secrecy, more continuity

In many cases, the first change that predicts recovery is not perfect abstinence, but the end of secrecy. When the person starts telling the truth early ("today I'm at risk", "yesterday I slipped"), the loop is interrupted: shame loses monopoly and co-regulation appears. Therefore, "truth" is not a moral ideal; it is a clinical mechanism. Programs that penalize truth foster relapse; programs that protect it foster continuity.

Contribution and service: purpose without grandiosity

In early sobriety, demanding a "big purpose" may be excessive. MDDMA suggests an incremental approach: micro-purposes (care for the body today, repair a conversation, attend group), then realistic contribution purposes (help a newcomer, participate in community tasks). Contribution reduces self-absorption, increases belonging, and provides behavioral evidence of dignity: "I am useful", "I can care", "I can repair".

Practical Implications for Clinicians and Editors

The model suggests concrete program design decisions: language policies, reintegration protocols, dignity protection, and prevention of humiliation. Editors and program leaders can treat dignity as a design variable.

Limitations and Future Directions

The model is integrative and requires empirical testing in diverse populations and settings. Future work should test temporal precedence of the dimensions, mechanisms in EMA studies, and comparative effectiveness of dignity-protective program designs.

Note on public health applications and digital settings

The model can also inform digital interventions (apps, teletherapy, online groups). The risk in these environments is reproducing anonymity without belonging; the opportunity is offering immediate access to truth (asking for help), care (micro-compassion practices), and purpose (values-based plans). Digital protocols that prioritize human contact, non-stigmatizing language, and rapid reintegration after slips may be especially useful in populations with barriers to in-person access.

Conclusions

When people say "my soul is ill", they may be naming a cluster of measurable processes: loss of coherence, injured dignity, collapsed care, reduced truth, and broken purpose. The Meaning–Dignity Disconnection Model of Addiction (MDDMA) translates that lived language into a pragmatic, testable, clinically usable framework. This approach turns lived language into a verifiable and actionable clinical map. Durable recovery can be strengthened when we treat the existential and moral layer as central—not peripheral—targets: protect dignity, reduce humiliation, restore meaning, and build caring relationships that make truth possible.

Final implication for systems: treat "soul" as a design variable

If the "illness of the soul" is, in reality, a package of measurable processes, then the system can intervene: language, protocols, reintegration, relational safety, and opportunities for purpose. Put simply: programs do not only treat addictions; they manufacture or reduce shame. When they manufacture dignity, they manufacture recovery.

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