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**Addiction: What is it?**

Substance Use Disorders (SUDs), a diagnostic term for alcohol and other drug addictions, are among the most prevalent, complex, and destructive disorders in human society. They are found in every population, regardless of race, religion, and socioeconomic class. They are seen in corporate board rooms, bars and taverns, on the street, and in the worship rooms of religious communities. These disorders have a significant impact on physical and mental health, spiritual life, family relationships and child development, highway safety, criminal justice, and the economy.

Experts in the field of alcohol and other drug dependencies differ in some respects; however, they agree on the following points:

1. Substance use disorders are progressive, chronic, and potentially fatal diseases when unrecognized and untreated.
2. The primary behavior characteristics of this illness are craving for the psycho-physiological effects of alcohol and drugs and continuing excessive use even when such use is harmful to oneself and to those involved in their life.
3. SUDs involve diminished freedom to decide to use or not to use the substance, or to limit the amount consumed to a safe and responsible level.
4. Continuing the substance use in spite of all the obvious problems that it causes to oneself and others is a clear indicator of compulsive, addictive behavior.
5. Drug addiction is any prolonged use of mind-altering drugs that are harmful to oneself and/or to others, resulting in the loss of control over the use of these drugs and becoming dependent upon them. Alcohol qualifies as a mind-altering, consciousness-changing drug, so alcoholism is a form of drug addiction.
6. Many view addiction to alcohol and other mind-altering drugs as a spiritual as well as a behavioral, psychological, and physiological problem.

The National Institute on Alcohol Abuse and Alcoholism (NIA.A.A) describes alcoholism as a disease that has the following four symptoms:

- Craving – a strong need, or urge to drink.
- Loss of control – not always being able to stop drinking once drinking has begun.
- Physical dependence – withdrawal symptoms, such as nausea, sweating, shakiness and anxiety occur once drinking has ceased.
- Tolerance – the need to drink greater amounts of alcohol to feel the effects.

The National Institute on Drug Abuse (NIDA) defines drug addiction as follows:

Drug addiction is a complex brain disease. It is characterized by drug craving, seeking, and use that can persist even in the face of extremely negative consequences. Drug-seeking may become compulsive in large part as a result of the effects of prolonged drug use on brain functioning and, thus, on behavior. For many people relapses are possible even after long periods of abstinence.
Drug addiction shares many features with other chronic illnesses, including a tendency to run in families (heritability), an onset and course that is influenced by environmental conditions and behavior, and the ability to respond to appropriate treatment, which may include long-term lifestyle modification.

http://www.nida.nih.gov/about/welcome/aboutdrugabuse/chronicdisease/ accessed 7-26-07

More recent definitions regarding alcoholism have emphasized the role of genetic vulnerability in addiction as a neurological disease. While it has long been known that children of alcoholics have four times the chance of becoming addicted themselves, the etiology of addiction is now widely viewed to include genetics as a precipitating feature, in addition to environmental, social, and other such factors influencing the development of the disease. Inherited biochemical/neurophysiologic functions of the brain are now being understood as contributing substantially to the development of alcohol and drug addiction. The growing knowledge of genetic pre-disposition further distinguishes alcohol addiction from mere moral weakness or sinfulness. While one’s environment, as well as past and current primary relationships, remain important considerations for both addiction and recovery, understanding the genetic factor helps eliminate blame, prejudice, and rejection.

One of the most important signs of substance dependence is continued use of drugs or alcohol despite experiencing the serious negative consequences of heavy drug or alcohol use. Often, a person will blame other people or circumstances for his or her problems instead of realizing that the difficulties result from use of drugs or alcohol. People with this illness really may believe that they drink normally or that “everyone” takes drugs. These self-deceiving beliefs are called denial. This denial is based in delusion and is part of the illness.

**The basic elements of the addictive process are:**

- **Tolerance** – A person will need increasingly larger amounts of alcohol or drugs to get high.

- **Craving** – A person will feel a strong need, desire, or urge to use alcohol or drugs, will use alcohol or a drug despite negative consequences, and will feel anxious and irritable if he or she can’t use them. Craving is a primary symptom of addiction.

- **Loss of control** – A person often will drink more alcohol or take more drugs than he or she meant to, or may use alcohol or drugs at a time or place he or she had not planned. A person also may try to reduce or stop drinking or using drugs many times, but may fail.
Physical dependence or withdrawal symptoms – In some cases when alcohol or drug use is stopped, a person may experience withdrawal symptoms from a physical need for the substance. Withdrawal symptoms differ depending on the drug, but they may include nausea, sweating, shakiness, and extreme anxiety. The person may try to relieve these symptoms by taking either more of the same or a similar substance.


Impact on Society of Addiction to Alcohol and other Drugs
Addiction to alcohol or other drugs impact a wide circle of persons and social systems. A large number of problems in families, health care, and the criminal justice systems stem from alcohol and other drug addictions. The sheer numbers are astounding, whether one considers the problem from a human, institutional, or an economic perspective. The estimates on the prevalence of alcohol addiction range from 14 to 25 million Americans. Other significant statistics related to family, health, and criminal justice concerns are:

- 50% of all children (35.6 million) live in a household where a parent or other adults use tobacco, drink heavily, or use illicit drugs.
- 23.8% of all children (17 million) live in a household where a parent or other adult is a binge or heavy drinker.
- 12.7% of all children (9.2 million) live in a household where the parent or other adults use illicit drugs.
- 20.3 million people were classified as dependent on or abusing drugs in 2003.
- 15.7 million (77.6%) people with substance use disorders are employed.
- 3.8 million persons received treatment for drug or alcohol abuse in 2003.
- Of the 21.1 million who needed treatment but did not receive it, only 1.3 million (5.8%) felt they needed it (denial gap). Of that 1.3 million, 441,000 (35.8%) said they made an effort but were unable to get treatment (treatment gap), 792,000 (64.2%) reported making no effort (motivation gap).

Family Matters: Substance Abuse and the American Family, March 2005
http://www.casacolumbia.org/supportcasa/item.asp?cID=12&PID=136 accessed 5-23-06

The first signs that alcoholism and drug dependence are problems may be unusual behaviors such as family dysfunction, children acting out at school and in church-based children and youth programs, chronic mental and physical health problems, and repeated run-ins with the criminal justice system. Unfortunately, too often these clues are ignored and the deeper issues of alcoholism and drug dependence are never identified. Furthermore, most individuals and families struggling with addiction hide their pain, shame and confusion effectively, seldom coming to the attention of the criminal justice or healthcare systems. This makes it even more important for clergy and faith communities to be knowledgeable and supportive of those in their congregations who are impacted by addiction.

As the facts listed demonstrate, alcoholism and drug abuse are pervasive problems in communities and congregations. There are a number of ways that congregations can react to those in their midst who are affected by alcohol or other drug related problems. Congregations tend to reflect one of the following responses to the problem:

- Ignore the problem and engage in the same kind of denial typical of an addicted person and the larger society
- Make the problem worse by judgmental and prejudicial attitudes
- Address the problem with compassion by seeking to understand addiction in its many forms and behaviors and its deleterious effects of families, and minister to affected persons as children of God who need love. These actions are informed by accurate knowledge and disciplined by awareness of relevant caregiving skills.

These responses can either perpetuate the problem or provide hope and help to those involved. The faith leader holds the key to how the congregation will react.
Stigma

Prejudicial attitudes can make treatment, recovery, and simply re-establishing oneself in society virtually impossible for many, making sobriety a disincentive for these persons. Churches and other religious communities are subject to these same prejudicial attitudes and need to find ways to express loving acceptance and reality-based support to persons who are seeking to recover their lives and relationships, as well as their spiritual faith.

There is a process with stigma that involves a downward spiral for those impacted by alcoholism or substance abuse and contributes to, rather than helps, the damaging addictive behavior. Stigma leads to shame. Shame leads to withdrawal. Withdrawal leads to isolation. Isolation leads to more drinking/drugging and denial which ultimately leads to hitting rock bottom. Thus, helping to remove stigma from alcoholism and other addictions is something that faith communities can do to end this vicious cycle. They can also encourage help at an early stage of addiction for both the afflicted individual and the impacted family members.
The Clergy’s Role

After participating in the development of the 12 Core Competencies, one of the clergy leaders who had been part of the process said he believed clergy and congregational leaders should be able to:

- **Show up**: would be alert to windows of opportunity for contact, assessment, intervention and treatment.
- **Be dressed**: would be prepared internally with the necessary information, resources and teaching tools.
- **Get through the door**: would know how to establish effective healing relationships with those affected by addictions.
- **Stay in the boat**: would do more than hand people off to treatment, they would establish helping relationships with other professionals, congregational caregivers and the affected individuals and their families.
- **Know when to leave**: would respect appropriate boundaries and know when to bring their involvement to a conclusion.

**Questions to consider:**

1. If these are the necessary tasks, how able are you, your congregation and your community to achieve them?
2. Since no clergy, congregation or community will be able to achieve all of these tasks equally well, what steps will you take to increase your current capabilities?
Important Information for Clergy

Clergy understand the negative impact of alcohol and drug use disorders on families, individuals, and children. Ninety-four percent of clergy members (e.g., priests, ministers, and rabbis) recognize that substance abuse is an important issue among families in their congregations (CASA, 2001). Among clergy members, 38% believe that alcohol abuse or alcoholism is involved in half or more of the family problems they encounter. They have a great desire to assist affected families, but are divided over whether to speak openly about alcoholism and drug dependence with their congregations.

Nearly 37% of clergy report that they preach a sermon on the impact of addiction to alcohol or substance abuse more than once a year, while almost 23% say they never do. Few clergy receive formal training on the topic, as only 12.5% of clergy have completed any coursework related to substance abuse while studying to be a member of the clergy.

Although some clergy members have shown hesitation to speak openly with their congregations about alcohol and drug abuse and addiction, many have taken it upon themselves to learn more about the illness. In a survey on their knowledge of substance abuse, religion, and spirituality since their ordination, two-thirds of clergy indicated that they had sought training on their own to assist parishioners seeking help with substance abuse. While many members of the clergy may have knowledge of substance abuse, the extent to which this knowledge is disseminated to congregations is quite limited. This may be due to lack of training that seminaries may offer or require. Perhaps if there were more requirements in this area, there could be an opportunity for clergy to acquire the skills to effectively disseminate this information and become knowledgeable about the following issues:

- The way a substance use disorder manifests itself, including the signs that a person has a dependence on alcohol and/or illicit drugs
- The effects of alcohol and drugs on thinking and reasoning
- The role alcohol or drugs may play in a person’s life
- The way substance use disorders affect families, workplaces, and communities as a whole
Spiritual Dimensions of Addiction

The traditions and rituals of the faith community are of value to an addicted person when the faith community offers acceptance, redemptive judgment, disciplined love, and awareness of limitations and use of other resources. From research published in *Alcoholism and Christian Experience*, Rev. C. Roy Woodruff, PhD, identified the following religious/spiritual dynamics that appear relevant to an addicted person:

- The variety of spiritual experiences
- Pride and humility
- Surrender and submission
- Shame and sin
- Confession and forgiveness
- Loss and recovery of hope
- The nature of early religious training
- The perception of the work of the Spirit in their lives
- The problem of identity
- The problem of meaning
- The need for harmony of values and behavior
- The role of family history and family responsibility
Spirituality as a Component of Treatment

Since so many Americans have some religious or spiritual beliefs, it is no surprise that many people incorporate these ideas into their approach to health care. A study in *Lancet* reported that 79% of Americans believe that spiritual faith can help people recover from disease and 63% of people think that physicians should talk to patients about their spiritual faith. However, while more than 80% of physicians generally refer their patients to clergy and pastoral care providers, only 19% recommend this kind of referral when the patient suffers from alcohol or drug use problems.

Clergy members or other pastoral ministers should establish relationships with local treatment providers, physicians, and other health care specialists, as well as persons in healthy recovery. Physicians and substance abuse treatment specialists are in an excellent position to engage patients in an open dialogue about their spiritual needs and desires and, where appropriate, refer people to clergy members or spiritually based programs to support their recovery. This relationship can not only educate clergy about alcoholism and other drug dependencies, but it also can put health care providers in a position to better respond to requests for a religious or spiritual element to be incorporated into a person’s treatment.

Alcoholism and other substance use disorders affect a large portion of the population. As many as 74% of Americans say that addiction to alcohol has had some impact on them at some point in their lives, whether it was their own personal addiction or that of a friend or family member. For many addicted individuals and their family members, spirituality and religion have been instrumental to successful treatment and recovery. However, spirituality and religion are often overlooked as relevant factors in preventing and treating these illnesses. Clergy are a critical yet relatively untapped resource in preventing substance abuse and addiction, helping people get treatment, and offering support for recovery.

Like most health care providers, clergy have been slow to recognize the power of the spiritual healing that happens through working the Twelve Step program of Alcoholics Anonymous. Both could gain a much clearer understanding of this healing process by attending an occasional “open” A.A. meeting and by working with and listening to A.A. members who have attained long term sobriety. By making connections with people in healthy recovery, clergy could have a reservoir of referral sources when an addicted congregant or an impacted family member is seeking help.
Helping the Addicted Congregant

Abraham J. Twerski, M.D.

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Dr. Twerski held a pulpit for ten years before becoming a physician and psychiatrist. He brings a comprehensive and insightful understanding to addressing the impact of addiction to alcohol and other drugs. Written for Jewish clergy, the information and approaches are relevant to clergy in all faiths.

Today’s rabbi, in addition to being the spiritual leader of his congregation, is also expected to be a competent counselor to the members of his community. Yet, rabbis often feel inadequately prepared for the difficult challenges of their counseling roles.

To many, rabbinic counseling appears deceptively simple, requiring no more than good intuition, fair judgment, and sincere empathy. Good counseling, in reality, is a complex process requiring a combination of knowledge, skill, self-awareness, and an understanding of human dynamics.

Why should a rabbi be familiar with chemical dependency problems?

“Chemical dependency is so prevalent that a rabbi can be certain that he will have to deal with such problems sometime. The idea that ‘it doesn’t exist in my congregation or school’ is misleading.”

Chemical dependency is a disease that affects men and women regardless of age, intelligence, socioeconomic status, religious affiliation, or profession. It is an “equal opportunity destroyer” which harms individuals, families and communities. Therefore, a rabbi should become familiar with chemical dependency, realize it can be a root cause for any congregant’s recurring behavioral problems and will certainly impact the congregant’s family.

Generally, the appeal for rabbinic intervention will come from a family member since it is not often that a person with an alcohol or drug addiction will voluntarily seek help. Denial, the inability to see how the use of alcohol and other drugs is severely impacting one’s life, is a key sign of addiction. In fact, the unwillingness to understand or see the persistent negative impacts of continued use as well as the inability to stop using, is one of the diagnostic criteria for addiction. Unfortunately, denial is also present in communities. For far too long, the adage shikker is a goy has given the Jewish community a false sense of protection against the disease of addiction.

Contributing to the person’s denial is the stigma that is associated with addiction. It is concealed since addiction is viewed as a shonda or shameful. Such stigma and shame make it that much more difficult for the rabbi to raise the question with the person or family member. “This person is a respected member of the congregation. He attends minyan daily as well as the Talmud shiur. He is generous with tzedakah. How can I insult him by asking him whether he drinks too much or uses drugs?” What is important to remember is if there is chemical dependency underlying the behavior problems, whatever the rabbi tries will be futile unless the addiction is also addressed.
Guidelines for Rabbinic Intervention

“If an older person suffers a heart attack while shoveling snow, we do not say, “It’s your fault. You should have known better.” We do everything to restore his health, and we do not refuse to treat or help him because of poor judgment. Our attitude toward addicts should be no different.”

Rabbinic effectiveness in addressing addiction depends on the rabbi’s own feelings and beliefs. If the rabbi feels that alcoholism or chemical dependency is a sin, a moral failure, a weakness of character, or anything that reflects on the value of the person, he is unlikely to be of much help. Even if he uses all the right words, his attitude that the condition is shonda (shameful) will convey itself to the person and reinforce the person’s denial and resistance.

At times, a family member will ask the rabbi for assistance and describe the issue as an alcohol problem. However, unless the rabbi has been trained in alcoholism counseling, the most appropriate response should be, “If your family member does not see his alcohol use as a problem, he may not avail himself of help. However, his drinking is obviously a problem for you. I suggest that you meet with a family counselor for alcoholism and attend Al-Anon meetings for families of alcoholics. These people are veterans in dealing with this kind of situation and can give excellent guidance.”

The rabbi can offer the names and contact information of local resources that can provide proper alcohol and substance abuse counseling for the family member. While the family member may request further support, the rabbi should be empathic, but firm. “This is a serious situation which is not going to be helped by telling me how much you are suffering. I believe you. Now you must go for help to the person who can actually provide what you need.”

Under pressure from family members, employers and/or law enforcement, the addicted person may concede he has an alcohol and/or drug problem. S/he may promise never to use again, cry tears of remorse and appear absolutely sincere in the promise. However, the rabbi should remember the addict has a compulsion which he cannot resist and the promises do not have any value. Not believing the person’s contrition may be especially difficult since the rabbi generally has a strong belief in a person’s teshuvah. But, what is important to remember is the only effective teshuva for the addict is recovery with treatment. And the greatest hope for family members is to understand the impact of the disease on their own lives and participating in their own recovery through support programs like Al-Anon (or Alateen for the adolescent and teenage children in the family).

CORE COMPETENCIES FOR CLERGY AND PASTORAL MINISTERS IN ADDRESSING ALCOHOL AND DRUG DEPENDENCE AND THE IMPACT ON FAMILY MEMBERS

These competencies are presented as a specific guide to the core knowledge, attitudes, and skills which are essential to the ability of all clergy and pastoral ministers to meet the needs of persons with alcohol or other drug dependence and their family members.

1. Be aware of the:
   • generally accepted definition of alcohol and other drug dependence
   • societal stigma attached to alcohol and other drug dependence

2. Be knowledgeable about the:
   • signs of alcohol and other drug dependence
   • characteristics of withdrawal
   • effects on the individual and the family
   • characteristics of the stages of recovery

3. Be aware that possible indicators of the disease may include, among others: marital conflict, family violence (physical, emotional, and verbal), suicide, hospitalization, or encounters with the criminal justice system.

4. Understand that addiction erodes and blocks religious and spiritual development; and be able to effectively communicate the importance of spirituality and the practice of religion in recovery, using the scripture, traditions, and rituals of the faith community.

5. Be aware of the potential benefits of early intervention to the:
   • addicted person
   • family system
   • affected children

6. Be aware of appropriate pastoral interactions with the:
   • addicted person
   • family system
   • affected children

7. Be able to communicate and sustain:
   • an appropriate level of concern
   • messages of hope and caring

8. Be familiar with and utilize available community resources to ensure a continuum of care for the:
   • addicted person
   • family system
   • affected children

9. Have a general knowledge of and, where possible, exposure to:
   • the Twelve Step programs – A.A., NA, Al-Anon, Nar-Anon, Alateen, A.C.O.A., etc.
   • other groups

10. Be able to acknowledge and address values, issues, and attitudes regarding alcohol and other drug use and dependence in:
    • oneself
    • one’s own family

11. Be able to shape, form, and educate a caring congregation that welcomes and supports persons and families affected by alcohol and other drug dependence.

12. Be aware of how prevention strategies can benefit the larger community.
The Stages of Change in Moving Toward Addiction Recovery

1. Pre-contemplation  The person is not considering change, does not see themselves with a problem about their drinking or using drugs.

2. Contemplation  The person is ambivalent, is considering change but also rejects it at the same time.

3. Preparation  The problem and need to change is accepted and the person is considering what to do next.

4. Action  The person is actively engaged in establishing behaviors to bring about change.

5. Maintenance  The person is continuing to maintain the change behavior.

6. Recurrence (relapse)  The person is drinking or using drugs again.
Motivating and Encouraging Change

Persons suffering from alcoholism or drug addiction and their family members learn over time how to “live the lie” of addiction’s presence and its impact on them. They often develop an amazing capacity to survive in the chaos and pain of addiction. Many of those afflicted today spent their early years in families impacted by alcoholism or drug addiction, and surviving is a way of life for them. Consequently, clergy and other pastoral ministers can assume that change will sometimes be slow, even in the midst of the pain. It is helpful to have an understanding of the stages of change, so that guidance through those stages can be given.

Other suggestions for assisting individuals and their families to make the changes needed to move from addiction to recovery:

- Expressing acceptance of the person with alcohol or drug misuse and of the affected family members
- Visiting the home, being open to talk frankly and listening, recommending and referring to other helping professionals when needed
- Keeping up one’s contact with the family over time
- Talking about family or individual concerns regarding embarrassment or anxiety over public awareness of the family problems
- Hearing out the fear and anger, talking about Divine presence, acceptance and compassion
- Prayer with the person or family that is focused on the individual’s or family’s specific need at the time, and including the themes of one’s faith beliefs: creation, sin and forgiveness, deliverance and personal responsibility, the consistent sustaining love of God
- Stating one’s commitment to pray regularly for the addicted person and individual family members and asking for permission to enlist others to do the same
- Guiding the addicted and/or recovering person and family toward Twelve Step mutual support groups like A.A., Al-Anon and Alateen, as well as toward relevant scriptural writings, enduring heroes of the faith, present-day inspiring stories about people of faith in recovery, and helpful books and pamphlets that enlighten about addiction and its family impact – and sources of recovery support
- Meeting individually with the person and/or family to give encouragement and support
- Mobilizing congregational support (selectively and with the permission of the person and family)
- Listening to the recovering person’s struggles, questions and “lostness;” celebrating individual and family recovery changes and successes
- Talking with the recovering person about the spiritual nature of addiction and recovery, and the transformations of life that both involve
- Sharing one’s wisdom about life and faith journeys, the strengths of one’s particular religious beliefs and empowerment gained from believing, the hope and restored dignity in the daily work of recovery.
- Reassuring the individual about one’s personal compassion and commitment to help, even when the person “slips” and drinks or uses again, or other problems worsen in the family.
As clergy and congregational leaders, you are respected, trusted and caring people who have numerous opportunities to raise awareness and questions concerning the impact that alcohol and other drugs have on your congregational members — not only with the person suffering from the alcohol or other drug related problems, but the other family members and children who suffer as well. Your understanding of addiction, the Stages of Change and recovery, along with your demonstrated concern, hope and support for all the family members will create a path to healing and health. Review the suggestions for assisting individuals and their families, talk with people already in recovery, discuss these issues with your congregation leadership to discover what else can be done as a spiritual community. Maintaining the status quo leaves more than 20 million individuals suffering with alcohol or drug dependency and untold millions more family members and children to suffer in secrecy, shame and silence.
Some bases for dialogue among faith-based, treatment and recovery communities:

1. There are many viable pathways and styles of addiction recovery.

2. Religious experience can serve as a powerful catalyst of recovery initiation for some people.

3. Religious beliefs, religious rituals, and supportive relationships within a faith community can serve as a framework of recovery maintenance.

4. Patterns of recovery pathways (religious, spiritual and secular) vary across developmental age and gender and between and within various ethnic communities.

5. The recovery and regeneration of people formerly addicted to alcohol and drugs is cause for celebration, regardless of the medium of recovery.

6. Recovery from addiction is a complex process, often involving physical, psychological, social, cultural and ontological (the meaning of existence) dimensions.

7. Addiction recovery often requires the involvement of multiple disciplines and service practitioners, each of which is ethically mandated to practice within, and only within, the boundaries of their education, training and experience.

8. Addiction treatment is best conducted out of respect for, and within, the cultural and religious heritage and the personal belief system that each client brings to the service environment.

Not everyone within the professional world of addiction treatment and diverse communities of recovery will agree with all of these propositions, but we believe that enough will to allow this dialogue to begin in an attitude of mutual respect and tolerance.

Use Recovery Month to Help Educate and Support Congregants.

Some actions you could take:

1. Incorporate information about substance use disorders, treatment, and recovery into a sermon during September.

2. Schedule Recovery Month awareness events in your congregation or with the broader community by hosting forums and educational workshops with speakers who are in recovery and their families.

3. Offer space in your church, synagogue, or mosque for recovery groups (such as Alcoholics Anonymous, Al-Anon and Alateen) to meet.

4. Prepare a fundraiser, such as a bake sale, car wash, or clothing drive, to help assist congregants who are in need of treatment and recovery support and their family members.

5. Create a community network of congregants and clergy to offer support for people with substance use disorders and those in recovery.

6. Offer opportunities for members of the congregation to tell their family’s personal recovery stories to assist in reaching out to others who may need hope and help to take the first step toward healing.

7. Write a letter in your congregation’s weekly or monthly bulletin to spread the word about Recovery Month events in your community and the resources that can help people in recovery.
Understanding and Supporting Families Impacted by Addiction

People suffering from alcohol or drug addiction may find themselves increasingly isolated from their families. The effects of these illnesses can also extend beyond the nuclear family. Extended family members may have a range of emotions, including abandonment, anxiety, fear, anger, concern, embarrassment, guilt, and even the desire to ignore or cut ties with the person dependent on alcohol and/or drugs. However there is hope, and family members can play a critical role in supporting loved ones on their path of recovery, especially when they too avail themselves of recovery support programs for affected children and other family members. Ultimately, the individual healing of each strengthens the potential for bringing healing to the entire family.

A child or other affected family member needs to recognize that he or she is not the cause of a relative’s alcohol or drug abuse problem. It is equally important to understand that, even though people can’t necessarily “cure” their relative’s addiction, they can help the family member through the recovery process by supporting and encouraging their recovery efforts and – at the same time – working on their own recovery from the pain and confusion caused by the presence of addiction in their own lives.


SAMHSA’s Children’s Program Kit, which is a free multi-media curriculum for all school age children, is a tool-kit for treatment and prevention providers, school-based student assistance programs, and faith-based and youth-serving agencies to help them provide structured activities and educational support groups for children and youth impacted by addiction in their homes. The activities help the children make sense of what they are experiencing at home, cope with the stress of their families’ alcohol and substance abuse problems and strengthen their potential for resilience and healthier lives. The activities are enjoyable as well as enlightening, and this encourages continued participation in the supportive learning process they facilitate. The Kit is based on four cornerstones:

- Children deserve to have their own recovery and healing
- Children deserve to be treated with dignity, respect, value, and worth
- Children deserve to be listened to and heard, and
- Children deserve the opportunity to be kids.

The Children’s Program Kit is free and can be ordered at [www.ncadi.samhsa.gov/promos/coa](http://www.ncadi.samhsa.gov/promos/coa) or by calling 1-877-726-4727.

Understanding Addiction and Supporting Recovery • Strategies and Tools for Clergy and Other Congregational Leaders - 2013 Webinar Series

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A Congregational Team Approach to Supporting Addicted Individuals and Their Family Members

Congregational Team Ministry
Congregational team ministry consists of a small group of trained lay people who work together to provide alcohol and other drug awareness, education and addiction recovery support to children, youth and adults served by the congregation. The team creates a ministry of presence, available to those reaching out for help or needing information.

This ministry can have many levels of involvement depending on the time, talents, energy and commitment of team members. This involvement could range from the simple act of providing literature on alcohol and drug abuse, addiction, and their impact on children and families – along with messages of hope and strategies for help – to hosting an annual worship service in which addiction is addressed and recovery celebrated – to an educational series or support group ministry.

The Clergy’s Role
Starting a team normally requires active clergy support. The clergy role may diminish (it is the pastor’s choice) after the first few months when the team begins to mature. To initiate a team ministry, clergy are encouraged to attend leadership training, have regular communication and work closely with the team facilitator, interpret the team ministry to the congregation, and find ways to incorporate issues and stories of prevention, simple supportive interventions and recovery into teaching and preaching. The clergy need to be confident that they can make confidential referrals to trained team members and know that appropriate action will follow for the individual and his/her family members.

The Role of Lay Leadership
The most important factor in starting a team ministry is finding one or two key lay members to provide leadership. Although not required, frequently the person called and committed to this ministry is a person who is in recovery from addiction, is a family member in recovery, and/or is a professional in the field of alcohol and other drug abuse prevention or treatment. This person needs to be healthy, mature, and willing to commit his or her time to the development of the team ministry. In addition, this person must be respected and trusted by the clergy.

Sustaining the Team Ministry
The team continues to maintain a positive and productive relationship with the congregation’s leadership, knowing this is vital for this ministry to be sustainable. This includes the staff, lay leaders, Sunday school teachers, youth leaders, and more. People in difficulty are referred to the team by the pastor, the staff and others in the congregation. They only continue to refer if they are confident in the team’s service, confidentiality and support of the entire congregational mission.

The team continues to recruit and train new members. Members who are mature and caring with special interest or expertise – both those in recovery from addiction and those primarily interested in prevention – make the team a cross section of the congregation. The passion of individual team members drives this work.

Resources Needed from the Congregation
A congregational alcohol and other drug team ministry is carried out through awareness, education and support activities. Teams will need the same communication system as other congregational programs: bulletin board, literature rack, library space, worship bulletin space, a newsletter space, and meeting space. A brochure or team handbook and other materials may require some printing. This is not an expensive ministry. Many free or low
cost resources – brochures, videos, and speakers – are available through community agencies and through the federal Substance Abuse and Mental Health Administration’s Health Information Network (SHIN), http://ncadi.samhsa.gov/ or call 1-877-726-4727.

How Does a Team Help the Congregation?
A team ministry equips youth and adults with the information, skills, and support they need to avoid alcohol, tobacco and other drug abuse and to ask for help when there is a problem in the family. Effective ministries of prevention in the congregation combine the best science-based research practices with the strength of personal and corporate religious faith. Ministries of recovery put a “face” on addiction and on the affected family members. They reduce stigma and shame, and offer hope and help that provides support for recovery and healing – for all members of the family.

Congregations and the 12-Step Recovery Support Groups
Alcoholics Anonymous (A.A.), Al-Anon, and other 12-Step groups, including Alateen for adolescents, play a critical role in helping people recover from addictions or recover from the pain and losses that come with having an addicted family member. Their steps toward spiritual healing and growth are compatible with most religious teaching, yet they are not a substitute for congregational life, which includes worship and religious education. The founders of A.A. urged their members to attend both A.A. meetings and the congregation of their choice. The alcohol and other drug team ministry in a congregation “builds bridges” to persons in recovery as well as to professional counselors and agencies. The process of recovery from addictions – for both the afflicted persons and the affected family members – takes time and multiple resources.
CASE #1 — Doing Good Doesn’t Mean Things are Good

She had four children, was president of the mothers’ club, had been a member of the parish council. She was lovely, kind, helpful, and a devoted wife, mother, and volunteer. And she was dead of alcoholism at age 40. There were many priests on the altar at her funeral. Most knew she had a serious drinking problem and had witnessed it often. They cared about her and her family and treated them kindly and with respect. They didn’t know what else to do and didn’t want to offend, so they said nothing when the children and other family members said nothing. They cared, but they weren’t equipped.

Educational Focus

People are not born knowing how to deal effectively with someone else’s addiction. Seldom do family members, friends, or clergy instinctively avoid enabling behaviors and find appropriate ways to intervene. The great majority stumble along managing each day the best they can, repeating what doesn’t work. Although this response to alcoholism is normal, it adds to the confusion and suffering of the children involved. It also does not address the underlying issue: A key family member or parishioner is suffering from a chronic, fatal disease and needs intervention and treatment which are frequently highly successful at arresting this disease and establishing the base for lifetime healing and recovery.

“Effective intervention strategies are counterintuitive, so they need to be learned.”
appropriate) the congregation, can make a life-altering impact on an individual or a family. Knowing the benefits of structured family intervention (see sidebar) and where to refer concerned family members for professional assistance can and does save lives and families from the devastation of chronic alcoholism.

CASE #2 — Behind the Marriage Failures

John P. petitioned for an annulment, blaming his wife’s irrational and controlling behavior for the collapse of their marriage. He had been a drinking alcoholic for the whole of their ten years of marriage, and there were three children ages four through eight.

Educational Focus

The majority of spouses of alcoholics are not irrational, mentally ill, or control freaks. They are simply overwhelmed by the insanity of someone else’s addiction. Often they are reliving the nightmare of their own childhood, growing up in the chaos caused by a parent’s drinking; feeling as helpless, confused, and frightened as adults as they did when they were children. Spouses of those addicted to alcohol or drugs need clarity about the disease that is crushing their lives and family. They need support offered by such groups as Al-Anon. They need to hear messages of hope and the possibility of recovery for their whole family, and they need help in finding the resources they need.

These messages of hope and healing must come from outside the family, preferably from a trusted source of care and support. In the faith community, these messages can come from posters in the halls; pamphlets in the racks; information in the parish bulletin; and Alcoholics Anonymous, Al-Anon or Alateen meetings on church property with the times listed in the bulletin. They can come from statements included in the homilies that describe the pervasiveness of the disease, making it clear that the only shame in this disease is doing nothing to help.

INTERVENTION WORKS

Intervention is a process which attempts to crack the delusion in which alcoholic/addicted people live. It is the delusion that keeps addicted persons in denial about their disease and its consequences—for themselves and for their loved ones. Intervention works because it punctures the delusion.

Intervention gathers together the people who:

• care most about the individual;
• have detailed information/facts which show that the person is in trouble; and
• are able to express love, concern, and a genuine desire for re-connection along with the stark facts of the disease’s impact.

The caring and facts presented together (neither alone) are what puts cracks in the delusion. While addicted individuals are brilliant at staying in denial if the concern and facts are presented on a one-to-one basis, it becomes too overwhelming to counteract when presented all at once in a group setting where it is clear that the people most important to them are united. When it all comes at once, the delusion begins to crumble, and the love and reality begin to set in.

The interventionist (a trained professional) is there to help the addicted person’s loved ones express their concerns and state the facts in a “receivable” form. Prior to the intervention meeting, the interventionist educates the family and other concerned participants, helps them to organize the intervention and what will be presented, guides them to understand their own options for healing, and assists in determining and arranging for the most appropriate treatment for the addicted family member. Most people will accept treatment on the day of the intervention.

Trained intervention specialists who are skilled in family therapy as well as the techniques of conducting an intervention can be found in most communities. Hazelden (1-800-328-9000 or www.hazelden.org) has two books on intervention: a landmark book, Intervention: How to Help Someone Who Doesn’t Want Help, and Love First: A New Approach to Intervention for Alcoholism and Drug Addiction. National sources for locating interventionists nationwide are: the Association of Intervention Specialists (301-670-2800) and the Intervention Resource Center (1-888-421-4321).
The annulment was granted, but before another marriage could be attempted, the husband was required to be certified “sober” for a year by a Tribunal-designated psychologist. He drank the whole year, but seldom appeared intoxicated. He was declared “sober” and cleared to marry. Less than three years later, the second wife left him because of his alcoholism.

The Diocesan Marriage Tribunal typically is a careful and caring investigative body, working to preserve the sanctity of the sacrament while acknowledging that a given marriage may never have existed in certain circumstances. What this Tribunal missed was the “main event” for the petitioner, his wives, and his children: Alcoholism was calling the shots, and the spouse’s response was “normal” for the situation. The disease needed to be addressed first as potentially causal for all presenting issues. The petitioner needed treatment; both wives and the children needed therapy and/or 12-step support services. The whole family was suffering from this disease, and everyone needed to recover—even the young children. Members of a Marriage Tribunal, however, cannot ask the requisite questions that will surface these needs when it does not have the basic knowledge and skills essential to do so.

CASE #3 — The Missed Topic in Marriage Preparation

It was a casual comment to a professional colleague who helped with the new marriage preparation programs in her diocese. “I wonder how many divorces we’d have prevented if we had included a session on alcoholism, other drug use problems, and the impact on adults of having grown up in an alcoholic family.” The colleague said she knew because she had instituted such a program in her diocese. In the first year, she reported, a half-day was added covering the nature of alcoholism, its signs and symptoms for the addicted person and for family members, its progression, and the negative consequences (often life-long if not addressed) of growing up in an affected family. After the educational session, 20% of the couples decided not to marry, or to postpone marriage until counseling was obtained for the unresolved childhood issues of being an adult child of an alcoholic parent or until one partner addressed his or her excessive drinking. After adequate treatment or counseling, about 25% returned to prepare for marriage.

Educational Focus

When one in four children under 18—across all economic, social, religious, and cultural groups—lives in a family with alcohol abuse or alcoholism, and countless others suffer because of parental drug use, it is crucial that clergy and other pastoral ministers have a clear understanding of addiction’s effect on the physical, emotional, and spiritual well-being of their parish families.

It is widely known that this disease, if untreated, destroys marriages and alienates families from their church. Not only does alcoholism block the capacity for a meaningful
spiritual life, it blocks the capacity for healthy, appropriate, interpersonal relationships and partnerships. Both engaged couples and their parishes would benefit from assuring that those who present themselves for the sacrament of marriage are actually capable of entering into and sustaining a sacramental partnership over a lifetime.

CASE #4 — Mother’s Day, Father’s Day, and So Much Pain

It was Mothers’ Day many years ago, and she had just returned from Sunday Mass. She called her mentor to say, “I remembered again this morning why I hated to go to church on Mother’s Day—because I had to listen to another sermon extolling mothers and the sacrifices they make for their families. All I could remember was her drunken rages, putting her to bed at night while my executive father “worked” in his library, and hiding in the attic in order to study for exams. I don’t want to be like her, and I don’t want to attend Mass with my children on Mothers’ Day and listen to what is a lie for too many children."

Educational Focus

When addiction is present, the “no talk” rules impede or block expressions of pain, fear, anger, and confusion. Consequently, these feelings don’t get processed and worked through in healthy ways. The rule of silence about the family’s “truth” is coupled with rigid expectations of “looking good” behavior, creating barriers to seeking help.

What would it take to add a note to that Mother’s Day sermon, asking parishioners to pray for those mothers who would like to live up to the ideal that has just been discussed but are trapped in alcohol or drug addiction—or in mental illness—and cannot be what their children need without outside help. Or add to the prayers of the faithful a prayer that these mothers and their families be guided into treatment and recovery soon, that children living in the confusion and fear created by alcohol or drug use in their families will find safe and supportive adults to whom they can turn.

CASE #5 — The Clergy as Counselors

She is the mother of five. She came to seek help for her husband’s drinking from the parish priest, whom her husband liked and admired, who was also a psychologist. She was reminded that her husband is a nice person and advised that she should be less critical and give him more support. She found Al-Anon, which saved her sanity, but her marriage ended. She raised the five children while he found a younger woman who was willing to tolerate his drunken behavior. The priest did care—about the husband, the wife, and the children—but his graduate training did not include adequate information on alcoholism, its impact on family members, especially developing children, and how to

RESOURCES FOR SEMINARY OR PARISH LIBRARIES


Helpful Web sites

Alcoholics Anonymous: www.aa.org
Al-Anon and Alateen: www.al-anon.org
Adult Children of Alcoholics: www.adultchildren.org
Co-Dependents Anonymous: www.codependents.org
Johnson Institute: www.johnsoninstitute.org
National Association for Children of Alcoholics: www.nacoa.org
National Center on Addiction and Substance Abuse at Columbia University: www.casacolumbia.org
National Council on Alcoholism and Drug Dependency: www.ncadd.org
National Clearinghouse for Alcohol and Drug Information: www.ncadi.samhsa.gov
help intervene and break the cycle of family confusion and pain. He didn’t understand that, when he visited the family, the children hoped he would notice, say something, do something to help. They were his friends and he cared deeply about them. But he didn’t understand their silence or how to break the “no talk” rule that trapped them all.

 Educational Focus

Hurting parishioners generally perceive clergy and pastoral ministers as potential sources of help and support. Parishioners may present with “marriage problems” or “unfaithfulness” and often do not name the alcohol or drug use as the culprit. Frequently, people who live with addiction do not recognize it for what it is—a chronic, debilitating disease that will get worse over time unless interrupted.

Clergy are seldom prepared to deal with addiction-related issues, yet those issues will affect the counseling and many decisions they will address throughout their priesthood. A survey (So Help Me God!) released by the Center on Addiction and Substance Abuse at Columbia University in November, 1999, reported that 94.4% of clergy considered addiction to be an important issue they confronted, yet only 12.5% had done any course work on it during their seminary studies. This begs the question: How can clergy attain the knowledge and skills necessary to be effective in addressing alcoholism and other drug dependencies in afflicted individuals and their affected family members? The “Core Competencies for Clergy and Other Pastoral Ministers In Addressing Alcohol and Other Drug Dependence and the Impact on Family Members” discussed by Reverend Roy C. Woodruff, Ph.D., elsewhere in this issue establish the basis for appropriate educational modules that can be incorporated into existing courses and post-ordination educational programs. We have waited too long and watched too many of our Catholic families crumble under the destructive power of alcoholism, affecting generation after generation. We must find a way to equip our present and future clergy to address this disease effectively.

Children of alcohol or drug dependent parents need a safe haven where they can meet adults who will talk to them openly about what may have been their “family secret.” The isolation and stigma the children may feel are lifted when trusted adults validate their experience, and when they learn that others face the same confusion and chaos that dominates their lives. When those “trusted adults” are part of their parish leadership, they gain hope and become free to pursue a spiritual connectedness with God and to feel that they can “belong” and be valued in the parish community. When they learn they are not responsible for what is happening in their families, that they are not alone, and that their parish community, especially its leadership, recognizes their intrinsic worth, children can be empowered to make healthy choices for themselves, with the support of their faith community.

Most parishes have members who are knowledgeable about addiction and recovery and are willing to join an effort to identify and support both those who are afflicted and their family members. Faith Partners, a congregational team-approach program offered by the Johnson Institute’s Rush Center in Austin, Texas, takes advantage of that pool of resources to create an education and support team at the parish level. This effective program has spread to several hundred faith communities across the country, including many Catholic parishes. A Faith Partners team of professionals and concerned persons—including some recovering alcoholics or family members as well as health and addiction treatment professionals—is pulled together from within the parish and approved by the pastor and parish council. The team surveys parish members about their concerns and services needed. It then crafts the initial solutions to meet the perceived needs of the parish. It provides educational programs, reading materials, referrals, and acts as the source to which concerned persons, including the parish leadership, can come for guidance and information about alcohol and drug-related issues.
The team can play a unique role in helping troubled family members seeking guidance about a loved one’s drinking or drug use, in supporting early intervention, and in recovery support for both parishioners who have entered treatment for addiction and for their families. This approach gives maximum help to parishioners suffering the consequences of addiction and their family members; yet it does not require the already-overburdened pastor to take on an additional responsibility. For more information, visit www.rushcenter.org.

“\textbf{Their picture of God may be the image of an abusive father, a codependent mother, or a parent that has abandoned them.}”

Application of the Core Competencies to the Seminary Curriculum

Each of these scenarios could be used as a case study as part of a course in pastoral counseling or to stimulate discussion at an in-service day on alcoholism and substance abuse. They warrant a critical review by seminary students who need to be exposed to the complexities and nuances of addiction. Seminary curriculum dealing with addictions usually teaches students how to refer and utilize community resources. However, seminaries also must remind the seminarians to develop a pastoral instinct that comes from integrating skills with personal formation. When seminaries teach these future pastors to follow their gut reactions and trust the spiritual traditions of the faith community, the competencies they learn become part of the healing ministry of the church.

Substance abuse and addiction is a systemic deconstruction that estranges, alienates, and sedates the self from God. Ministers who support individuals in treatment need to be ready to offer some guidance, especially after treatment. The aftercare process of recovery often includes the need to forgive oneself. It involves a reconciling community that invites those who have been estranged from each other to rediscover each other and themselves all over again. This process of healing is often initiated within a parish community through the assistance of a priest or pastoral minister who serves as a spiritual mentor. This mentor in faith reformation needs to be attentive to the faulty images of God the persons in recovery have constructed. Their picture of God may be the image of an abusive father, a codependent mother, or a parent that has abandoned them. The person in recovery may be overcompensating with rigid behaviors and beliefs or have little or no religious formation. As individuals reengage intrinsic support systems, they may need some pastoral assistance in clarifying their faith connections. They may need to feel the welcoming hands of a faith community that provides patience, understanding, and acceptance. The priest can help the person in recovery rebuild a biblical and theological anthropology that includes a God who forgives.

One’s self-image throughout addiction is poor. Helping individuals appreciate the Christian perspective of a saved and redeemed humanity is essential for recovery and healing. Seminarians that can link their systematic theology courses with the art of pastoral healing may one day be priests that provide spiritual guidance for individuals who have lived in tangled relationships with shattered hopes. As future priests, seminarians will constantly invite people to be members of a faith community. They will need to assist those who have lost meaning for their life. Furthermore, ongoing ministry is needed to help individuals reshape feelings of guilt or resentment into self-forgiveness and a positive self-love. The future ministers would do well to appreciate that they possess a reservoir of lived faith and always have access to a religious tradition that is firmly rooted in reconciliation, contrition, and conversion. This delicate and complex process of recovery is a process that demands patience, gentleness, understanding, and sympathy.

Seminarians at one point or another in their curriculum should understand the dynamics of Alcoholics Anonymous, especially the Fifth Step Process (see The Clergyperson and the Fifth Step...
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in Robert J Kus, ed., 1995, Spirituality and Chemical Dependency. The Haworth Press). Students need to appreciate the importance of support groups during recovery. The seminary internship year affords many opportunities to become acquainted with various support groups. Students in their pastoral year could interview and visit local agencies that support addiction recovery. The personalization that comes from meeting a sponsor in an “Alcoholics Anonymous” or “Al-Anon” support group, or a meeting with a counselor who organizes family interventions helps shape the mind and heart with hands-on learning that can later serve as a valuable resource.

Conclusion

The “Core Competencies for Clergy” provide a framework for acquiring the knowledge and skills needed in each of these case studies. In Case #2, for example, core competencies #1, 2, 3, 6, and 9 would have provided the parish priest an opportunity to offer support and guidance to the spouse and children, while helping to intervene and refer the alcoholic to treatment. In this way, the priest could be instrumental in a family’s healing process and return to emotional stability. The priest’s actions would also offer to the family members a renewed capacity to connect with their spiritual roots.

Mastering the Core Competencies can help prepare the seminary student to develop a healthy attitude about alcohol use, the impact it might have had on his own life, and the ability to reach out and support the many individuals and families in their parishes affected by alcohol or drug dependence.

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