

*Spiritual Caregiving to Help
Addicted Persons and Families*

**HANDBOOK FOR USE BY
PASTORAL COUNSELORS IN
CLERGY EDUCATION**

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Introduction

Alcoholism, alcohol abuse and other drug addictions and abuse, are among the most prevalent, complex, and destructive illnesses in human society. They are found in every segment of society, regardless of race, religion, and socioeconomic class. They are seen in corporate board rooms, in bars and taverns, on the street, and in the worship rooms of religious communities. They have a significant impact on physical and mental health, family relationships, child development, highway safety, criminal justice, and the economy, as well as all other arenas of human society.

What does all this mean to the pastoral leadership of religious communities? Why is it important that clergypersons gain a compassionate awareness of the complexities of these disorders, and also learn how to recognize these illnesses and their impact on the individuals, families and communities whose lives they touch? It has long been recognized that alcoholism and drug dependence contain a spiritual dimension that must be integrated into treatment more than other disorders. This spirituality is fundamental in the approach to recovery of Alcoholics Anonymous (AA) and other self-help groups as clearly stated in their 12 steps. It is integral to their effectiveness. This connection between recovery and spirituality needs to be handled with sensitivity, understanding, and competence by clergy and congregational leaders. It is especially important given the stigma, denial and secrecy that accompany the physiological and other behavioral aspects of alcoholism and drug dependence, and which also have a significant impact on children and families.

Historically, the role of clergy in relating to addicted persons and their family members has been mixed. A lack of knowledge and understanding has made the relationship problematic more often than it has been helpful. Yet, there is a great potential for informed and caring clergypersons to play an important role in ministry to addicted persons, their spouses, and their children, especially in partnership with addiction treatment professionals and other groups in the larger community.

This training material, based on the *Core Competencies for Clergy and Other Pastoral Ministers In Addressing Alcohol and Drug Dependence and the Impact on Family Members*, is specifically designed for those clergypersons who wish to enhance their ministries and deepen their professional pastoral relationship

with addicted persons and their families. It combines scientific knowledge with faith awareness and practice in a comprehensive approach to understand, take action, and help heal the impact of alcohol and substance use addiction on individuals, families and the community.

Chapter I

Recognizing Addiction – The First Step in Spiritual Caregiving

This Chapter addresses:

- a. Generally accepted definition of alcohol and other drug dependence
- b. Signs and symptoms of alcohol and other drug dependence
- c. Characteristics of withdrawal and stages of recovery
- d. Awareness of family, mental and physical health, and criminal justice consequences of addiction

Definitions

There are numerous statements by experts in the field defining alcoholism and other forms of drug dependence. However, they agree on several points:

1. Alcohol and drug dependence are progressive, chronic, and potentially fatal diseases when unrecognized and untreated.
2. The primary behavioral characteristics of this illness are cravings for the psycho-physiological effects of alcohol and drugs and continuing excessive use even when such use is harmful to oneself and to those others who are in one's circle of relationships, especially one's family.
3. Alcohol and drug dependence involve diminished freedom to choose 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 is causing 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 one self 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 (NIAAA) describes alcoholism as a disease that has the following four symptoms:

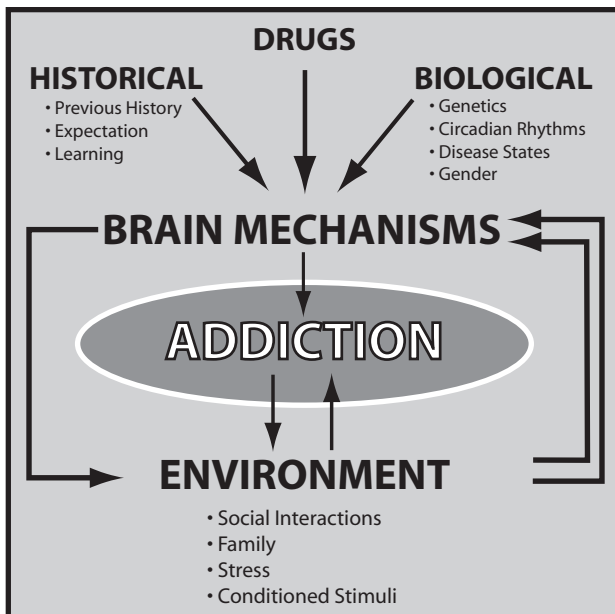
- **Craving** – a strong need, or urge, to drink
- **Loss of control** – not being able to stop drinking once drinking has begun
- **Physical dependence** – withdrawal symptoms such as nausea, sweating, shakiness and anxiety after stopping drinking
- **Tolerance** – the need to drink greater amounts of alcohol to get “high”

(For more information go to www.niaaa.nih.gov)

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.

NIDA developed the depiction of the multiple factors that can lead to drug addiction shown below.



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 (McLellan et al., 2004).

(For more information go to www.nida.nih.gov)

The Diagnostic and Statistical Manual (DSM-IV), published by the American Psychiatric Association (1994), lists seven diagnostic criteria for substance use disorders. To qualify as addicted, a person must show three or more of the following symptoms within a twelve-month period.

1. Tolerance, defined as a need for increasingly larger amounts of the substance to achieve intoxication (over time the drug produces less intense reactions at the same dose)
2. Withdrawal symptoms, which include hand tremors, sweating, elevated pulse rate, insomnia, nausea, or anxiety; these symptoms may develop into hallucinations, grand mal seizures, and/or psychotic symptoms; or, the same or similar substance is taken to relieve withdrawal symptoms
3. The substance is often taken in larger amounts or over longer periods than intended
4. Persistent desire or unsuccessful attempts to cut down or control substance use
5. Spending a significant amount of time trying to obtain the substance, use the substance, or recover from its effects
6. Giving up or reducing social, occupational, or recreational activities because of substance use
7. Continuing to use the substance despite persistent or recurrent physical or psychological problems caused or exacerbated by the substance

Genetic vulnerability

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, that is now viewed as indicative of genetics as one of the dominant, precipitating factors in the etiology of addiction. Environmental,

social, and other such factors also influence the development of the disease. Inherited biochemical/neurophysiologic functions of the brain are now being understood as important causal factors. The growing knowledge of genetic predisposition distinguishes alcohol addiction from moral weakness or sinfulness. While one's environment and past and current primary relationships remain important considerations for both addiction and recovery, understanding the genetic factor helps eliminate blame, prejudice, and rejection often associated with alcoholism and drug dependence.

Behavioral Indicators of Addiction

One of the characteristic behaviors of alcoholics is hiding their drinking from others. They may prefer to drink alone and actually hide alcohol in stashes around the house. Their attempt to deceive others and hide or deny their compulsion to drink is itself a prime indicator of the problem. Other individual behaviors which are signs of alcohol or other chemical dependence include the following:

- Preoccupation with alcohol or other addictive substance
- Inability to resist, control, or stop the drinking or other addictive behavior
- Increased tension prior to drinking or other addictive behavior
- Frequent and progressive involvement with drinking or other addictive behavior
- Progressive deception and dishonesty regarding addictive behavior
- Drinking or using drugs to the neglect of job, school, family, church, etc.
- Continuation of drinking or related behavior in spite of problems posed.

It may be difficult to detect an addiction when an addicted person shows up regularly at church, synagogue, or mosque. For example, a Sunday School teacher who drinks heavily during the week can sober up on the weekend to teach the class and maintain the illusion of not being an alcoholic. Increasing unexplained absence of someone who has been a regular attendee may be a clue, as well as observations of increasing stress in the spouse or children. The ability to keep these behaviors hidden decreases the longer the alcohol or drug abuse continues.

Key Elements of Addiction

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 as follows:

- **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 (Center for Substance Abuse Treatment[CSAT], 2004).

Forms of Withdrawal

A needed first step toward recovery for a person with a severe, chronic substance use disorder may be referral for medically supervised withdrawal, often called detoxification or detox. Detox is a medical treatment aimed at mediating severe withdrawal symptoms and restoring physiological balance after protracted alcohol and/or drug binges. Symptoms may include agonizing hangovers, delirium tremens, and hallucinations. These result from the withdrawal of alcohol and/or drugs from the body after it has adjusted biochemically to their presence in the system. They are painful and frightening.

People who have been taking large amounts of opioids (e.g., heroin, OxyContin, or codeine), barbiturates or sedatives (“downers”), pain medications, or alcohol, either alone or together, may need this medically monitored or managed withdrawal service. This process usually lasts a few days to a week, and it should be followed by treatments aimed at physical rehabilitation and restoring basic health to the person, who is likely to be suffering from such ailments as malnutrition, liver disease, and neurological problems. Medically supervised withdrawal can take place on a regular medical ward of a hospital, in a specialized inpatient detox unit, or on an outpatient basis with close medical supervision.

Not everyone needs inpatient medically supervised detox. Those with mild withdrawal symptoms from alcohol or drugs generally do not need to be hospitalized for detoxification. They may, however, need outpatient care and a supportive environment with the capability of watching the person’s medical condition and assisting them through the most difficult part of withdrawing from alcohol and drugs. Where drug or alcohol use has been ongoing for a shorter duration and more moderate amount, and where basic health is stable, the addicted person may be able to manage the withdrawal without medical intervention. Some persons may experience spontaneous spiritual or psychological transformation, such as a sudden conversion experience or a gradual awakening, which can put the person on the road to sobriety without major withdrawal symptoms being involved.

The Process of Recovery

Further treatment seeks to address the psycho-social-spiritual dimensions of the addiction through group and individual therapy by qualified professionals, preferably including involvement in 12 step and other recovery supports. Emerging sobriety can be accompanied by considerable levels of anxiety, depression, guilt, anger, shame, and related emotional responses. Qualified counseling and psychotherapy can be valuable if not essential once sobriety has been stabilized and maintained for an adequate period. It is usually very important for the counseling phase to include marriage and family counseling if the addicted person is in those relationships. Children are greatly at risk and need their own age-appropriate education and support program.

As with all phases of the addictive process, the treatment phase has significant impact on the whole family, including spouse, children, and parents of the addicted person. All of these persons need attention and support, and a clergy member may be the most natural person to provide that support, or to

make sure that it is being provided by appropriate persons or groups in the congregation. Referrals to groups like Al-Anon and Alateen are also important considerations. Recovery includes the critical component of family education and support since everyone has to learn new ways of being “family.” Divorce following sobriety is not unusual, and it most often happens in the absence of the whole family receiving adequate recovery support services. Counseling therapy with a skilled and qualified professional who understands addictions and recovery can be invaluable for persons with substance use disorders, preferably in combination with 12 step programs and other recovery support programs.

Pastoral Counselors certified by the American Association of Pastoral Counselors (AAPC) work closely with community clergy and are excellent resources as a primary therapist or to assist in referral to a treatment program. Professionals and programs that take seriously the spiritual along with the traditional components of addiction treatment tend to be the most trusted referrals for a pastor or other congregational ministers to make, usually for good reason. AA includes the non-sectarian spiritual dimension as fundamental to its approach, referring to God as the “Higher Power” and “God as you understand him.” Therapy needs to help addicts make progress to a new way of life based on inner strengths and healthy relationships rather than addictive substances. Key elements of recovery include improved physical, mental, and spiritual health, ability to get and keep a job, and improved family communication and relationships.

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 of reality, which ultimately leads to hitting bottom. Thus, helping to remove stigma from alcoholism and other addictions is something that religious communities can contribute to ending this vicious cycle and encouraging help at an early stage of addiction for both the afflicted individual and the impacted family members.

Impact of Alcoholism and Drug Dependence on Larger Society

Alcoholism and drug dependence impact a wide circle of persons and social systems. A large number of problems in families, health care, and the criminal justice system 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 have received treatment for drug or alcohol abuse
- 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) (National Center on Addiction and Substance Abuse [CASA], 2005).

The first clues that alcoholism and drug dependence are problems may be unusual behaviors such as family dysfunction, children acting out at school and in church-based child 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. At the same time, most individuals and families struggling with addiction hide their pain, shame and confusion effectively and seldom come to the attention of the criminal justice or mental health 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 has been demonstrated by the data above, 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 alcoholism and drug dependence. 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 on families; and minister to affected persons as children of God who need love that is informed by accurate knowledge and disciplined by awareness of relevant care giving skills.

These responses can either perpetuate the problem or provide hope and help, and the faith leader holds the key to how congregations react.

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Chapter II

Pastoral/Spiritual Care of Addicted Persons and Families

This Chapter addresses:

- a. The erosion and blocking of religious and spiritual development
- b. The role and practice of religion in recovery in the context of the faith community
- c. Appropriate pastoral interactions with the addicted person and family members
- d. Communicating and sustaining an appropriate level of concern, hope, and caring

A Characterization of Spirituality

Spirituality resides in the reality of God as God is understood

Spirituality is centered in the core of the self

Spirituality is realized in relationships

Spirituality is celebrated in community

Spirituality is rooted in reconciliation.

Each of the above statements is both true within itself and equal in value to all the others. Fully realized spirituality includes all of these realities. Addiction acts as an impediment to each of these components of spirituality and negates spiritual growth and awareness. It erodes whatever spirituality has developed and blocks the spiritual pathways. Recovery involves not only the recovery of mental, physical, and relational health, but also spiritual health and possibility.

Erosion and Blocking of Religious and Spiritual Development

“The disease of alcoholism is as toxic to the soul as it is to the liver or the brain,” says Ketcham et al., (2000), in *Beyond the Influence: Understanding and Defeating Alcoholism*. The impact of addiction on one’s spirituality and faith system is enormous. Spirituality and faith are closely linked to all the other dimensions of the self. Becoming aware of the life stories of many alcoholics and other addicts makes it clear that addiction toxically denudes the spiritual center of personality for both the addicted person and the family members. AA cofounder Bill Wilson became convinced of that in his own experience

with alcoholism, saying “We must find some spiritual basis for living, else we die.” He believed that alcoholism is directly related to looking for “God in a bottle,” a self-defeating process and spiritually deadening behavior. Al-Anon also addresses this critical component of addiction’s effect on families and its importance in recovery.

Addiction is a psychic cave into which one withdraws and hides from the demands, expectations, and benefits of both the outside world and deep interior of the soul in its connection with God and with others.

In addiction, the reality of God becomes blurred at best and non-existent at worst. The addicted person and the impacted family members eventually lose touch with the inner self and drown it in the addiction or in reacting to it. Relationships are badly bruised if not destroyed. Community is diminished to perhaps a few drinking or drugging buddies, and is otherwise heavily damaged. What the addicted person needs most, reconciliation to self, others, and Higher Power, he or she is least likely to find as long as the addiction controls them. Addiction is a psychic cave into which one withdraws and hides from the demands, expectations, and benefits of both the outside world and deep interior of the soul in its connection with God and with others.

This erosion may be difficult to observe in what is referred to as a “high functioning addict,” someone who does not have the usual appearances or social behavior of a person with alcoholism or drug dependence. Some people are able to maintain amazing composure in public places when their private life and internal frame of mind, body, and spirit are slowly decomposing. The general public was surprised to learn that well-known persons such as Betty Ford and Joan Kennedy, and various performers in theater and popular music were struggling with these illnesses until they sought treatment and used their fame to bring attention to the prevalence of the problem and the need for treatment, or until the media brought it to public attention. The main thing to learn from these examples is that even among leaders in religious communities, lay and clergy, substance use disorders exist and can begin to surface when the inner disintegration begins to become visible either through inappropriate behavior or dropping out of leadership or even out of the congregation for no apparent reason. One needs to be careful not to jump to conclusions, but also not to ignore possible symptoms that need attention.

The Role and Practice of Religion in Recovery in the Context of the Faith Community

The Clergy's Role

After the development of the core competencies (see Appendix A), one of the clergy leaders who had been part of the work said he believed clergy and congregational leaders should be able to:

- **Show up:** be alert to windows of opportunity for contact, assessment, intervention and treatment.
- **Be dressed:** be prepared internally with the necessary information, resources and teaching tools.
- **Get through the door:** know how to establish effective healing relationships with those affected by addictions.
- **Stay in the boat:** 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:** respect appropriate boundaries and know when to bring their involvement to a conclusion (Substance Abuse and Mental Health Services Administration [SAMHSA], 2004).

Many persons in religious communities assume that alcoholism and other addictions are problems only for those outside communities of faith. Yet, every congregation of almost any size will have within it persons who are either actively addicted or who are being or have been negatively affected by addiction within the family. Moreover, clergy themselves are not immune to alcoholism and drug dependence. Hidden from view in a pastor-congregation conflict may be alcohol or other addictions which distort reality, interfere with relationships, undermine trust, and damage communication. Therefore, it is in the best interest of all concerned to give close attention to addictive processes and the danger they pose for one's spiritual life and development. There are also some things religious communities can learn from 12 step and other recovery support groups. These generally relate to realities like acceptance, humility, non-judgmental behavior, equality of all group members, support system, and using one's own experience to help others struggling with similar experiences.

The importance of the spiritual dimension in one's life and in recovery from alcoholism has been successfully maintained in AA due to several factors. One

To disown the lies in one's life and move into truth and openness is a profoundly spiritual experience...

factor is the “Higher Power” recognition which is based on experiential reality rather than doctrinal or sectarian debates. Theology is not argued, it is lived. God is referred to as the Higher Power, or “God as you understand him,” to keep it experiential and avoid doctrinal debates that could become divisive and distracting. Another is the emphasis on self-examination, through a moral inventory of oneself, rather than judgments about others. A third factor is the emphasis on confession and restoration where appropriate and possible. Much of the life of an alcoholic is a lived lie. To disown the lies in one’s life and move into truth and openness is a profoundly spiritual experience which requires courage and transformation that is renewed on a daily basis.

Faith leaders and communities need to convey four basic attitudes toward the alcoholic.

- **Acceptance:** Acceptance is the doctrine of grace practiced in interpersonal relationships. It is what Carl Rogers, an influential psychotherapist, called “unconditional positive regard.” The alcoholic must be accepted for who and what he or she is. By accepting persons as they are we give them the incentive to become what they can be.
- **Redemptive Judgment:** To be non-judgmental does not mean that no judgment can ever take place. To make a realistic appraisal of a person, their behavior, and their life situation is to make a form of judgment. However, the judgment should be based on understanding, love, and reality, and not on old prejudices, condemnation, and rejection. One’s judgment should have a redemptive quality of grace as well as a redemptive intent for change.
- **Disciplined Love:** This form of love does not act out of a compulsive or “do-good” attitude. Disciplined love is patient. It does not bail someone out of all troubles and nourish childish dependency. It understands that the addicted person must be open to help if help is given, but it stands close enough by to be ready to help when the opportunity comes.
- **Awareness of Limitations:** While the religious community should mobilize reasonable resources to help the addicted person and

the affected family members, it should realize that it cannot do everything. Other caregivers need to be involved. Medical care is needed. The rich resources of 12 step programs and people in recovery are needed to help with the problems they know so well. Referral to treatment programs and therapists is needed. Prayer is a resource which allows us to reach beyond our own limitations and turn the person over to God while doing what our limits will allow.

The traditions and rituals of the faith community are of value to an addicted person and to affected families during recovery when they reinforce acceptance, redemptive judgment, disciplined love, and awareness of limitations and use of other resources. Prayer and scripture that direct the recovering addict and family members to a loving and accepting God, as well as reflect a caring community, are valuable spiritual resources that are generally well received.

Spiritual Dimensions of Addiction

From research published by Woodruff (1968), religious/spiritual dynamics were identified that are relevant to an addicted person as follows:

- 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 a loving and welcoming God
- The problem of identity
- The problem of meaning
- The need for harmony of values and behavior
- The role of family history and family responsibility.

Appropriate Pastoral Interactions with Addicted Persons and Family Members

The pastoral care of an alcoholic or other addicted person can be a challenging and sometimes frustrating experience. It is easy to feel overwhelmed with the magnitude of the need, the manipulation of the addicted person, and the fear and confusion of the family members. There is a temptation to withdraw

and avoid a relationship with these persons. By following certain principles, however, relating to persons hurt by addiction can be a rewarding ministry.

- Try to understand them and avoid irritation or disgust. Addicted persons are used to having others disgusted with them and family members are used to people being critical and impatient with them. If you follow suit, then you are included with all the others who “don’t understand.” An alcoholic will often use irritation to keep people at a safe distance. Their family members will be more likely to deny the severity of the problem, look for quick fixes and turn away when confronted with their own role in the family dysfunction.
- Expect them to lie, but never accept the lie. Lying is one of the symptoms of the illness. The truth may be painful, but to accept a lie is to deny reality and support the addictive behavior.
- Never let them promise you they will quit drinking or taking drugs. Most addicted persons have “quit” a number of times. If s/he promises you s/he will quit and then does not, his guilt may cause him to break his relationship with you. It is a good rule not to accept such promises and to guide concerned family members not do so as well.
- Do not preach, scold, or tell them they ought to join a religious community and/or be baptized. The alcoholic scolds himself daily and may have been baptized more than once already. You may offer an invitation to church/synagogue/temple, but if you push you risk pushing them away. The early stages of the relationship are precarious at best. If the addicted person is not attending a 12 step program or group, suggesting and even arranging for that may be more important initially than getting him/her involved in faith activities.
- Show genuine interest in them. Addicted persons are very sensitive and will discover quickly how much you care. Your concern may be a stepping stone to finding the concern and love of God and a community of faith. The same is true with the family members.
- Do not ask them to take on responsibility in the church in the early stages of sobriety. More than one recovering alcoholic has been asked to speak on their conversion experience and has shown up drunk. A fear of people or of not being well received may have reinforced excessive drinking in the first place. Be sensitive to a need for a gradual recovery.

- Be aware of the impact of addiction on the family, assess the needs of spouse, parents and children, and provide a support system for them. Family members should be encouraged to attend Al-Anon, Alateen, and other self-help support groups. These are important resources where family members can find a supportive community, whether or not the person with the alcohol and drug dependence is ready to address his/her problem. School-age children should also be referred to their school counselors or student assistance programs where educational support programs are offered. (Remember that one in four children lives in a household with alcoholism or alcohol abuse, and many additional students live with parental drug use. Every school has a critical population of affected children.)
- Use scripture/sacred readings in ways that value the individual and show God's love, grace, and transformational concern for the addicted person and their family members. Scripture should encourage motivation, not increase guilt, fear, or low self-esteem.
- Be aware of treatment resources and refer to them when there is an opportunity to do so.
- Above all, be honest. Pretense and deception are the alcoholic's game, and they can quickly spot them in anyone else. Honesty, patience, and genuine understanding are things an alcoholic needs most. A conscious effort to recognize both harmful and helpful attitudes and a critical evaluation of one's own attitudes are a necessary first step in accentuating the positive and eliminating the negative.

What Can Family Members Do?

- Participate in a family support group such as Al-Anon/Alateen or Families Anonymous. At these support groups, you can find others who have family members or close friends with substance use disorders. Listening to others' stories can help some people overcome negative internal perceptions about substance use disorders and to bring balance and peace to their own lives.
- Become involved in your family member's treatment and recovery and understand that substance use disorders can be treated just as other diseases can be.

- Volunteer to be a mentor for a child who has a parent or close relative with a substance use disorder. Mentors may serve as crucial educators and support figures, promoting learning and capability, providing exposure to positive influences, increasing a sense of efficacy, and helping youth realize their full potential.
- Encourage pediatricians, schools, and other people who routinely interact with children to identify children of parents who have substance use disorders and intervene to provide support.
- Consult helpful organizations to learn more about overcoming stigma and substance use disorders. (*Note: A suggested listing of resources is in Appendix 6*)

Communicating Through Appealing to Motivation

William R. Miller and Stephen Rollnick, in *Motivational Interviewing: Preparing People for Change* (2002), apply client-centered principles to counseling people with alcohol and drug dependence. Considerable research has demonstrated this to be an effective means of engaging people suffering with addiction and engaging their family members to take action for their own recovery as well as their afflicted loved ones. Motivational interviewing is respectful, builds trust, and strengthens the helping relationship by acknowledging the person's ambivalence about change, developing their own motivation for change and offering assistance as s/he goes through stages of change. This approach seems congruent with the caring, shepherding role of pastors and other congregational ministers, as well as minimizing resistance to pastoral involvement.

In motivational interviewing:

1. The pastoral person avoids an authoritarian style of relating and communicates more as a partner in the process rather than an expert teacher or a superior, collaborating rather than confronting.
2. Exploration is used rather than exhortation, and support rather than argumentative persuasion. Rather than trying to educate the person about what they should know, this approach seeks to draw out motivation from the person. As Miller and Rollnick (2002) say, "It requires finding intrinsic motivation for change within the person and evoking it, calling it forth."
3. The pastoral person affirms the addicted person's capacity for self-direction and facilitates informed choice. "The crucial attitude is a respectful listening to the person with a desire to understand his or her perspectives. Paradoxically, this kind of acceptance of people

as they are seems to free them to change, whereas insistent non-acceptance tends to immobilize the change process.” The process works equally for family members frozen by the fear of addressing the problem after so many failed attempts.

One of the powerful paradoxes of this approach is that it reframes the way one deals with resistance. Resistance is an interpersonal process that requires two opposing forces in order to operate. The manner in which the pastoral person responds, therefore, will shape whether resistance from the addicted person will increase or diminish. When resistance is not directly opposed, but rather “rolled with,” resistance loses power and diminishes. When resistance is encountered, that is a signal to respond differently in order to keep the addicted person or the affected family member(s) involved in problem solving. This not only redirects the flow in more positive and creative ways, it also reinforces self-confidence in the addicted person.

Miller and Rollnick describe the signs of readiness for change as follows:

- **Decreased resistance** -The wind seems to have gone out of the sails of resistance
- **Decreased discussion about the problem** -The person seems to have talked enough about the area of concern
- **Resolve** – The person reaches some sense of resolution, may appear more relaxed and unburdened, or tearful and resigned
- **Change talk** - Whereas resistance decreases, change talk increases
- **Questions about change** - The person may begin to ask questions about what to do, what actions to take
- **Envisioning** - The person talks about how life may be after a change
- **Experimenting** - The person may begin to experiment with change actions between sessions.

Motivational interviewing can also be effective with family members, and can even be adapted to working with young members of the family. In an article in *Contemporary Pediatrics*, the following example was given showing how this approach is used in a technique called TEAR to help a young teenager who has begun to get into fights in school and whose father has an alcohol problem.

Teach – *“Billy, you know it is OK to be concerned about a parent or another person’s alcohol or drug use. One of the most important initial things we can do*

is help you to learn more about how alcohol and drug abuse affect the individual involved, such as your Dad, as well as how it affects you and others who live in the same house and care about him.”

Express empathy – *“Billy, I’m concerned about what we just talked about and how it is making you feel. I’d like to help you so that you can feel better and resume getting the good grades that you used to get in school.*

Advise action – *“Billy, I think it would be helpful for you to learn about alcohol and drug abuse and how it can affect everyone in the family. You can talk to a counselor at your school or attend meetings of a group called Alateen to learn about the disease of alcoholism and learn healthy ways to deal with anger.”*

Reach agreement – *“Billy, I’m glad you are willing to agree to talk with your school counselor to learn more about alcohol and drug abuse and to explore attending an Alateen meeting. I think this is great, and I know you can be successful at dealing better with this problem if you try this.”* (Adger et al., 2004)

Whereas long-term counseling with motivational interviewing requires discipline and training, its basic principles greatly enrich the interaction between pastoral persons and addicted persons and affected family members in positive and healing ways. It communicates and sustains an appropriate level of concern, as well as embodying implicit messages of hope and caring.

(See Appendix C for an application of the stages of change that lists the indicators of each stage and possible tasks for a helping person.)

Pastoral Communication With Children of Alcoholics

“One particularly difficult impact from family alcohol and substance abuse is that many of the children hide their suffering quite well. They have picked up habits of denial, secrecy and social withdrawal that their family members have modeled for them. Too often, we do not approach them and offer the information and support they need. By ignoring their pain, we send the message that their feelings and concerns are not real or important.” Sis Wenger, President/CEO, NACoA

In one of the earliest books written expressly for pastors in regard to the problem of alcoholism in the church, Wayne E. Oates (1966) makes the following observations about pastoral communication with the children of alcoholics.

“The church and its pastors, Sunday School teachers, youth group leaders, ministers of music, and ministers of education are faced with a dilemma in ministering to the children of alcoholics. On the one hand, the child needs to have a strong, consistent, and basically happy spiritual leader with whom he (she) can identify, like whom he (she) can become, and in whom he (she) can confide. On the other hand, he (she) needs to respect and keep whatever is true, honorable, just, pure, lovely, and gracious, . . . about his (her) father or mother who may be alcoholic. The temptation of the religious leader is simply to exclude the alcoholic parent, reject him or her completely, and to attempt to take over a parental role in the life of the young person. These efforts are often doomed to fail because intuitively the child senses that this is wrong.”

Oates (1966) continues his insightful comments by offering a more helpful and realistic approach to the child of an alcoholic parent, as follows. These suggestions are conditioned by the developmental age of the child.

1. “Do not ‘splurge’ sympathy on the child, but honestly assure him (her) that he (she) is not the only person who has had an alcoholic parent, nor will he (she) be the last one. Other people have had this experience. Much has been learned about how to handle it.
2. Begin teaching the child what is known about alcoholism. Alcoholism is one of the most insidious diseases known. The overwhelming mental urge to drink is beyond control. The alcoholic needs help and love; help and love should be wisely and carefully given. Other people who have alcoholic family members have gotten together to share their experience.
3. The pastor or religious worker should not allow himself (herself), either consciously or subtly, to take over the parental role in the life of the young person. He (she) should be available on an emergency standby basis to give help when the parent becomes inadequate and incompetent, and he (she) should offer support, encouragement, and affection when the alcoholic is drunk and incompetent. As one nine-year-old boy said of his pastor, ‘I know that when my father gets to where he can’t help me, my pastor is my friend and will pinch-hit.’
4. If there are other children in the community who also have alcoholic parents, the pastor can help them relate to each other as friends. Sometimes an anonymous, casual get-together of these young persons to talk about what they have in common can be remarkably useful. One pastor found that in a subdivision where

he himself lived, three families had one parent or another who were problem drinkers. Through his own children the pastor developed a sustaining friendship with the children of these three families. His wife was a good neighbor and friend to the wives of these three problem-drinker husbands. On the regular routines of birthday parties, picnics, school carpools, and neighborhood yard maintenance chores, the pastor and his family maintained lasting relationships with these three families over a period of sixteen years.”

These observations, while written long ago, show remarkable insight and pastoral care awareness from one of the great authors and professors of pastoral care and counseling. The comments are as relevant today as they were in 1966.

If A Child Comes to You For Help, What Should You Do?

The following list may help you prepare for and respond to a call for help.

DO develop and maintain a list of appropriate referrals to helping professionals. Knowing which organizations have resources to help children will make it easier to respond promptly when a child comes to you.

DO maintain a small library of current books, pamphlets, and reprints of articles on addiction-related problems that have been written for children. Many of these are available from the National Association for Children of Alcoholics (NACoA), Alateen, the National Clearinghouse for Alcohol and Drug Information (NCADI), and the National Council on Alcohol and Drug Dependence (NCADD).

DO make sure that the child understands three basic facts:

First, he or she is not alone. There are more than 19 million children of alcoholics under the age of 18 in the United States. Countless others are affected by alcoholic or drug abusing parents, siblings, or other caregivers.

Second, the child is not responsible for the problem and cannot control the parent’s drinking behavior.

Third, the child is a valuable, worthwhile individual.

DO follow through after the child asks for help. You may be the only person the child has approached. You might choose among several courses of action:

- Help the child “think through” all the sympathetic adults who play significant roles in his/her life (a favorite aunt or uncle, grandparent, minister, or school counselor) who might be able to help;

- Help the child contact a local Alateen group, where others who understand and share the problem of addicted parents are available for support;
- If the child’s school has educational support groups, life skills groups or friendship groups for these children from troubled families, explain their benefits to the child and refer the child to the school person responsible for the program; and/or
- Refer the child to an appropriate helping professional.

DO be sensitive to possible cultural differences. If the child is from a different culture, learn about that culture including family structure, customs, beliefs, and values. This knowledge may show you how you can most effectively help the child.

DO be aware that children of addicted parents may be threatened by displays of affection, especially physical contact.

DON’T act embarrassed or uncomfortable when the child asks you for help. Your reaction may discourage the child from seeking help and increase his or her sense of isolation and hopelessness.

DON’T criticize the child’s alcohol or drug using parent or be overly sympathetic. The child may gain the greatest benefit just by having you listen.

DON’T share the child’s problems with others who do not have to know. This is not only important for building trust; it also protects the child.

DON’T make plans with the child that you cannot keep. Stability and consistency in relationship are necessary if the child is to develop trust.

DON’T try to counsel the child unless you are trained to do so. Refer the child to an appropriate helping professional in the school or community, or help the child contact a local Alateen group (National Association for Children of Alcoholics [NACoA], 1989).

When in doubt, you can always remember to share, support, and convey the messages of the “Seven Cs.” Sensitive communication with children impacted by alcohol and drug dependence is important and sometimes challenging. Children who come to understand and internalize the “Seven Cs” are often better able to find trusting adults to help direct their lives in safe and healthy ways despite what is happening in their families. These basic messages are:

You didn't **CAUSE** it

You can't **CURE** it

You can't **CONTROL** it

You can help take **CARE** of yourself

By **COMMUNICATING** your feelings,

Making healthy **CHOICES**, and

CELEBRATING being yourself

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Chapter III

Self-Understanding/Understanding Prevention Strategies

This Chapter addresses:

- a. Acknowledging and addressing values, issues, and attitudes regarding alcohol and other drug dependence in oneself and one's own family
- b. Awareness of how prevention strategies can benefit the larger community, and activating a ministry response to addicted persons and their families

Suggestion: Get the DVD or video of the excellent documentary entitled *LOST CHILDHOOD: Growing Up in an Alcoholic Home* (available from NCADI 800-729-6686). This program presents an experiential and true account of children and families caught in addiction. It gives a longitudinal perspective by interviewing young children of addicted parents who had the opportunity to go to a special camp for children of alcoholics (COAs) under the direction of Jerry Moe, a talented and sensitive counselor and friend of children who, like himself, grew up in addictive families. Then these same persons were interviewed again 20 years later and share aspects of the hurt, the healing, and the hope that relates to this experience in their lives. The DVD has an accompanying viewer's guide that can help frame questions and issues for discussion. The program itself is 30 minutes in length.

Acknowledging and Addressing Values, Issues, and Attitudes Regarding Alcohol and Other Drug Dependence in Oneself and One's Own Family

No matter how much one knows about facts, theories, therapies, community resources, or any other such objective awareness, it is self-knowledge that lays the groundwork for a trusted, healing, and caring relationship. Knowledge of oneself, one's attitudes, and the shaping forces in one's background and environment are important for anyone who is providing pastoral care or counseling to others. Otherwise, vulnerability is created for both the caregiver and care-receiver by transferences, counter-transferences, and projections that occur in human relationships, as well as by manipulative or maladaptive behavior arising from patterns shaped earlier in one's personality development. A caregiver must know the appropriate boundaries in human relationships and be aware of potential blind spots and inappropriate interactions.

Interactions with addicted persons can stir up a variety of reactions within the caregiver, and those need to be anticipated, recognized, and managed. This is especially critical if the caregiver is the adult child of an alcoholic or other addicted parent. One must know one's own family system and psychodynamics and address and understand issues and attitudes developed in that system in order to respond helpfully to those of another. Unmanaged or unsuspected needs for control and authority can be damaging in a helping, caring relationship, as can hidden prejudice or anger. Sexual and role boundaries must be clearly delineated and maintained in such relationships where power imbalances and prestige differentials abound.

Persons long addicted to alcohol and/or drugs tend to suffer from an erosion of competent judgment about their own values and behavior, or that of others, and deep personal need for acceptance and nurture can make them especially vulnerable to being abused by someone in a helping relationship. Caregivers, pastoral or otherwise, who cannot see themselves in a relationship of equality with the one receiving help, and who do not respect the essential worth and dignity of the other, can be a danger in ongoing relationships of care and counseling. Also, those who work in isolation from other caregiving resources and beyond the scope of their competence endanger the well-being and chances of recovery of the person needing care. The following cases illustrate how clergy may respond to an individual or family member impacted by addiction in their congregations.

The Case of Sally - Sally was a congregation member who was known by friends as an excessive drinker. This had been shared with the pastor who took it upon himself to confront Sally with her drinking and tell her that she must stop. She felt his confrontation as negative judgment and resented his intrusion into her life. She continued to drink and reached the point of hitting bottom where she knew within herself that she had to get help. She sought the help through AA and in the process experienced a sudden spiritual conversion, finding a depth of spiritual experience and grace that she had never known. Having found sobriety, Sally returned to her pastor to talk with him about her experience. She found, however, that the pastor rejected the validity of what had occurred. He told her that AA was a substitute for God and the church and that any sudden religious experience was merely evidence of emotional insecurity and instability. Sally was hurt by the authoritarian, rejecting attitude of her pastor, who responded in a way that indicated not only lack of respect and valuing of her experience, but an arrogant disregard for sources of healing other than himself and his narrow points of view. He seemed to have little awareness

of his own behavior, and what in his own experience might be shaping that, as well as no helpful understanding of Sally. One wonders if he had an unresolved childhood experience with an addictive parent. Sally went to another church and found a supportive and understanding pastor who helped her assimilate her experience and grow as a person. It is not uncommon to hear recovering alcoholics describe this kind of experience.

The Case of Carl - Carl's experience illustrates a different and more positive pastoral response. He was active in his church and thought he was hiding his addiction from his pastor. Neither he nor the pastor ever mentioned it to each other. However, after he had gained sobriety and began recovery, motivated by attending a Billy Graham Crusade, he discovered that for the few previous months, his wife had been in regular contact with the pastor, and the pastor had visited with the teenage children as well as alerting the Youth Pastor about their situation at home. They all had been supported and comforted by the pastor's concern and understanding. Carl was deeply appreciative of the pastor's "behind-the-scenes" help, and he sought out the pastor for support in his recovery. The pastor encouraged him to remain active in AA and offered his friendship and spiritual counsel in any way it was needed. This pastor showed great respect and regard for Carl in the way he stood by the family while waiting for Carl's readiness for change. He was non-judgmental and caring, showing good self-awareness, as well as awareness of his strengths and limitations. While some may criticize him for not approaching Carl more directly, the outcome indicated the wisdom of his approach. He also showed his respect for AA and other support systems in recovery.

The Case of Patricia - This case illustrates another understanding but more directive role of a pastor. Patricia's pastor knew of her alcoholism and had talked with her about it. He was patient, and his visits did not threaten her. Two weeks after Patricia had a transformational spiritual experience that gave her a new openness to change, the pastor encouraged her to attend an AA meeting. She was not comfortable going by herself, but she agreed to accompany someone in recovery to a meeting where she could be introduced to other AA members. She found genuine acceptance in this group and became an active AA member, moving into recovery. She continued to have a durable relationship with her pastor and maintained her church relationship. This pastor showed open and honest respect for his parishioner while taking the initiative in encouraging her to find help. She experienced him as a caring and trustworthy person and followed his lead. He was able to introduce her to AA and still maintain his own pastoral role with her, indicating a healthy sense

of personal and pastoral identity that was not threatened by other options for help. The congregation became a supportive and caring community for her, complementing her AA group in a positive way.

The case of Sally is an example of pastoral ineffectiveness. The pastor was too absorbed with himself and too unaware to provide sensitive pastoral care for Sally. The cases of Carl and Patricia exemplify effective pastoral care through different procedures. These two cases indicate that no legalistic rules can be set concerning what a pastor should do in every case. Each person and their family is different. Nevertheless, the guidelines of showing understanding, respect, and sensitivity toward the addicted person and the family; recognition of both internal strengths and limitations; and the awareness of community resources can apply to the pastoral role in every case of addiction in the congregation.

Prevention Strategies and the Larger Community

When congregations engage in efforts to increase awareness and education of the facts and realities concerning addiction, not only does the congregation benefit, but so does the larger community. As congregants participate in the workplace, the neighborhood, and other gathering places of the larger community, new knowledge, understanding and compassion can become the basis for addressing individual, family and community concerns.

However, there is another aspect to engaging in prevention efforts other than raising awareness and education, perhaps a more effective one. Through informed service to those who are afflicted with addiction, clergy and congregants learn first hand about the negative consequences of addictive behavior. They see ways in which lives have been damaged or destroyed through addiction. They see the enormous impact on spouses and children. They experience the complexity and the power of an addictive process in full swing. They hear the stories of pain and suffering that are shared by addicted persons and their families. They come to know the disparities within communities and learn about risk and protective factors, resiliency and social norms. Therefore, congregations that actively reach out to touch an addicted person and/or the family of that person are using a case method of education to learn about family and community life they may never have discovered otherwise.

Ways that congregational clergy and members can become facilitators of prevention as well as caregivers for the impaired are varied and can reflect both an “eyes/ears open” educational approach as well as a “hands-on” approach. A combination of the two may be the most effective. The following examples represent both approaches.

- Integrate alcohol/drug education into the ongoing educational programming in the church, synagogue, or temple. Invite other religious communities to attend or co-sponsor. Addiction is truly an interfaith and ecumenical concern.
- Invite an AA member with solid, long-term recovery, and/or an Al-Anon member, to speak on the experience of addiction and recovery. They will generally tell their story which provides an experiential learning process for those attending. They may give wonderful testimonies of the spiritual dimensions of their struggle and recovery.
- Make creative use of the “tract rack” by making available informational material on addiction and the impact on families and children.
- Include addiction-related illustrations and information in occasional sermons and teaching sessions.
- Incorporate questions and guidance regarding addiction and the general use of addictive substances in pre-marital pastoral counseling. Include information on family impact and the importance of adult children of alcoholics addressing the effects of living in their family of origin in order to have a healthy marriage relationship.
- Be sure that pre-school and early childhood teachers, as well as youth leaders, are aware of the indicators of possible family addiction in the behavior of children, and that they are aware of referral resources.
- Present reality-based programs to the youth group on the serious effects of addiction in young persons.
- Present programs to older adult groups on the prevalence of addiction in the later years of life and the debilitating consequences of alcohol and drug dependence.
- Sponsor an Addiction Screening Day, with trained professionals available to help people assess the use of alcohol and drugs in their lives, and whether or not they may have an addictive disorder. Several churches could join in co-sponsoring such an event. If there is a professional Pastoral Counseling Center in your community, that staff would be an excellent resource for recognizing the spiritual components of addiction and recovery.

- Create a library of information and materials about alcoholism and drug dependence.
- Develop a discussion group on alcohol and drug dependence issues, possibly viewing current or past Recovery Month web casts.

You can identify organizations working on Recovery Month initiatives in your state at the Recovery Month Web site at www.recoverymonth.gov. Additionally, clergy can help celebrate National Alcohol and Drug Addiction Recovery Month each September and “Join the Voices for Recovery.”

- Incorporate information about substance use disorders, treatment, and recovery into a sermon during September.
- Encourage Recovery Month events in your community, such as forums and educational workshops with speakers who are in recovery.
- Offer space in your church, synagogue, or mosque for recovery groups (such as Alcoholics Anonymous) to meet.
- Create a community network of congregants and clergy to offer support for people with substance use disorders and those in recovery.
- Offer opportunities for members of the congregation to tell their personal recovery stories to help in reaching out to others who may need assistance.
- 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.

Chapter IV

The Role of Community in Recovery from Addiction

This Chapter addresses:

- a. Shaping and educating a caring congregation that welcomes and supports persons and families affected by alcohol and other drug dependence
- b. Awareness of the potential benefits of early intervention to the addicted person, family system, and affected children
- c. Learning and utilizing community resources to ensure a continuum of care, and becoming knowledgeable about 12 step programs such as AA, Al-Anon, Alateen, Nar-Anon, etc.

Shaping and educating a caring and welcoming congregation

One of the common themes that exists in all the major religions of the world is the welcoming of the stranger, the theme of hospitality. Hebrews 13:2 admonishes us to “show hospitality to strangers, for thereby some have entertained angels unawares.” In the Christian scriptures this theme is expressed in the final word about who will enter the Kingdom of God, found in Matthew 25 where Jesus says that one will enter the Kingdom because, among other actions, “I was a stranger and you welcomed me,” and “I was sick and you visited me.” He extends the meaning of doing good by saying that “when you have done it to one of the least of these my brethren, you have done it unto me.” Thus, it is clear that such welcome and support for those persons in need is central to the spiritual meaning of being a community of faith.

However, few religious communities are seen in this way by addicted persons. Most alcoholics and other addicted persons feel disconnected and even disowned by churches and other religious communities, a feeling that often spills over into members of their families. Reversing that image comes about only by intentionality and effort in creating a caring congregation that welcomes and supports persons and families affected by alcohol and other drug dependence. It requires such congregations to be both informed and compassionate in reaching out to addicted persons and families. There are posters and pamphlets that are available through NACoA or NCADI (www.nacoa.org or www.ncadi.samhsa.gov) that reach out to hurting members of congregations.

There are a number of dynamics that impact and define the meaning of “caring congregation.” Three of these are:

- 1) **Isolation and Community** – A common experience for alcoholics and other addicted persons is to move into isolation as their addiction intensifies. They become disconnected from community, even from their own families. Yet, they have a deep longing for community. This is one of the important roles that 12 step programs and other recovery supports offer to these persons. The religious community has the potential to address this need, as well. However, it has to overcome some of the bad press it receives within addiction circles as being judgmental and rejecting. In a study of types of conversions experienced by alcoholics, those that achieved the most far-reaching, healing, and comprehensive conversions, and thus the most complete recoveries, were the ones who had meaningful connection to both 12 step groups and a religious community.
- 2) **Disguise and Disclosure** – Congregations that disguise themselves as “practically perfect people” and cover their own failings and sin with judgmental attitudes and self-righteous behavior will not be places alcoholics and other addicted persons can feel more comfortable and accepted. Will Durant captured the need for self-reformation as the context of the reformation of others. He wrote: “I went forth to reform the world. I denounced the ways of mankind, and bemoaned the backwardness of my time. . . . But the world would not listen, and I grew bitter. I gathered anecdotes of human stupidity, and heralded the absurdities and injustices of men. One day, an enemy said, ‘You have within yourself all the faults which you scorn in others; you, too, are capable of selfishness and greed; and the world is what it is because men are what you are.’ I considered it in solitude, and found that it was true. Then it came to me that reform should begin at home, and since that day I have not had time to remake the world.”
(Wassil, 1965)
- 3) **Guilt and Grace** – Related to the above dynamic is the pervasive question of the alcoholic: “What do I do with my guilt?” This question is both conscious and unconscious in the mind of the addicted person. The answer is grace, God’s most loving gift. Psychiatrist and spiritual director Gerald May (1988) defines

grace as the dynamic outpouring of God's loving nature that flows into and through creation in an endless self-offering of healing, love, illumination, and reconciliation. It is a gift that we are free to ignore, reject, ask for, or simply accept. And it is a gift that is often given in spite of our intentions and errors. At such times, when grace is so clearly given unrequested, uninvited, even undeserved, there can be no authentic response but gratitude and awe (May, 1988). Congregations that understand their own need for grace to deal with their multitude of human failings will be perceived as caring congregations by those addicted to alcohol and drugs and by their family members.

Awareness of the Potential Benefits of Early Intervention

The Addicted Person

As in any disease, treatment and recovery in addiction is best achieved when the intervention occurs early in the disease process, before too much damage has been done to restore the person to full or reasonable capacity for function. In alcohol and other substance addictions, intervention has become an accepted and generally approved method of getting the person into treatment, although it is not without its critics. The primary requirement for a successful intervention is that it be done by someone trained, who is working with family members and/or close friends who care enough about the addicted person to join together, get trained by an experienced professional, and confront the person with his/her self-defeating and destructive behavior. The goals are to get the person to agree to go to a prearranged treatment facility, whether he/she wants to or not and to help direct the family members into their own recovery from addiction's impact on them. Excuses and rationales are not accepted. It is a "tough love" kind of approach that was introduced by Vernon E. Johnson, a recovered alcoholic and founder of the Johnson Institute, in his well-known book, *I'll Quit Tomorrow* (1973). Effective intervention can be achieved with love, gentle concern and kind firmness, respecting the addicted person as a person while portraying the reality of his/her damaging and progressive disease. Intervention offers the addicted person the hope of healing, reconnection with persons important to him/her, and the promise of a better life. Johnson stressed early intervention, believing that to wait for addicted persons to hit bottom and seek help on their own may well be too late for a life to be saved.

Formal interventions usually involve several weeks of planning and preparation, led by a qualified and experienced counselor who will guide the process. It is important that addiction education be given to the family and friends involved

so that they will fully understand that they are intervening to save the addicted person's life. Everyone must be convinced of that reality. The facts related to the addicted person's behavior should be carefully gathered and lovingly presented. In her autobiography, former First Lady Betty Ford (1978) reveals the process of the intervention which her family did with her. After describing what she recalled being said, she says, "All of them hurt me. I collapsed into tears. But I still had enough sense to realize they hadn't come around just to make me cry; they were there because they loved me and wanted to help me."

It is becoming more evident that strategically planned and sensitively conducted interventions can provide a therapeutic breakthrough which interrupts the downward spiral of the alcoholic's behavior and its impact on family members. *(Note: Further information on interventions is in Appendix B.)*

The Family System

If a counselor only deals with the addicted person and the individual behavior, success will be partial at best. It is very important that the family members be included in the treatment process and that the family system be identified and modified so that the dysfunction can be addressed. An alcoholic or addictive system occurs when the family organizes itself around the issue of alcohol or drugs. It makes little theoretical difference, according to Berenson (1976), who is doing the actual drinking. Everyone in the family generally modifies their behavior to adapt to the behaviors caused by the addiction. For example, spouses may change their behavior abruptly when the drinking spouse comes home, not unlike the abrupt changes of behavior in the addicted person. It is important to remember that alcoholism and drug dependence impact all the family members.

Many clergypersons have become familiar with the family systems work of psychiatrist and family therapist Murray Bowen, MD, and Rabbi Ed Friedman, pastoral counselor and marriage and family therapist. Fundamental points in Bowen's theory are:

1. the family as a system is more than the sum of its parts;
2. changes in any part of the system affect the entire system;
3. subsystems are embedded throughout the larger family system;
4. families exist within a larger social environment context and interact with other social systems; and
5. families are multigenerational and are influenced by their histories.

Change in the family system is stressful and produces tension and instability. Dysfunctional systems are maladaptive attempts to manage stress. For this reason, they are resistant to change. Systems seek homeostasis and an individual's drinking and the adaptation to it becomes a family system's homeostatic solution to otherwise distressed relationships. Difficulties that are likely to appear during a long-term recovery from alcoholism include:

- Challenges in family role adjustment as the previously alcoholic individual attempts to regain significant roles abandoned through drinking (e.g., decision making, authority, sex, intimacy, etc.)
- Difficulties in parent-child relationships, especially around behavior management and communication involving adolescent children
- Developmental changes of family members, family life cycle transitions, or situational change events experienced by the family system – e.g., launching children, job loss, adult developmental change of either partner.

Just as recovery is a process for the addicted person, so it is for the family. Alcohol and drug addictions are not solitary illnesses. They affect all those who are in contact with the addictive person. For children, early recovery is often traumatic and confusing. Families generally collude, sometimes for years, to cover up the addictive behavior. This is referred to as co-dependency, behavior which actually enables excessive drinking or drugging. The non-addictive family members may need to learn how their behavior reinforces the problem rather than helps to address it.

Families impacted by alcoholism and drug dependence generally have a pervasive sense of powerlessness, so an initial goal would be to help the family members understand what is happening to each of them, where help is available, and what they need to do to confront and change their life situation. Generally, a well-informed and trusted pastor or other congregational minister is usually wise to encourage and support the process of intervention but to suggest that the participants include other trusted friends or extended family members as well as the immediate family. The clergy can then be seen as supportive of all members of the family and not taking sides, thus remaining as a trusted recovery support for all. Referral to a qualified family therapist, while remaining in contact as a supportive person, may be the optimal strategy for a pastoral person. Awareness of both family and pastoral strengths and limitations is needed in these situations. Treatment programs often urge, if not require, family involvement in the treatment of the addicted person, but family members should also participate in programs such as Al-Anon and Alateen for their own recovery.

Living with a non-recovering addicted person in the family is stressful for all members of the family, but not all family members react to the stress the same way. Each member may be affected differently. The level of resiliency of the non-addictive spouse is a key factor in understanding the possible impact of alcoholism and drug dependence on the children.

The Affected Children

One out of every four children lives in an addicted family, more than 19 million under the age of 18. Pastoral/spiritual care of children in addicted families is an especially important ministry, though it is seldom easy to connect with these children and to mobilize the program resources and workers in the congregation to care for them. Growing up in a family with an alcoholic parent has enormous effects on children. Children are very vulnerable and are highly influenced by the dynamics of family living. Studies and therapy with adult children of alcoholic parents reveal how growing up in addicted families distorts reality and interferes with a child's developmental process in almost every area of life. The constant adaptations to the dysfunction in the family leave a child always feeling unsure about what normal is, and this shows up in their own adult years and relationships and affects their self-esteem, intimate relationships, ability to trust, and overall mental health. Addicted parents fail to make healthy emotional connections with their children which creates deep-seated pain in the child that may later be dealt with by their own excessive use of alcohol or other drugs or strained and unfulfilling relationships

The National Association for Children of Alcoholics (NACoA) publishes the following points which are important for religious communities to know.

- Based on clinical observation and preliminary research, a relationship between parental alcoholism and child abuse is indicated in a large proportion of child abuse cases.
- Children of alcoholics exhibit symptoms of depression and anxiety more than children of non-alcoholics.
- Children of alcoholics experience greater physical and mental health problems and higher health care costs than children from non-alcoholic families.
- Children of alcoholics score lower on tests measuring verbal ability.
- Children of alcoholics often have difficulty in school.
- Children of alcoholics have greater difficulty with abstraction and conceptual reasoning.

- Children of alcoholics may benefit from adult efforts to help them.
- Children of alcoholics can be protected from many problems associated with growing up in an alcoholic family.

(Note: See Children of Addicted Parents: Important Facts in Appendix D.)

Adverse Childhood Experiences (ACE) Study

- A long term study which examined childhoods of 17,000 middle-aged patients found a strong relationship between adverse childhood experiences (physical, emotional, sexual abuse; living with an alcohol or drug abuser; living with someone who is chronically depressed, suicidal, or mentally ill; witnessing domestic and family violence; emotional or physical neglect; one or no parent) and physical or mental health problems later in life.
- The research showed that the higher the number of adverse childhood experiences (ACEs) the higher the number of adult risk behaviors and ensuing health-related problems such as heart disease, stroke and diabetes.
- The chronic emotional stress caused by adverse childhood experiences changes the structure and chemistry of the brain and affects judgment, emotions and behaviors.
- The research found that those patients who reported having alcoholic parents were significantly more likely to have experienced ACEs. In addition, these patients were more likely to suffer from depression in adulthood and a higher incidence of alcoholism (Anda, et al., 2002).

Developmental Stages and the Impact of Addiction

The developmental psychology of Erik Erikson helps us understand how addiction in the family interferes with personality development, and how the age of the child when addiction begins to be a problem impacts that child's development. Erikson describes eight stages in human development, from birth to old age. The first five stages cover birth through adolescence, indicating that most of the forces shaping our individual growth occur by the time one enters adulthood, with most concentrated in our first 12 years.

Erikson bases his stages on the epigenetic principle of development; each stage is based upon successful completion of the psycho-social tasks of the previous stage. Failure to accomplish the essential tasks of one stage of development

will significantly impair a person as s/he attempts to progress to the next stage. We, therefore, carry the “unfinished business” of one developmental stage into another, as well as the positive experiences of what was accomplished. The more unfinished business we accumulate, the greater the difficulties of later life.

Addicted parents can have a profoundly negative effect on children, interfering with their developmental needs at early stages and making their lives more difficult in later stages. Thus, an adult child of an alcoholic may suffer from the unlearned psycho-social tasks of a much earlier stage of development. Through counseling and psychotherapy, as well as through being in healthy and supportive adult relationships, the deficits of earlier years can be addressed and maturity gained.

One can easily see how the burden of addiction within the family makes normal developmental tasks more difficult and treacherous to experience. Accumulated failures through the childhood stages that can be created by an addictive family environment set up the risk of failure in the adult stages. (See following chart.) The younger the child impacted by parental addictive behavior, the greater the risk of problems. Intervention with children during the early years enables them to move beyond the crises and reduces the risk of negative outcomes.

Erikson's childhood stages are fully identified and adulthood stages are summarized as follows:

Erikson's Stage	Age	Resulting Behavior	Positive Resolution	Alcoholic/ Dysfunctional Family Response	Impact on COA
1. Trust vs. Mistrust Basic biological needs of infant need to be met	0-1 yr	Patterned response of caregiver to infant's needs are established	Virtue of Hope	Inconsistency and unpredictability cause variety of response without pattern.	Fear
2. Autonomy vs. Shame and Doubt Social demands for self control and bodily regulation	1-3	Establishment of wide variety of physical skills and socially acceptable behaviors	Virtue of Will	Rigid and/or intolerant behavior in reaction to children's experimental behaviors.	Self Doubt
3. Initiative vs. Guilt More detailed motor activity, refined language and vivid use of imagination	4-5	Learning is now intrusive and vigorous Limits constantly tested	Virtue of Purpose	Curiosity about world is often treated as inappropriate. Ridicule of self-initiated behaviors and fantasy causes conflict.	Sense of Un-worthiness
4. Industry vs. Inferiority Development of school and social skills	6-11	Established ability to work cooperatively Need to learn pleasure of work completion by steady attention, planning and diligence	Virtue of Competence	Lack of parental interest and input in child's accomplishments compounds sense of inferiority and inadequacy.	Ineptitude
5. Identity vs. Role Confusion Solidarity with adolescent group ideals	12-20	Painful time of rebellion "Identity crisis"	Virtue of Fidelity	Child is more likely to identify with negative aspects. Family identity overshadows individual identity. Difficulty with separation.	Uncertainty
6. Intimacy vs. Isolation Persons with secure identity risk entering into a loving relationship	20-24	Establishment of a primary, loving relationship and giving and taking of intimacies	Virtue of Love	COA reports inability to feel close to anyone. "Alone-in-the-crowd" syndrome. Uses physical as substitute.	Promiscuity

The level of resiliency of the non-addictive spouse is a key factor in understanding the possible impact of alcoholism and drug dependence on the children. While most children of alcoholics (COAs) survive the multiple crises of childhood, and many develop great strengths that contribute to productive lives, all COAs experience loss and some deficits which can impair their lives and relationships to some extent. Growing up with a significant number of caring adults can help children gain competence and cope more effectively with the trauma of parental alcoholism (Werner and Johnson 2000).

Learning and Utilizing Community Resources to Ensure a Continuum of Care

A large number of professions are involved in the care and treatment of persons with alcoholism and drug dependence and its impact on family members. The religious community can do much for these persons, and it should partner with others for maximum help to hurting congregants. Faith leaders need to be aware that there are others in the community who are dedicated, trained, and willing to be of service. Ministers and members in congregations can introduce addicted persons and their families to these resources while maintaining a relationship of support and concern. A general knowledge of and, where possible, exposure to these resources e.g., intake process, range of treatment services, availability of support services, is extremely important.

Treatment Locator

For information on the nearest treatment facilities, the Federal Government maintains a Substance Abuse Treatment Facility Locator at <http://findtreatment.samhsa.gov>. The Locator includes outpatient treatment, residential treatment, hospital inpatient and partial hospitalization/day treatment programs for drug addiction and alcoholism in all 50 states, the District of Columbia and territories. New facilities are added monthly and the entire list is updated annually. It is also advisable to reach out to identify community therapists and pastoral counselors who work with addicted persons.

12 Step Support Groups

For the alcohol addicted person, there is no better community support than Alcoholics Anonymous. Knowledge of the locations of AA meetings and of persons who are active members as recovering alcoholics is essential to the faith community's ability to provide an appropriate referral when the opportune moment arrives. For drug addicts, the same is true with Narcotics Anonymous, the 12 step equivalent program for drug addiction. For those of the Jewish faith, JACS (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) can also be a supportive program for both the addicted person and family members.

For family members, 12 step related groups such as Al-Anon for spouses and other adult family members and Alateen for older children and teen-agers in the family are valuable resources for support, feedback, information, and guidance. Contact information for all 12 step and support programs is usually listed in your community's phone book.

However, please remember that every community is unique. Each has different problems, opportunities, resources and a history of collaborating, so the religious community must make an effort to understand what is needed, available and accessible. Furthermore, besides knowing the range of modalities, becoming familiar with the “philosophy” of the various treatment agencies may allow for a successful matching of congregants’ needs and service providers.

Alcoholics Anonymous

Surveys conducted by AA’s General Service Office indicate that only 1% of those in AA were referred by a member of the clergy. This is an indication of the severe lack of awareness among clergy of this valuable resource. Pastoral professionals who attempt to minister to alcoholics and other addicted persons without knowledge of and referral to AA and other 12 step programs may become overwhelmed in the effort and are operating without extremely valuable allies in the care of addicted persons and their families. Clinebell (1984), reinforces this statement by saying, “In all the long, dark, dismal history of the problem of alcoholism, the brightest ray of hope and help is Alcoholics Anonymous! This conclusion has two important corollaries: First, AA and the many 12 step recovery programs that have come from it are the most effective and widely available referral resources available today. Second, it behooves everyone concerned with helping victims of alcoholism and drug addictions to become thoroughly familiar with AA, and other 12 step groups like Al-Anon, NA, and Overeaters Anonymous.”

Whereas AA is not for everyone, and does not claim to be, it has enabled more than approximately two million alcoholics to achieve sobriety and gain recovery in its many years of activity since being founded in 1935 in Akron, Ohio, by two recovering alcoholics, Bill Wilson and Dr. Bob Smith. The concept for AA grew out of the Oxford Group Movement which was popular in many churches in the 1930s and 1940s. It utilized small group sharing, confession, self-examination, and support in the context of Christian tradition and belief. Bill Wilson and Bob Smith were involved in this movement and saw its relevance for alcoholics. They felt, however, that in order for a group to have wide appeal and a non-sectarian identity it had to develop separate from the Oxford Group Movement. While retaining the essential spiritual focus and group dynamics, AA was developed, therefore, without religious or theological identity or alignment with any institutional entity.

What followed has given clear evidence of the wisdom of this decision as AA has become a world-wide phenomenon and a source of help for millions of

persons. While the AA General Service Office in New York City implements the decisions of the Board and Conference, as well as serves as a clearinghouse for AA groups, literature, and other services, each local AA group is autonomous and maintains its own style and group personality. All groups, however, have one overarching goal: to help alcoholics stop drinking and gain sobriety, based on following the 12 Steps and the 12 Traditions of AA.

The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understand Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose, there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose – to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or communities directly responsible to those they serve.
10. Alcoholics Anonymous has no opinions on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and film.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

While the spiritual dimensions of these AA 12 steps and traditions are obvious, and while the developers of the 12 steps and traditions, Bill W. and Dr. Bob, were Christians who founded a spiritual program for recovery, AA is not a religious program and is not allied with any religious group or specific spiritual belief. AA members tend to make a distinction between the words “spiritual” and “religious,” with spiritual being deeply personal and religious being institutional in nature. While many have found recovery through spirituality, they have felt hurt and “turned off” by religion, institutionally speaking. Pastoral

approaches to alcoholics, therefore, need to be sensitive to this factor and focus on spiritual realities and issues rather than on doctrinal or institutional religion.

Many AA and affiliated 12 step groups end their meetings with everyone repeating the “Serenity Prayer.” This familiar prayer, the origin of which was traced back to Reinhold Niebuhr, professor at Union Theological Seminary in New York, who used it at the close of a longer prayer probably given in the seminary chapel around 1932, has been used for many years as an integral part of the AA experience, without knowing its origin. It reflects a very basic, simple, and poignant meaning not only for alcoholics and other addicts, but also for all who are struggling with the varied experiences of living and growing. “God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.”

Al-Anon

Al-Anon was started by Lois and Ann, the wives of the co-founders of AA. It is a 12 step program for spouses, families, and friends of alcoholics. It operates under the same traditions as AA and follows the 12 steps as they apply. It includes all kinds of people from all walks of life who are impacted by the addiction of someone to whom they related: wives, husbands, lovers, sisters, brothers, and parents. It is a very helpful educational and support group in which stories are shared and feedback is given.

Alateen

Alateen works on the same model as Al-Anon, but with the focus on the younger relatives and friends of alcoholics through age nineteen. Alateen is sponsored by Al-Anon, and all meetings have an Al-Anon member as the meeting leader.

Narcotics Anonymous and Nar-Anon

NA and Nar-Anon operate in the same model and procedure as AA and Al-Anon, with the obvious difference being the focus on addiction to drugs other than alcohol.

Adult Children of Alcoholics

ACA was formed as a support and educational group for those who grew up in families with an alcoholic parent. The ways in which that dysfunctional family system impacted the personality and relationships of the adult child are shared, explored, and seek to be transcended.

Women for Sobriety

This program is based on the premise that women need a different path for recovery, a path only for women. It grew out of feelings that AA was primarily a male-dominated program and the discomfort that created in some women. The assumptions are that women need to take charge of their own lives and develop a sense of competence, improved self-esteem, and change maladaptive behaviors. It emphasizes positive thinking and cognitive restructuring. It is not a 12 step program.

Professional Treatment Resources

In addition to valuable resources such as 12 step groups, pastoral caregivers need to be aware of professional treatment resources available in the community. These resources are found in the following categories.

Inpatient Treatment – Treatment in a setting that is connected to a hospital or a hospital-type setting where a person stays for a few days or weeks.

Outpatient Treatment – Treatment provided at a facility. The services vary but do not include overnight accommodation. Sometimes it is prescribed after inpatient treatment.

Residential Treatment – Treatment in a setting in which both staff and peers can help with treatment. It provides more structure and more intensive services than outpatient treatment. Participants live in the treatment facility. Residential treatment is long term, typically lasting from one month to a year or more, depending on client need, insurance coverage and affordability.

Halfway House – A place to live for people recovering from substance use disorders. Usually several people in recovery live together with limited or no supervision by a counselor, although involvement in regular outpatient treatment or 12 step group meetings is desirable if not required.

Private Providers – Professionals from a variety of clinical services who specialize in psychotherapy with addicted persons and families. These generally are found in the fields of family medical practice, internal medicine, psychiatry, psychology, social work, licensed professional counseling, certified substance abuse counseling, and certified pastoral counseling.

Recovery Support Groups – Recovery is commonly viewed as continuing abstinence from alcohol and drugs. Many pathways to recovery exist. An emerging definition goes beyond abstinence alone to include a full re-

engagement—based on resilience, health, and hope—with one’s family, friends, and community.

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Appendix A

Core competencies

CORE COMPETENCIES FOR CLERGY AND OTHER 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 12 step programs – AA, 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.

Appendix B

Elements of an Intervention

This information is for raising clergy awareness on what is needed for an effective intervention only. It is strongly recommended that only someone who has successfully completed specialized training facilitate an actual intervention. This discussion should not be construed as sufficiently specialized.

The authors of *Beyond the Influence* (Ketchum et al., 2002) present the essential elements of an intervention as follows:

- 1) The facts and data must be presented by a number of people who are close to the alcoholic or exert a powerful influence on the alcoholic's life – family members, friends, bosses, supervisors, coworkers, physicians, etc.
- 2) Specific firsthand evidence is especially convincing. The most powerful evidence is, says Vernon Johnson, “descriptive of events which have happened or conditions which exist.” Opinions and generalizations, such as “You drink too much,” should be avoided.
- 3) Everyone involved in the intervention should avoid moral judgments and any tone of censure. All the facts presented should be used to support the reasons why the family members and friends are concerned. For example, “Jane, three weeks ago this Saturday you insisted on driving Alison and her friend to a slumber party. You had been drinking wine all afternoon. I tried to take your keys away, but you became very upset, yelled at the kids to get in the car, and drove off. I waited in agony for you to come home, scared to death that you would all be killed in a car wreck. I know how much you love your children and how devastated you would be if anything happened to them. I want you to get well. We all want you to be healthy again.”
- 4) Whenever possible, the facts should center around the use of alcohol/drugs; highlighting the contradictions or conflicts in values caused by drink/drugging makes the point even stronger. Example: “You are so gracious and loving when you're sober, Mom, but when you drink (or take drugs), you are a completely different

person. Last Wednesday you got so drunk (or high) that you slapped me several times and bruised my face. “

- 5) Vivid details are particularly effective, for they give the addicted person a wide-screen view of his or her behavior at a particular point in time. Videotapes taken when the person is drinking/drugging and intoxicated are very convincing and leave no room for denial.

Two resources for locating interventionists nationwide are: the Association of Intervention Specialists 301-670-2800 and the Intervention Resource Center 888-421-4321

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Appendix C

Stages of Change

Pre-contemplation

Description	Indicators
<p>This is the entry point of a person into the change process. The individual has not even considered the prospect of change. The individual is unlikely to perceive a need for change. It is usually someone else who perceives a problem. At this stage, a person is not likely to respond positively to a helper being confrontational or demanding change.</p>	<ul style="list-style-type: none"> • Total resistance to doing anything, no willingness to meet, talk to the worker, or get assessed • Angry at any indication from another that there is a drug or alcohol problem • blaming others • “Everything is O.K.” statements • Willingness to work on other things, but not drugs or alcohol • Refuses to let the worker in and work with him/her • Lack of awareness • Uses drugs and believes there is no connection to problems

Contemplation

Description	Indicators
<p>Once the person has some awareness of the problem, then the person enters the stage called Contemplation. It is a state of ambivalence, where the individual both considers change and rejects it. If allowed to just talk about it, the person goes back and forth about the need to change and there being no justification for change.</p>	<ul style="list-style-type: none"> • Saying one thing, doing another • Rationalizations • Minimizing • Their anxiety is rising • Trying some things which are not working • Both talking about change and arguing against it

Preparation

Description	Indicators
<p>The person is ready to change. This is a window of opportunity when the person has resolved the ambivalence enough to look at making change.</p>	<ul style="list-style-type: none"> • Admitting the need for change • Accepting negatives of their use behavior • Asking for help • Saying things like “I’m ready” • Starting to look at alternatives

Action

Description	Indicators
<p>The person engages in particular actions intended to bring about change.</p>	<ul style="list-style-type: none"> • They are starting to work a plan • They are making changes in their use behavior • They are asking for your help, or using your help to make their plan more successful

Relapse

Description	Indicators
The person has a slip, or returns to using at a level higher than acceptable to either the person or family. At times, the person may slip and not regard it as serious enough to be concerned, yet someone may be at risk; the worker needs to help the person look holistically.	<ul style="list-style-type: none">• Person uses alcohol or the drug they are trying to not use• Person increases over the amount they had reduced their use to• Person begins using a new drug and sees this as failure

Maintenance

Description	Indicators
The person identifies and implements strategies to maintain progress, and to reduce the likelihood of slips or a full relapse into old behaviors.	<ul style="list-style-type: none">• They are making the long-term life changes needed to “actualize” the changes made in action• They focus less on not using and more on a “recovery” lifestyle

Appendix D

Children of Addicted Parents: Important Facts

Alcoholism and other drug addiction have genetic and environmental causes. Both have serious consequences for children who live in homes where parents are involved. More than 28 million Americans are children of alcoholics; nearly 11 million are under the age of 18. This figure is magnified by the countless number of others who are affected by parents who are impaired by other psychoactive drugs.

Alcoholism and other drug addiction tend to run in families. Children of addicted parents are more at risk for alcoholism and other drug abuse than are other children.

- Children of addicted parents are the highest risk group of children to become alcohol and drug abusers due to both genetic and family environment factors.¹
- Biological children of alcohol dependent parents who have been adopted continue to have an increased risk (2-9 fold) of developing alcoholism.²
- Recent studies suggest a strong genetic component, particularly for early onset of alcoholism in males. Sons of alcoholic fathers are at fourfold risk compared with the male offspring of non-alcoholic fathers.³
- Use of substances by parents and their adolescent children is strongly correlated; generally, if parents take drugs, sooner or later their children will also.⁴
- Adolescents who use drugs are more likely to have one or more parents who also use drugs.⁵
- The influence of parental attitudes on a child's drug taking behaviors may be as important as actual drug abuse by the parents.⁶ An adolescent who perceives that a parent is permissive about the use of drugs is more likely to use drugs.⁷

Family interaction is defined by substance abuse or addiction in a family.

- Families affected by alcoholism report higher levels of conflict than do families with no alcoholism. Drinking is the primary factor in family disruption. The environment of children of alcoholics has been characterized by lack of parenting, poor home management, and lack of family communication skills, thereby effectively robbing children of alcoholic parents of modeling or training on parenting skills or family effectiveness.⁸
- The following family problems have been frequently associated with families affected by alcoholism: increased family conflict; emotional or physical violence; decreased family cohesion; decreased family organization; increased family isolation; increased family stress including work problems, illness, marital strain and financial problems; and frequent family moves.⁹
- Addicted parents often lack the ability to provide structure or discipline in family life, but simultaneously expect their children to be competent at a wide variety of tasks earlier than do non-substance-abusing parents.¹⁰
- Sons of addicted fathers are the recipients of more detrimental discipline practices from their parents.¹¹

A relationship between parental addiction and child abuse has been documented in a large proportion of child abuse and neglect cases.

- Three of four (71.6%) child welfare professionals cite substance abuse as the top cause for the dramatic rise in child maltreatment since 1986.¹²
- Most welfare professionals (79.6%) report that substance abuse causes or contributes to at least half of all cases of child maltreatment; 39.7% say it is a factor in over 75% of the cases.¹³
- In a sample of parents who significantly maltreat their children, alcohol abuse is specifically associated with physical maltreatment, while cocaine exhibits a specific relationship to sexual maltreatment.¹⁴
- Children exposed prenatally to illicit drugs are 2 to 3 times more likely to be abused or neglected. ¹⁵

Children of drug addicted parents are at higher risk for placement outside the home.

- Three of four child welfare professionals (75.7%) say that children of addicted parents are more likely to enter foster care, and 73% say that children of alcoholics stay longer in foster care than do other children.¹⁶
- In one study, 79% of adolescent runaways and homeless youth reported alcohol use in the home, 53% reported problem drinking in the home, and 54% reported drug use in the home.¹⁷
- Each year, approximately 11,900 infants are abandoned at birth or are kept at hospitals, 78% of whom are drug-exposed. The average daily cost for each of these babies is \$460.¹⁸

Children of addicted parents exhibit symptoms of depression and anxiety more than do children from non-addicted families.

- Children of addicted parents exhibit depression and depressive symptoms more frequently than do children from non-addicted families.¹⁹
- Children of addicted parents are more likely to have anxiety disorders or to show anxiety symptoms.²⁰
- Children of addicted parents are at high risk for elevated rates of psychiatric and psychosocial dysfunction, as well as for alcoholism.²¹

Children of addicted parents experience greater physical and mental health problems and higher health and welfare costs than do children from non-addicted families.

- Inpatient admission rates and average length of stay for children of alcoholics were 24% and 29% greater than for children of non-alcoholic parents. Substance abuse and other mental disorders were the most notable conditions among children of addicted parents.²²
- It is estimated that parental substance abuse and addiction are the chief cause in at least 70-90% of all child welfare spending. Using the more conservative 70 percent assessment, in 1998 substance abuse and addiction accounted for approximately \$10 billion in federal, state and local government spending simply to maintain child welfare systems.²³

- The economic costs associated with Fetal Alcohol Syndrome were estimated at \$1.9 billion for 1992.²⁴
- A sample of children hospitalized for psychiatric disorders demonstrated that more than 50% were children of addicted parents.²⁵

Children of addicted parents have a high rate of behavior problems.

- One study comparing children of alcoholics (aged 6-17 years) with children of psychiatrically healthy medical patients found that children of alcoholics had elevated rates of ADHD (Attention Deficit Hyperactivity Disorder) and ODD (Oppositional Defiant Disorder) measured against the control group of children.²⁶
- Research on behavioral problems demonstrated by children of alcoholics has revealed some of the following traits: lack of empathy for other persons; decreased social adequacy and interpersonal adaptability; low self-esteem; and lack of control over the environment.²⁷
- Research has shown that children of addicted parents demonstrate behavioral characteristics and a temperament style that predispose them to future maladjustment.²⁸

Children of addicted parents score lower on tests measuring school achievement and they exhibit other difficulties in school.

- Sons of addicted parents performed worse on all domains measuring school achievement, using the Peabody Individual Achievement Test-Revised (PIAT-R), including general information, reading recognition, reading comprehension, total reading, mathematics and spelling.²⁹
- In general, children of alcoholic parents do less well on academic measures. They also have higher rates of school absenteeism and are more likely to leave school, be retained, or be referred to the school psychologist than are children of nonalcoholic parents.³⁰
- In one study, 41% of addicted parents reported that at least one of their children repeated a grade in school, 19% were involved in truancy, and 30% had been suspended from school.³¹
- Children of addicted parents compared to children of non-addicted parents were found at significant disadvantage on standard scores of arithmetic.³²

Maternal consumption of alcohol and other drugs during any time of pregnancy can cause birth defects or neurological deficits.

- Studies have shown that exposure to cocaine during fetal development may lead to subtle but significant deficits later on, especially with behaviors that are crucial to success in the classroom, such as blocking out distractions and concentrating for long periods.³³
- Cognitive performance is less affected by alcohol exposure in infants and children whose mothers stopped drinking in early pregnancy, despite the mothers' resumption of alcohol use after giving birth.³⁴
- Prenatal alcohol effects have been detected at moderate levels of alcohol consumption in nonalcoholic women. Even though a mother may not regularly abuse alcohol, her child may not be spared the effects of prenatal alcohol exposure.³⁵

Children of addicted parents may benefit from supportive adult efforts to help them.

- Children who coped effectively with the trauma of growing up in families affected by alcoholism often relied on the support of a non-alcoholic parent, stepparent, grandparent, teachers and others.³⁶
- Children of addicted parents who rely on other supportive adults have increased autonomy and independence, stronger social skills, better ability to cope with difficult emotional experiences, and better day-to-day coping strategies.³⁷
- Group programs reduce feelings of isolation, shame and guilt among children of alcoholics while capitalizing on the importance to adolescents of peer influence and mutual support.³⁸
- Competencies such as the ability to establish and maintain intimate relationships, express feelings, and solve problems can be improved by building the self-esteem and self-efficacy of children of alcoholics.³⁹

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National Association for Children of Alcoholics
11426 Rockville Pike, Suite 301 • Rockville, MD 20852
1-888-55-4COAS (2627) • Fax (301)468-0987

www.nacoa.org

Appendix E

Explanation of Erickson's Stages

Stage One: TRUST VS. MISTRUST (from birth to around age one)

Through the appropriate nurture of having the basic physiological and psychological needs met by trustworthy parents, the infant learns to trust the environment and those powerful people in it. Basic trust is learned from trustworthy parental persons. However, trustworthiness is seldom a trait of addicted parents, with inconsistent and unpredictable behavior and relationships. Thus, stage one children may respond with a deep, unconscious mistrust for others and have their own trustworthiness impaired. They are conditioned by the unspoken rules prevalent in addicted families, Don't Talk – Don't Trust – Don't Feel. Whereas the positive resolution of the tension between trust and mistrust results in the instilling of the virtue of HOPE in the infant, the child of an alcohol or drug dependent parent is more likely to learn fear and, in extreme cases, hopelessness.

Stage Two: AUTONOMY VS. SHAME AND DOUBT (ages one to three)

When an adequate level of basic trust has been established, the next stage involves the social demands for self-control and bodily regulation. This is the toilet training stage, an obvious task requiring mastery of both of these demands. The task extends beyond this function, however, and relates to the sense of self-mastery and self-regard in the child, which leads to the establishment of a wide variety of physical skills and socially acceptable behaviors. From an adult perspective, it determines whether the child is a pleasure or a problem to be around. Positive resolution of this stage results in the virtue of WILL, as well as the rudiments of identity formation in personality. By gaining a sense of autonomy, the child is encouraged and guided in the venture of self-expression and experimentation. In an addicted family, however, children's experimental behavior tends to be responded to with rigid and/or intolerant behavior, resulting in a sense of shame and self-doubt. The emergence of will that is built on basic trust leads to the personality dynamic of willingness rather than willfulness. When that does not happen, an adult child of an addicted parent may therefore feel that they will not get what they need unless they are willful and demanding in relationships.

Stage Three: INITIATIVE vs. GUILT (ages four to five)

This involves more detailed motor activity, refined language, and vivid use of imagination. It is the pre-school age when learning becomes more active and limits are constantly tested. The child in normal development learns to make things happen, to initiate activity rather than just copy others. The positive emergence of healthy initiative leads to the virtue of PURPOSE, the act of being purposeful in one's behavior. In addictive families, a child's curiosity about the world may be treated as foolish or inappropriate. Ridicule of self-initiated behaviors and fantasy causes conflict, guilt, and a sense of unworthiness in the child that can remain into adulthood.

Stage Four: INDUSTRY VS. INFERIORITY (ages six to eleven)

This relates to the development of school and social skills. It becomes evident in the child's struggle to establish the ability to work cooperatively, to feel good about work completed through consistent attention, planning, and implementation. Success in this struggle leads to a sense of being industrious. The resulting virtue of this positive developmental task is COMPETENCE, a comfortable belief in oneself to handle problems and opportunities that appear. Competence is fostered by parental encouragement and interest in the child's activities and performances. When there is a lack of parental interest and response to the child's accomplishments, as in the case of many addicted families, the child is likely to feel inferior and inadequate and to develop an abiding sense of incompetence, reinforcing the problem of childhood depression.

Stage Five: IDENTITY VS. ROLE CONFUSION (ages twelve to twenty)

Relationships are the hub and focus of this stage as the adolescent tries to gain a sense of personal identity through making and breaking of relationships and experimenting with various social roles. There is a sense of solidarity with peer group ideals and behaviors, often in conflict with those of the parents. This close identification with the adolescent group is the first movement away from parental dominance and control and a greater risk of experimentation in understanding oneself, whoever that is. The important virtue that is developed at this stage is FIDELITY, faithfulness to oneself and one's primary group. This can also involve the first serious attempt to find faithfulness to God through attachment to a religious leader and/or youth group. Adolescent children of addicted parents are more likely to identify with negative behaviors and more anti-social group attachments out of a feeling of being different from the more socially and developmentally adjusted peers. The family identity tends to overshadow individual identity, and separation can be painfully difficult. This

fosters a generalized sense of uncertainty about oneself, rather than a sense of positive identity. These dynamics create a higher risk for alcohol and drug experimentation, use and dependence in these adolescents.

These five critical stages take place in the short years between birth and roughly twenty years of age. Sufficient accomplishment in each stage of development prepares the person to enter the remaining three stages that take place into old age. Insufficient accomplishment greatly complicates success in later stages.

Stage Six: INTIMACY VS. ISOLATION (ages 21 to 45)

The primary task is establishing commitment to a primary love relationship and responsible, mature intimate behavior. Positive development in this stage leads to the virtue of Love, the act of being oneself by extending oneself to another. Negative development can lead to promiscuity and manipulation.

Stage Seven: GENERATIVELY VS. STAGNATION (ages 46 to 65)

This lengthy middle adult stage is characterized by the tension between generating a positive family and social order for the next generation, on the one hand, or stagnating in preoccupation with oneself and gratifying the needs of the self on the other hand. Positive completion of this long and major stage of life produces the virtue of CARE.

Stage Eight: INTEGRITY VS. DESPAIR (ages 65 until death)

By integrity, Erikson means the sense of wholeness and completion marked by definition and consistency within the self, meaning and trustworthiness in relationships and vocational endeavor, and a sense of “being through having been” that accepts and values one’s history and past as that which had to be, while living fully in the present without fear of the future. The enduring virtue in this last stage is WISDOM. Despair, conversely, is the sense of regret and perhaps anger in regard to one’s life. It is a rejection of what one has been and the non-acceptance, or fear, of what is yet to be, namely death.



Appendix F

Resources for Further Study

Books:

Abbot, Stephanie, Editor, *Children of Alcoholics: Selected Readings Vol. II*. National Association for Children of Alcoholics, 2000.

Addictions and Ministry Formation, *The Core Elements of Priestly Formation Programs: A Collection of Readings, Vol. 4*. National Catholic Educational Association, 2005.

Black, Claudia, *It Will Never Happen to Me: Growing up with Addiction 2nd Edition*. MAC Publishing, 2001.

Clinebell, Howard, *Understanding and Counseling Persons with Alcohol, Drug, and Behavioral Addictions*. Abingdon Press, 1984.

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How Al-Anon Works for Families & Friends of Alcoholics, Al-Anon Family Groups, 1995.

Johnson, Vernon E., *I'll Quit Tomorrow*. Harper & Row, 1973.

Ketcham, Katherine, and William F. Asbury, et. al., *Beyond the Influence: Understanding and Defeating Alcoholism*. Bantam Books, 2000

Miller, William R., and Stephen Rollnick, *Motivational Interviewing: Preparing People for Change*. The Guilford Press, 2002.

Morgan, Oliver J. and Merle Jordan, eds., *Addiction and Spirituality: A Multidisciplinary Approach*. Chalice Press, 1999.

May, Gerald G., MD, *Addiction and Grace: Love and Spirituality in the Healing of Addictions*. HarperCollins, 1988.

Oates, Wayne E., *Alcohol: In and Out of the Church*. Broadman Press, 1966.

Roberts, Linda J. and Barbara S. McCrady, *Alcohol Problems in Intimate Relationships: Identification and Intervention*. NIAAA, 2003.

Twerski, Abraham J., MD, *Caution: "Kindness" Can Be Dangerous to the Alcoholic*. Prentice-Hall, 1981.

Twerski, Abraham J., MD, *The Clergy and Chemical Dependency*. Edgehill Publications, 1990.

Wholey, Dennis, *The Courage to Change: Hope and Help for Alcoholics and the Family*. Houghton Mifflin Co., 1984

Women Under the Influence. National Center on Addiction and Substance Abuse at Columbia University, Johns Hopkins University Press, 2006

Woodruff, C. Roy, *Alcoholism and Christian Experience*. Westminster, 1968.

Appendix G

Other Suggested Resources

National

Al-Anon

Al-Anon is an organization for spouses and other relatives and friends of alcoholics. Al-Anon groups help families cope with the problems that result from another's drinking, and they help foster understanding of the alcoholic through sharing experiences. Local groups are listed in your telephone directory under "Al-Anon Family Groups." Al-Anon Family Group Headquarters can assist you in finding a local affiliate. Contact:

Al-Anon Family Group Headquarters
1600 Corporate Landing Parkway,
Virginia Beach, VA 23454
Phone 1-800-356-9996 or 757-563-1600
Web site: www.al-anon.org

Alateen

Alateen, part of Al-Anon, is for young people whose lives have been affected by the alcoholism of a family member or close friend. Members of Alateen fellowships help each other by sharing their experiences, hopes, and strength. Alateen is listed in some telephone directories, or information may be obtained by contacting local Al-Anon groups. If you are having trouble locating an Alateen group near you, contact Al-Anon Family Group Headquarters at the previously listed address. Alateen also has a Web site at www.al-anon.alateen.org.

Alcoholics Anonymous (AA)

AA is a voluntary fellowship open to anyone who wants to achieve and maintain sobriety and is an important adjunct to many treatment programs. The fellowship was founded in 1935 by two individuals in an effort to help others who suffer from the disease of alcoholism. AA is the oldest of the organizations designed to help alcoholics help themselves. It is estimated that there are more than 2 million members in local AA groups worldwide. For further information, look for "Alcoholics Anonymous" in your telephone directory. The Alcoholics Anonymous General Service Office can help to locate a nearby affiliate.

Contact:

Alcoholic Anonymous
P.O. Box 459
Grand Central Station
New York, NY 10163
Phone 212-870-3400
Web site: www.aa.org

American Association of Pastoral Counselors (AAPC)

AAPC represents over 3,200 pastoral counselors and more than 100 pastoral counseling centers in the United States. AAPC Pastoral Counselors relate to more than 80 faith groups and represent a broad spectrum of theological and spiritual traditions. They provide services within increasingly multi-cultural, interfaith, multi-disciplinary and racially diverse communities and within a vastly more interconnected, conflicted and technically sophisticated world scene.

AAPC
9504A Lee Highway
Fairfax, VA 22031-2303
703-385-6967
Web site: www.aapc.org

Faces and Voices of Recover (FAVOR)

FAVOR is an advocacy organization working to mobilize, organize and rally the families, friends and allies of the millions of Americans in recovery from addiction. For more information on campaigns, resources and state/local recovery supports and services contact:

Faces & Voices of Recovery
1010 Vermont Ave. #708
Washington, DC 20005
Phone 202-737-0690
Web site: www.facesandvoicesofrecovery.org

National Association for Children of Alcoholics (NACoA)

NACoA is the voice for the one in four children impacted by addiction in the family. It is a national membership and affiliate organization and a clearinghouse for information and support materials for children of alcoholics and other affected family members and for those in a position to assist them. NACoA provides videos, booklets, tools to help professionals, and newsletters. For more information, contact:

National Association for Children of Alcoholics
11426 Rockville Pike, Suite 301
Rockville, MD 20852
Phone 301-468-0985 or 1-888-55-4COAS.
Web site: www.nacoa.org

National Association of State Alcohol and Drug Abuse Directors

Each state has a department of alcoholism/drug addiction prevention and treatment services, a governmental agency responsible for the alcohol- and addiction-related programs, resources, and initiatives offered throughout the state. States vary widely in the titles of these agencies and in their organizational affiliation within state government structures. In some instances, the alcohol and drug abuse agencies are combined with mental health services. To locate your state agency, look in your telephone directory under “State Government” listings or contact:

National Association of State Alcohol and Drug Abuse Directors
807 17th Street, NW, Suite 410
Washington, DC 20006
Phone 202-293-0090
Web site: www.nasadad.org

National Clearinghouse for Alcohol and Drug Information (NCADI)

NCADI, a resource of the Federal Government’s Substance Abuse and Mental Health Services Administration, is a supplier of relevant materials covering the entire gamut of alcohol- and drug-related issues. Many materials are free and available to be ordered through a toll-free number or over the Internet. For more information, contact:

NCADI
Phone 1-800-729-6686.
Web site: www.ncadi.samhsa.gov

National Council on Alcoholism and Drug Dependence (NCADD)

NCADD is a nonprofit, national voluntary health agency with a hundred local affiliates that are well acquainted with the problems of those with addictions and are dedicated to helping them. Information about addiction and alcohol treatment opportunities is available through the local affiliates. In some instances, counseling of addicted persons and their families may be provided through the local unit. Look for the listing of your local NCADD affiliate in the telephone directory. If you are having difficulty locating a unit near you, contact:

NCADD
20 Exchange Place, Suite 2902
New York, NY 10005
Phone 212-269-7797
Web site: www.ncadd.org

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

NIAAA is a Federal Government agency that makes available free information and research materials on many aspects of alcohol use, alcohol abuse, and alcoholism.

NIAAA
5635 Fishers Lane
MSC 9304
Bethesda, MD 20892-9304
Phone 301-443-3860
Web site: www.niaaa.nih.gov

National Institute on Drug Abuse (NIDA)

NIDA is a Federal Government agency that supports more than 85 percent of the world's research on the health aspects of drug abuse and addiction.

NIDA
6001 Executive Blvd., Rm. 5128
Bethesda, MD 20892
Phone 301-443-4577
Web site: www.nida.nih.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA is a resource that provides a wide variety of Federal Government publications dealing with alcohol and drug abuse. The Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment are a part of SAMHSA. Through NCADI, SAMHSA provides prevention and treatment information and materials.

SAMHSA

1 Choke Cherry Road

Rockville, MD 20857

Phone 1-877-SAMHSA-7 (1-877-726-4727)

Web site: www.samhsa.gov

Faith-based Organizations

Alcoholics Victorious

This is a Christian-oriented 12 step support group for those recovering from alcohol or chemical dependency. It offers information and referrals, literature, phone support, conferences, support group meetings, and a newsletter.

1045 Swift Street

Kansas City, MO 64116-4127

816-471-8020

www.alcoholicsvictorious.org

Catholic Charities, USA

This membership association provides vital social services to people in need, regardless of their religious, social, or economic backgrounds.

1731 King Street

Alexandria, VA 22314-2756

703-549-1390

www.catholiccharitiesusa.org

Celebrate Recovery

Celebrate Recovery is a worldwide Christ-centered recovery ministry. By working the Twelve Steps and their Biblical principles and the corresponding Eight Recovery Principles found in the Beatitudes, individuals find freedom from past hurts and harmful addictive and dysfunctional behaviors.

25422 Trabuco Road # 105-151

Lake Forest, CA 92630

949-581-0548

www.celebraterecovery.com

Clergy Recovery Network

The Clergy Recovery Network mentors ministry professionals through personal crises and early recovery. It seeks to help clergy guide their ministries toward spiritual and organizational health before, during, and after a leadership crisis.

P.O. Box 313
Joplin, MT 59531
406-292-3322
www.clergyrecovery.com

General Board of Global Ministries of the United Methodist Church

This organization offers faith-based programs for people with substance use disorders.

110 Maryland Avenue NE, Suite 404
Washington, D.C. 20002
202-548-2712
www.gb-gm-umc.org

Institute for Public Health Faith Collaborations Rollins School of Public Health, Emory University

This institute promotes vital learning at the intersecting boundaries where faith and health overlap, merge, and emerge transformed.

1256 Briarcliff Road NE
Building A, Suite 107
Atlanta, GA 30306
404-727-5199
www.ihpnet.org

Jewish Alcoholics, Chemically Dependent Persons and Significant Others

This group assists Jewish alcoholics, chemically dependent persons and their families, friends, and associates to explore recovery in a nurturing Jewish environment.

850 Seventh Avenue, Penthouse
New York, NY 10019
212-397-4197
www.jacsweb.org

Lutheran Services in America

This organization advocates for sound and compassionate public policies on behalf of Lutheran social ministry organizations and the people they serve.

700 Light Street
Baltimore, MD 21230-3850
800-664-3848 (Toll-Free)
www.lutheranservices.org

National Council of Churches

The Council helps parents communicate with their children about alcohol, tobacco, and illegal drugs.

475 Riverside Drive, Suite 880
New York, NY 10115
212-870-2227
www.nccusa.org

Overcomers In Christ (OIC)

OIC is a recovery program that deals with every aspect of addiction and dysfunction (spiritual, physical, mental, emotional, and social). Members overcome obstacles using Christ-centered motivations.

P.O. Box 34460
Omaha, NE 68134
402-573-0966
www.overcomersinchrist.org

Presbyterians for Addiction Action (PAA)

Presbyterian, Health, Education, and Welfare Association

PAA assists Presbyterians as they minister in an increasingly addictive society to restore people of the Presbyterian faith.

100 Witherspoon Street, Room 3041
Louisville, KY 40202
888-728-7228 ext. 5800 (Toll-Free)
www.pcusa.org/phewa/paa.htm

The Rush Center of the Johnson Institute

The Rush Center engages and assists people of faith in the development of caring communities that promote the prevention of alcohol, tobacco, and other drug abuse where recovery from addiction is valued and supported. FAITH PARTNERS is a congregational lay team ministry approach that provides training, resources and technical assistance to interested clergy and communities. For more information contact:

2525 Wallingwood Drive
Building 8, #804
Austin, TX 78746
512-451-9504
www.rushcenter.org

Salvation Army

The Salvation Army provides a broad array of social services that include providing food for the hungry, relief for disaster victims, assistance for the disabled, outreach to the elderly and ill, clothing and shelter to the homeless, and opportunities for underprivileged children.

615 Slaters Lane
P.O. Box 269
Alexandria, VA 22313
703-684 5500
www.salvationarmyusa.org

Volunteers of America

Volunteers of America is a large faith-based provider of substance abuse treatment and other social services.

1660 Duke Street
Alexandria, VA 22314
703-341-5000
www.volunteersofamerica.org