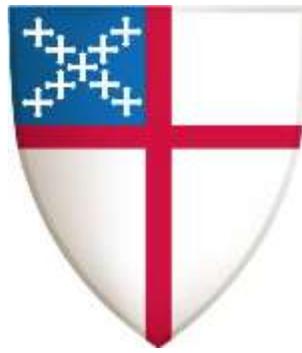


RESOURCE GUIDE

For

CLERGY



ADDICTIONS:

*THE MISUSE OF
ALCOHOL AND DRUGS*



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January 2017



*O God, we pray Your blessing upon this
guide. May it be used to help those suffering
from addictions and may they find sobriety
and a new life in You.*

Amen

**This document
has been co-edited
by
The Rev. Dr. Judith Krom, Dcn.
and
Catherine Regan-DeCicco, B.A.**

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**Members of the Recovery Ministries
of the Diocese of New Jersey
have also contributed to this document.**



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TABLE OF CONTENTS

Letter from the Right Reverend William Hallock Stokes, D.D.	1
Letter from the Reverend Cathy Brunson, Dcn.	2
Before You Start	3
Chapter I: Recognizing Addiction – The First Step in Spiritual Caregiving	4
Definitions	4
Causes of Alcohol and Drug Addiction	5
Consequences of Alcohol and Drug Abuse	7
Signs and Symptoms	9
Addiction in the Family	13
The Affected Children	14
Chapter II: Pastoral/Spiritual Care of Addicted Persons and Families	18
The Role of the Clergy.....	19
Pastoral Interactions with Addicted Persons and Family Members	22
Pastoral Communications with Children of Addicts	26
Addiction and the Church’s Congregation	30
When the Clergy Person is the Addicted One	31
Chapter III: Understanding Yourself in Relation to Addicted Persons	33
Acknowledging and Addressing One’s Own Values, Issues, Attitudes	33
Chapter IV: Treatment and Recovery	37
Benefits of Early Intervention	37
The Family System and Treatment	38
Generic Resources – “12 Step” Support Groups	40
Professional Treatment Resources	45
Chapter V: Recovery, Prevention and the Larger Community	47
Recovery and the Faith Community	47
Prevention and the Larger Community	48



REFERENCES53

APPENDICES

A. 78th General Convention of the Episcopal Church: Policies on Alcohol and Drug Abuse56

B. Diocese of New Jersey: Policy on the Use of Alcohol at Church Functions59

C. Recovery Ministries of the Episcopal Church60

D. Diocese of New Jersey, Recovery Ministry Commission: Members 61

E. Compendium of Commonly Misused Substances62

F. Treatment Options in Diocese of New Jersey73

Emergencies73

Other Professional Resources74

List of Counties within Diocese to Contact for Drug and Alcohol Prevention75

Other Diocesan Resources75

Suggestions to Clergy76

Books76

Movies78





The Diocese of New Jersey

January 2017

Dear Friends,

Almost everyone knows an alcoholic or a drug addict. We are also very aware that addiction - to both alcohol and drugs -- is a growing problem in our country and in our diocese as well.

My goal in commissioning this guide was to provide the clergy of our diocese with common sense, readable information and a compendium of resources which will help us all to be more knowledgeable and comfortable in addressing the various aspects of addiction.

Please read this guide carefully and keep it as a reference source in your ministry. Familiarize yourself with the signs and symptoms exhibited by alcoholics and drug abusers, as well as the pain and turmoil experienced by their families. Read carefully the information and guidance it provides about practical ways to interact with addicts and other people affected by their addiction. Finally, use the extensive information about how and where to find help and the various treatment modalities available in this diocese.

May God bless our efforts as we work to address the myriad issues involved in the misuse of alcohol and drugs in our diocese.

Faithfully Yours in Christ,

The Right Reverend William Hallock Stokes, D.D.

12th Bishop of the Diocese of New Jersey



The Diocese of New Jersey

January 2017

Dear Fellow Clergy Members,

The Recovery Ministry Commission is proud to provide this practical guide for your use in your various ministries in the Episcopal Diocese of New Jersey. We have labored to produce a document that will be useful to you in recognizing and dealing with addiction as you confront it in the ordinary circumstances of your work.

Our goal has also been to provide a comprehensive guide to the many organizations and groups whose purpose is to assist suffering people in confronting and overcoming the demons underlying their addictions.

The members of the Recovery Ministry Commission are listed in Appendix D to this guide. We are available to answer questions and offer advice on specific issues you may encounter as a result of your heightened awareness of the many aspects of alcohol and drug addiction. We hope you will feel comfortable in approaching us - among us we have many years of experience in this area and we feel deeply the need to help others conquer the scourge of addiction.

Yours in Recovery,

*The Rev. Cathy Brunson, Dcn., Chair
Recovery Ministry Commission*



BEFORE YOU START...

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 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 so important that clergy acquire 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.

Addiction:
There is a
spiritual dimension

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 clergy 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.

CHAPTER I

RECOGNIZING ADDICTION – THE FIRST STEP IN SPIRITUAL CAREGIVING

Welcome to the Resource Guide for Clergy! We begin in the usual way with some definitions. Later on in this guide we become more specific about symptoms, causes, and treatments, and the role of clergy in addressing these issues.

DEFINITIONS

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

1. Alcohol and drug dependence are progressive, chronic, and potentially fatal diseases.
2. The primary behavioral characteristics of this illness are a) cravings for the psycho-physiological effects of alcohol and drugs, and b) continuing excessive use even when such use is harmful to oneself, to one's family and other relationships.
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 oneself and/or to others, resulting in the loss of control over the use of these drugs and becoming dependent upon them. Alcohol qualifies as a mind-altering, consciousness-changing drug, so alcoholism is a form of drug addiction.
6. Many view addiction to alcohol or other mind-altering drugs as a spiritual as well as a behavioral, psychological, and physiological problem.

DEFINITION OF ALCOHOLIC

Alcoholism, which is called **Alcohol Use Disorder (AUD)** in the professional literature, is the over-consumption of alcoholic beverages to a level where problems are likely to occur, such as personality changes, physical and psychological dependency, and serious problems within the work place and the family. Alcoholism may be present immediately when the first drink is consumed or may take years to develop. It is a disease and not a moral failing, and if left untreated may end in jail, hospitalization and death. While it is the butt of many jokes, it is a very serious disease and needs to be treated.

DEFINITION OF DRUG ADDICT

According to the National Institute on Drug Addiction (NIDA), “Drug Addiction” (now called **Substance Use Disorder [SUD]** in the professional literature) is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs alter the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.



CAUSES OF ALCOHOL AND DRUG ADDICTION

There are thought to be two primary causes of AUD and SUD: genetics and environment. Reasonably strong evidence suggests that there is a genetic component to addiction but without alcohol or drugs in a person’s environment, the addiction will not “blossom.” There are also strong hints in the literature of a relationship between depression and addiction, in that the intake of alcohol/drugs is an attempt on the part of the addict to reduce the pain of depression.

Addicts, both alcoholics and drug abusers, are trying to change how they feel, get rid of emotional pain which they may not realize they have. All they know is that the intake of a substance makes them feel better. Some people use drugs and alcohol because they like the rush it gives them or because they are thrill-seekers. Teens especially may try a drug out of curiosity or because of peer pressure.

Doctors say there is a link between the repeated use of an addictive substance and how the human brain experiences pleasure. The use of the addictive substance gives a nice reward, leading to further and more frequent use. The addictive substance, be it alcohol, a drug (or even nicotine), actually causes physical changes in some nerve cells in the brain.

A psychological addiction to alcohol should be distinguished from a physical addiction. A person with a psychological addiction may not suffer the usual withdrawal symptoms when alcohol is no longer consumed. Unfortunately, a person with this type of addiction often does not stop drinking but rather continues to drink until s/he becomes physically addicted as well.

***ALCOHOLISM IS A DISEASE,
NOT
A MORAL FAILURE***

Returning to the subject of genetics, recent definitions regarding alcoholism have emphasized the role of genetic vulnerability. It has long been known that children of alcoholics have four times the chance of becoming addicted themselves as compared to children of non-alcoholics. Genetics is now viewed as one of the dominant, precipitating factors in the etiology of addiction. Certainly, environmental, social, and other such factors also influence the development of the disease, but inherited biochemical neurophysiologic functions of the brain are now also being understood as important causal factors.

The growing knowledge of genetic predisposition distinguishes alcohol addiction from moral weakness or sinfulness. While one's environment, plus past and current primary relationships, remain important considerations for both addiction and recovery, understanding the genetic factor eliminates blame, prejudice, and rejection often associated with alcoholism and drug dependence.

GENDER AND RACE DIFFERENCES

Women are often more secretive drinkers than men – they often drink alone at home. Women have a greater sense of shame about their alcoholism and this sense of shame may prevent them from

seeking help. Women experience physical damage because of alcohol faster than men, with some researchers suggesting that estrogen may be responsible for this. It takes less alcohol to do damage to a woman's body because she usually weighs less than a man and alcohol is processed differently in her body. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), "Research suggests that women are more vulnerable than men to alcohol-related organ damage, trauma, and legal and interpersonal difficulties."

Differences between races are apparent also. Although Alcoholics Anonymous (AA) does not keep statistics on the race of AA members, we know that drinking patterns, treatment patterns and consequences of alcoholism are evident, with white Americans being more likely than black Americans to have used most kinds of illegal drugs, including cocaine, marijuana and LSD. Blacks, however, are far more likely than whites to go to prison for drug offenses.

Jane Fellner, author of the *Human Rights Watch* report, offered an explanation for this discrepancy.

The race issue isn't just that the judge is going, 'Oh, black man, I'm gonna sentence you higher,' she said. 'The police go into low-income neighborhoods and that's where they make most of their drug arrests. If they arrest you, now you have a "prior," so if you plead or get arrested again, you're gonna have a higher sentence. There's a kind of cumulative effect.'

The federal government can deny public housing assistance to anyone who has been convicted of a felony drug offense. Students who have been convicted of drug possession are barred from receiving federal financial aid and substantial education tax credits. Also, employers often require applicants to disclose their criminal histories, despite a growing nationwide movement to ban this practice.

CONSEQUENCES OF ALCOHOL AND DRUG ABUSE

STATISTICS

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 2014 NIAAA survey shows that 87.6 percent of people ages 18 or older reported that they drank alcohol at some point in their lifetime; 71 percent reported that they drank in the past year; and 56.9 percent reported that they drank in the past month. This data also indicates that 16.3 million adults ages 18 and over (6.8 percent of this age group) had a problem with alcohol in 2014. With respect to illicit drugs, NIAAA estimated that in 2013 approximately 24.6 million Americans aged 12 or older (9.4 percent of the population) had used an illicit drug in the past month. This number is up from 8.3 percent in 2002, mostly reflecting the increasing use of marijuana.

According to the NIAAA survey, 86 percent of American high school students said that some classmates drink, use drugs or smoke during the school day. Additionally, 44 percent of high school students knew a student who sold drugs at their school. Asked what drugs students sold on school grounds, 91 percent said marijuana, 24 percent said prescription drugs, 9 percent said cocaine and 7 percent said ecstasy.

The survey also revealed that 52 percent of high school students said there was a place on school grounds or near school where students can go to use drugs, drink or smoke during the school day, and 36 percent said it was easy for students to use drugs, drink or smoke during the school day without getting caught.

ADDICTION AFFECTS THE COMMUNITY

- **Homelessness:** Over a third of America's homeless suffer from drug abuse or alcoholism.
- **Crime:** More than half of adults in Federal prisons are there for drug related crimes.
- **Education:** Children with prenatal cocaine exposure are more likely (1.5 times) to need special education services in school. Special education costs for this population are high.
- **The Workplace:** Illicit drug users are more likely than others to have missed 2 or more days of work in the past month and to have worked for three or more employers in the past year.



ADDICTION CAUSES MANY SOCIAL PROBLEMS

- **Violence:** At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest.



- **Drugged Driving:** The National Highway Traffic Safety Administration estimates that drugs are used by approximately 10-22 percent of drivers involved in crashes, often in combination with alcohol.
- **Stress:** Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts.
- **Child Abuse:** At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children.

ADDICTION AFFECTS EVERYONE

Substance abuse impacts the individual, family, and community. Almost everybody knows someone who is or has been affected by drug abuse.

Individuals:

- **Adolescence:** This is a time period of high vulnerability to drug and alcohol abuse and other risk taking behaviors.
- **Mental Illness:** People with mental illness are particularly at risk for problems related to substance abuse.
- **Ramifications of Substance Abuse:** These can include illness, injuries, and death. Each year approximately 40 million debilitating illnesses or injuries occur among Americans as the result of their use of alcohol, tobacco, or another addictive drug.
- **Deaths:** In 2013, more than 75,000 people in the U.S. died as a result of drugs and alcohol-induced illnesses. This number is almost certainly underestimated because these substances often underlie other illnesses which are listed on death certificates.

Families:

- **Prenatal:** Babies born to mothers who abuse cocaine during pregnancy can be born prematurely and have low birth weights. There may be as many as 45,000 cocaine-exposed babies per year.
- **Child Abuse:** Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents.



SIGNS AND SYMPTOMS

ALCOHOL

NIAAA describes alcoholism as a disease that has the following four symptoms:

1. Craving – a strong need, or urge, to drink.
2. Loss of control – not being able to stop drinking once drinking has begun.
3. Physical dependence – withdrawal symptoms such as nausea, sweating, shakiness and anxiety after stopping drinking; however, some people will not experience physical dependence on alcohol.
4. Tolerance – the need to drink greater and greater amounts of alcohol to get “high.”

DRUGS

With respect to drugs, as stated above, 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. The substances abused can be illegal drugs, such as marijuana and cocaine, or legal substances used improperly, such as prescription drugs like oxycodone and Valium. Nail polish, vanilla extract, Listerine, cough medicine and gasoline are among the legal substances that can be abused and cause addiction.



Marijuana under cultivation

Notable Facts –

- ✓ Substance abuse can be identified by the maladaptive way in which it takes over the user's life, disrupting relationships, daily functioning and peace of mind.
- ✓ Drug addiction can be physical, psychological, or both. A psychological addiction involves a subjective feeling on the part of the addict that s/he "needs" the drug to numb unpleasant feelings, to relax, or to "feel normal."
- ✓ Physical addiction is characterized by tolerance – the need for increasingly larger doses in order to achieve the initial effect – and withdrawal symptoms when the user stops.
- ✓ Substance abusers very often try to conceal their symptoms and are often the last ones to recognize their own dependence and addiction.
- ✓ Anxiety is almost always present in an alcoholic, as is denial.
- ✓ An addicted person will deny having a problem and seems to be unaware that there is a serious issue which affects many people in addition to him or herself.

SYMPTOMS OF ALCOHOL AND DRUG ADDICTION

A PERSON MAY HAVE AN ADDICTION IF HE OR SHE. . .

<u>ALCOHOL</u>		<u>DRUGS</u>
Spends a lot of time and effort making sure s/he can get alcohol	1.	Spends a lot of time getting, using and recovering from the effects of a drug
Develops a tolerance and it takes more and more alcohol to feel the same level of intoxication	2.	Becomes progressively drug tolerant – needs to use more of the drug to achieve the same results
Has withdrawal symptoms and hangovers, including nausea, sweating, shakiness and anxiety	3.	Experiences withdrawal symptoms (nausea, tremors, restlessness, insomnia, concentration problems, sweating, anxiety) after reducing or stopping drug use. Taking a drug to avoid withdrawal symptoms.
Often drinks more than originally intended	4.	Taking a larger amount of a drug than planned. Using a drug more frequently or for a longer period of time than intended.
Attempts to cut down or stop drinking but all attempts are failures and continues to drink more and more	5.	Desires or unsuccessfully attempts to cut down or stop drug use
Gives up opportunities for social, recreational, and professional activities because of drinking	6.	No longer spends time with friends who don't use drugs and/or associates with known users; Abandoning or spending less time on previously-enjoyed activities, such as hobbies, sports, and socializing, in order to use drugs.
Continues to drink despite having physical and psychological problems because of the drinking; has an eating disorder and/or a poor diet; suffers abdominal pain	7.	Continues to use despite physical problems (blackouts, flashbacks, infections, injuries) or psychological problems (mood swings, depression, anxiety, delusions, paranoia) the drug has caused. Has an inability to relax or have fun without doing drugs
Begins to miss work or is less successful at work	8.	Demonstrates sudden changes in work or school attendance and quality of work or grades. Neglects school, work, or family responsibilities (flunks classes, skips work, neglects children)
Makes a ritual of having drinks before, during and/or after dinner and becomes annoyed when this ritual is disturbed or questioned	9.	

<u>ALCOHOL</u>		<u>DRUGS</u>
Physically or emotionally abuses members of the family	10.	Physically or emotionally abuses family members
Drinks alone or in secret	11.	Engages in secretive or suspicious behaviors, such as making frequent trips to the restroom, basement, or other isolated areas where drug use would be undisturbed
Is irritable as the usual time for drinking approaches, esp. if alcohol isn't available	12.	Talks about drugs all the time and pressures others to use
Hides bottles at home, at work, or in the car	13.	Frequently borrows money, sells possessions, or steals items from employer, home or school
Gulps drinks and orders doubles, intentionally becoming drunk to feel good or to feel "normal"	14.	
Makes excuses for drinking	15.	Makes excuses for taking drugs
Exhibits a lack of control over drinking (An alcoholic may not have had anything to drink for months or years, but when s/he does, s/he has difficulty stopping.)	16.	Onset of withdrawal feelings or symptoms necessitates continued use of drugs
Drinks first thing in the morning	17.	Uses drugs first thing in the morning
Drives under the influence of alcohol	18.	Risky drug use: using a drug under dangerous conditions, such as while driving or operating machinery. Taking risks while high, such as starting a fight or engaging in unprotected sex.
Repeatedly arrested for DUI, suspension of driver's license, other legal troubles	19.	Encounters legal troubles because of drug use, such as arrests for disorderly conduct, driving under the influence, or stealing to support drug habit
Exhibits mood swings; seems angry a lot	20.	Has angry outbursts, mood swings, irritability, manic behavior, or overall attitude change
Experiences paranoia, unnatural fears or contemplates suicide	21.	Expresses feelings of exhaustion, depression, and hopelessness
Neglects his/her physical appearance	22.	Shows a deterioration of physical appearance and grooming
Exhibits confusion, has difficulty thinking clearly	23.	Talks incoherently or makes inappropriate remarks
Has a sleeping disorder, such as waking up in the middle of the night when the alcohol wears off, then craving another drink	24.	Experiences sleep disorders
Shows redness and enlarged capillaries in the face (red eyes and/or nose, puffy face)	25.	Wears sunglasses and/or long sleeves frequently or at inappropriate times

ADDICTION IN THE FAMILY

The first clues that alcoholism and/or drug dependencies are problems in a family 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 until much damage has occurred. 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.

Members of an alcoholic's family very often become co-dependent. According to C. Wekesser, "Co-dependency is an unconscious addiction to another person's abnormal behavior." Most alcoholics have periods when they stop drinking for a short while and seemingly do well, leading the codependent person to believe that the problem can be solved. Co-dependent members often forget about their own needs and desires. They devote their lives to attempting to control or cure the drinker.



Codependent family members often become "enablers." An enabler is a "person who ... helps the alcoholic by denying the drinking problem exists and helping the alcoholic to get out of troubles caused by his drinking problem" (Silverstein). The enabler will clean up the alcoholic's vomit and make excuses to his or her boss, teacher, or friends. The enabler lies for the alcoholic and thus enables the alcoholic to continue drinking.

The spouse of an alcoholic suffers many negative impacts due to his/her partner's drinking. The spouse may harbor feelings of intense anger, hatred, and self-pity. He/she may avoid social contacts and become isolated, in addition to being exhausted much of the time. When a spouse is drinking, child rearing, discipline and most other parental duties fall to the non-drinker.

EVERYONE IN THE FAMILY NEEDS TREATMENT

Everyone in the family is affected by an alcoholic's drinking. Family members do everything possible to hide the problem, preserve the family's prestige and project the image of a "perfect family." The spouse and children may avoid making friends and bringing other people home, in order to hide problems caused by alcoholism.

Today, experts who study alcoholic families know that family and marital problems often start because of alcoholism, but they have also learned that spouses and children may contribute to the drinker's habit and make it worse. Some of the families allow heavy drinking to continue rather than deal with serious family problems, and keep the habit going in exchange for keeping the family together. Denial is an essential problem for alcoholics and family members. Family members use denial to rationalize the drinker's alcohol dependency. In the beginning, denial is understandable because every family loves and wants to protect its members, but there comes a time when denial negatively affects family members. When family members deny the obvious and refuse to look for help, their behavior can trigger multiple emotional problems in the children of the family.

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.

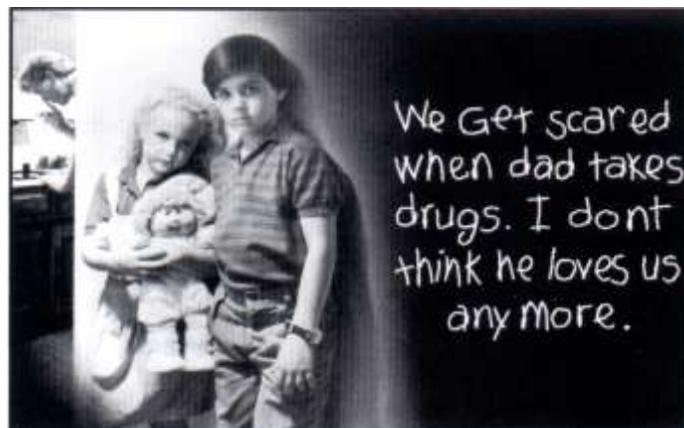
Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents

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 adaption 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.

1. 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.
2. Children of alcoholics exhibit symptoms of depression and anxiety more than children of non-alcoholics.
3. Children of alcoholics experience greater physical and mental health problems and higher health care costs than children from non-alcoholic families.
4. Children of alcoholics score lower on tests measuring verbal ability.
5. Children of alcoholics often have difficulty in school.
6. Children of alcoholics have greater difficulty with abstraction and conceptual reasoning.
7. Children of alcoholics may benefit from adult efforts to help them.
8. Children of alcoholics can be protected from many problems associated with growing up in an alcoholic family.

A long term study, initiated between 1995 and 1997 and sponsored jointly by the Centers for Disease Control (CDC) and the Kaiser-Permanente Health Maintenance Organization, examined childhoods of 17,000 middle-aged patients. The *Adverse Childhood Experiences (ACE) Study*, found a strong relationship between ACEs and physical or mental health problems later in life, misuse of alcohol and drugs among the most prevalent.



ACEs can be any or a multitude of circumstances. As the number of ACEs increase, so does the risk for the following: 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.

The CDC continues ongoing surveillance of individuals in the ACE study by assessing the medical status of the study participants via periodic updates of morbidity and mortality data. Additional important findings to come out of the study pertinent to this document include the following:

- ❖ The chronic emotional stress caused by adverse childhood experiences changes the structure and chemistry of the brain and affects judgment, emotions and behaviors.
- ❖ 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.
- ❖ Children who experience abuse and neglect are at increased risk for smoking, alcoholism, and drug abuse as adults, as well as engaging in high-risk sexual behaviors.

Actually, children of alcoholic parents are four times more likely than children of non-alcoholics to themselves develop alcoholism. Both genetic and environmental factors play a role in this case.

DRUG ADDICTION IN TEENAGERS

Many of the same signs and symptoms of addiction experienced by adults will also be experienced by teenagers, but teens exhibit behaviors that are peculiar to their age group. The challenge for parents is to distinguish between normal, sometimes volatile ups and downs of adolescent development and the red flags of substance abuse.

Some things to watch for include the following:

- Sudden or extreme changes in personality, appearance, school performance, or extracurricular activities may indicate teen drug use. For example, a previously well-behaved, respectful teenager may become emotionally volatile, hostile, or violent.

In 2013, 22.6 % of 18- to 20-year-olds reported using an illicit drug in the past month.

- A teenager who is abusing drugs may also withdraw from family and friends, drop previously-enjoyed activities and neglect schoolwork.

- Secretive behavior and lying to cover up drug use is also common. In addition, teen drug users may steal, ask for money, or sell valuables in order to support their habit.

- Specific warning signs:
 - Increased secrecy about possessions or activities;
 - Use of incense, room deodorant or perfume to hide smoke or chemical odors;
 - New friends;
 - Subtle changes in conversations with friends (more secretive, using “coded” language);
 - Change in clothing choices – new fascination with clothes that highlight drug use;
 - Increase in borrowing money;
 - Evidence of drug paraphernalia, such as pipes and rolling papers;
 - Evidence of inhaling products and accessories, such as hairspray, nail polish, correction fluid, paper bags and rags, common household products;
 - Bottles of eye drops which may be used to mask bloodshot eyes or dilated pupils;
 - Missing prescription drugs from a parent’s drug cabinet.

O Lord!

Mercifully regard your servant who is bound with the chains of addiction. Give him/her strength that he/she may be freed from fear and guilt and be restored in you to the liberty of the children of God, now and forever. Amen

Lutheran Prayer

CHAPTER II

PASTORAL/SPIRITUAL CARE OF ADDICTED PERSONS AND FAMILIES

*“The disease of alcoholism
is as toxic to the soul as it is
to the liver or the brain.”*

Ketcham, et.al.

This quote from Ketcham et al., (2000), in *Beyond the Influence: Understanding and Defeating Alcoholism*, indicates that 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. Alcoholics Anonymous (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.

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 God, he or she is least likely to find as long as the addiction controls them.

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 public figures such as Betty Ford and Joan Kennedy struggled with these illnesses. Likewise, various performers in theater and popular music have had similar problems until they sought treatment and used their fame to bring attention to their addictions and their 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 OF THE CLERGY

The Clergy Education and Training Project® of *the National Association for Children of Alcoholics* (NACoA) developed the following “core competencies” to be used by clergy and other pastoral ministers in addressing alcohol and drug dependence and their impact on family members. These competencies were developed by NACA 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 addicted persons.

TO EFFECTIVELY MINISTER TO ADDICTED PERSONS AND THEIR FAMILIES, THE CLERGY PERSON SHOULD:		
1.	Be aware of the . . .	<ul style="list-style-type: none"> • generally accepted definition of alcohol and other drug dependence • societal stigma attached to alcohol and other drug dependencies
2.	Be knowledgeable about the . . .	<ul style="list-style-type: none"> • 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, . . .	<ul style="list-style-type: none"> • marital conflict • family violence (physical, emotional and verbal) • suicide • hospitalization • encounters with the criminal justice system

4.	Understand that . . .	<ul style="list-style-type: none"> • addiction erodes and blocks religious and spiritual development • one should be able to effectively communicate the importance of spirituality and the practice of religion in recovery, using the scriptures, traditions, and rituals of the faith community
5.	Be aware of. . .	<ul style="list-style-type: none"> • the potential benefits of early intervention to the addicted person, the family system and affected children
6.	Be aware of. . .	<ul style="list-style-type: none"> • appropriate pastoral interactions with the addicted person, the family system and any affected children
7.	Be able to communicate and sustain. . .	<ul style="list-style-type: none"> • an appropriate level of concern • messages of hope and concern
8.	Be familiar with and utilize	<ul style="list-style-type: none"> • available community resources to ensure a continuum of care for the addicted person, the family system and affected children
9.	Have a general knowledge of, and where possible, exposure to. . .	<ul style="list-style-type: none"> • the 12-step programs – AA, NA, Al-Anon, Nar-Anon, Alateen, ACOA • other groups
10.	Be able to. . .	<ul style="list-style-type: none"> • acknowledge and address values, issues and attitudes regarding alcohol and other drug use and dependence in oneself and one’s own family
11.	Be able to. . .	<ul style="list-style-type: none"> • 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. . .	<ul style="list-style-type: none"> • how prevention strategies can benefit the larger community

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 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 factor 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:

1. **ACCEPTANCE**: Acceptance is the doctrine of grace practiced in interpersonal relationships. It is what twentieth century psychotherapist Carl Rogers 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.



2. **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 life situation is to make a form of judgment. The judgment, however, should be based on understanding, love, and reality, 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.
3. **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, if help is initially spurned, it stands close enough by to be ready to help when the opportunity comes.
4. **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.

PASTORAL INTERACTIONS WITH ADDICTED PERSONS AND FAMILY MEMBERS

It is possible that a clergy member will notice a problem with a member of his/her congregation before a family member comes to talk about it. Clergy may see a parishioner who exhibits some of the symptoms mentioned in the previous chapter (red face, stumbling, slurring words, smelling of alcohol, shaky hands, blood shot eyes, obvious drunken or drugged behavior at church functions).

On the other hand, the clergy person may be unaware of a problem until a parishioner's spouse raises the issue, distraught over what is going on in the home. The role of the clergy person is to be a listener, a counselor and a referrer.

The pastoral care of an alcoholic or other addicted person can be a challenging and sometimes frustrating experience. It is easy for a clergy person not schooled in the world of addiction to feel overwhelmed with the magnitude of the troubled person's need, the manipulation by the addicted person, and the fear and confusion of the family members. There might be 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 be 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. Be especially watchful for denial: one's own as well as the alcoholic's/addict's. The first vignette below (Scenario 1) illustrates how clergy denial can work; Scenario 2 shows how the same situation might have been handled better.
- ✓ **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 to 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 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 his/her 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. As a counselor, you can use the resources listed in the appendices to this document to recommend what you believe to be appropriate. If you are uncomfortable with making a firm recommendation, a referral to a general agency that is able to help sort it out is appropriate. [See Appendix F.]

- ✓ **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.

TWO SCENARIOS

The following scenarios illustrate two possible reactions to a parishioner in need.

SCENARIO 1—CLERGY DENIAL

Scene: office, desk, cross, two chairs, clergy person sitting behind desk. Knock on door.

Clergy (C) says: "Come in." Person enters room. C gets up and says:

C: Hello Sam/Sue (S/S). I've been expecting you and I'm glad to see you today. Please sit down. When you called for this appointment, you said you had a serious problem to talk about. What's happening?

S/S: Hi Father/Mother. Yeah, I thought we had a problem but now I'm not so sure.

C: What do you mean?

S/S: Well, I thought my husband/wife is drinking too much but now I'm not so sure.

C: Everybody likes a drink now and then. So you think there's a problem?

S/S: Yeah, I just don't know what a normal amount for someone to drink is.

C: A couple of drinks a day is probably normal and maybe more on weekends. That's what I drink and I certainly don't have a problem! We all need to relieve the stress in our lives and we are all under a lot of stress! I wouldn't worry too much about this. Everything will be just fine.

S/S: But at the church dinner last week, didn't you think s/he was drunk? Slurring words?

C: I didn't notice any of that. Do you think you may be exaggerating?

C: Anything else on your mind? If not, see you in church.

In this scene we see a clergyperson who is not tuned into what the parishioner is saying. In fact, there may be some defensiveness on his/her part – s/he may be aware at some level that his/her own drinking could be questioned. Unfortunately, the parishioner does not get the help s/he needs because the clergy is not really paying attention, does not probe for additional information, really wants to be rid of this problem, and doesn't offer any resources to follow up.

The next scene demonstrates a more sympathetic and helpful response.

SCENARIO 2 – HELPFUL CLERGY

Clergy (C) says: Hello Sam/Sue. When you called for this appointment, you said you had a serious problem to talk about. What's happening?

S/S: Hi Father/Mother. Yeah, I thought we had a problem but now I'm not so sure. I thought my husband/wife is drinking too much but now I'm not so sure.

C: Talk to me. What's happening that leads you to wonder about this?

S/S: Well, s/he has been drinking every night and not just a drink before dinner. After dinner too. S/he stumbles too.

C: Has his/her behavior changed in other ways?

S/S: Yes, s/he's argumentative and sometimes s/he seems really sad. For years s/he just had one drink before dinner but not lately. Last week, I thought s/he was drunk at the church dinner. Sometimes I have the feeling s/he is hiding something.

C: Yes, I noticed s/he was slurring words when s/he was talking to me at the dinner. It does sound like there's something going on. How can I be helpful?

S/S: You're already helpful by confirming my observations. I don't know what to do. Are there resources available? I know a little about AA but, really, I don't know much about it.

C: I can tell you about AA and I have an AA pamphlet here which may be a good option for your wife/husband. Of course, s/he may be resistant but we can continue to talk and figure out how to handle it. But you don't have to wait for her/him to get help. There is help for families available right now. Let me tell you about Alanon. It is for spouses, family and friends of a person who misuses alcohol and who find it hard to understand what's happening. Here is a pamphlet for you to read. Try Alanon for a few meetings and come back for another time together and let me know what you think. By the way, there are Alanon and Alateen meetings (for teenagers) at our church.

C: Let's pray about this before we end our time together.

PASTORAL COMMUNICATIONS WITH CHILDREN OF ADDICTS

Sis Wenger, President and CEO of NACoA states, “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.”

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 communications with the children of alcoholics. The following largely applies to children of drug abusers as well.

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 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 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 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. In 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. [See Appendix F for an extensive list of resources.]
- ✓ **DO** maintain a small library of current books, pamphlets, and reprints of articles on addiction-related problems that have been written for children.
- ✓ **DO** make sure the child understands three basic facts:
 - 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.
 - The child is not responsible for the problem and cannot control the parent's drinking behavior.
 - 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, 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 professional.
- ✓ **DO** be sensitive to possible cultural differences. If the child is from a different culture than yours, 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 or 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 a need to know.
 - ✓ **DON'T** make plans with the child that you cannot keep. This is not only important for building trust; it also protects the child.
 - ✓ **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.

When in doubt, 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:

THE SEVEN C'S
I DIDN'T CAUSE IT.
I CAN'T CURE IT.
I CAN'T CONTROL IT.
I CAN HELP TAKE CARE OF MYSELF
BY COMMUNICATING MY FEELINGS,
MAKING HEALTHY CHOICES, AND
CELEBRATING BEING MYSELF.

WHAT CAN FAMILY MEMBERS DO?

Family members of addicted persons who experience the need to “do something,” can explore the following:

- ✓ **PARTICIPATE IN A FAMILY SUPPORT GROUP** such as Al-Anon/Alateen or Families Anonymous. At these support groups, a person 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 bring balance and peace to their own lives.
- ✓ **BECOME INVOLVED IN THE ADDICT’S TREATMENT/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 them to 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. Appendix F contains information on such resources.

ADDICTION AND THE CHURCH'S CONGREGATION

As has been demonstrated 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. [See further discussion on page 49 and following.]

***THE REACTION OF THE CONGREGATION
WILL DEPEND --TO A LARGE EXTENT--
ON THE REACTION AND THE ATTITUDE
OF THE CLERGY IN CHARGE.***

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.

Stigma usually fosters a process of 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 lead to isolation. Isolation leads to more drinking/drugging and denial of reality, which ultimately leads to hitting bottom. Helping to remove the stigma from alcoholism and other addictions is something that religious communities can contribute to, thus ending this vicious cycle and encouraging help at an early stage of addiction for both the afflicted individual and the impacted family members.

WHEN THE CLERGY PERSON IS THE ADDICTED ONE

[Several bishops and clergy of the Diocese of New Jersey contributed to this section through personal interviews.]

Clergy themselves are not immune to alcoholism and drug dependence. The *2014 National Survey on Drug Use and Health*, underwritten by the Substance Abuse and Mental Health Services Administration (SAMHSA), estimated that approximately 6.7 percent of the population of the United States over the age of 12 had a serious problem with either alcohol or drugs (or both) Clergy are represented in this data, as are congregants.



Clergy need to be mindful of their own use of alcohol and/or drugs and that of other clergy with whom they work. They should be familiar with the symptoms of alcohol and drug misuse and alert to the signs in themselves, colleagues, and their own families. All clergy should be familiar with AA materials for use with congregants and for themselves, as necessary.

A clergy member who is an alcoholic or drug abuser can wreak havoc on the congregation he or she serves, leading to a loss of congregants, loss of faith in the church, sadness and emotional distress. Eventually the problem will become known and an intervention may be necessary. In the Diocese of New Jersey, the Bishop will be involved and the matter will be taken seriously. A process designed to solve the problem will be put in place. Referrals to appropriate agencies will take place and a recovery process will be initiated or more serious repercussions will occur.

There is no such thing as an anonymous alcoholic. Priests and deacons who reveal their struggle with alcohol to the Bishop will find support and resources. In general, most bishops have training or

experience in the field and some bishops have family members who have had a problem with alcohol and/or drugs. Increasingly, seminary education includes this topic in its curriculum.

CONFIDENTIALITY

IS

CRITICAL!

The issue of confidentiality is really important. Drawing on people who are already involved in AA to be helpers is also important. Ideally, clergy should be aware of one or two people who are in AA and have achieved successful sobriety to refer congregants to, or use themselves, if they need it.

As one diocesan clergyperson said:

The question of trust is unavoidable. Since we are talking about someone's livelihood, if s/he doesn't get into recovery, it won't be long before s/he is out of a job. That's not altogether a bad thing, if it gets someone to wake up. What a relief it is to get out of the lying, the deception and the phoniness. They're not fooling anyone. If we could just find a way to face the truth together. We are an addictive church. We have a problem because we are human. God is merciful, and in His mercy people can change and get into recovery. This is not only life-changing, but life-saving.

The screening process for candidates for the priesthood is very thorough and potential problems with alcohol and drugs are likely to be discovered during this process, but often the problem will develop later in a person's ministry. Whenever addiction occurs, it is usually not possible to hide the problem from the congregation.

CHAPTER III

UNDERSTANDING YOURSELF

IN RELATION TO ADDICTED PERSONS

ACKNOWLEDGING AND ADDRESSING ONE'S OWN VALUES, ISSUES AND ATTITUDES

No matter how much one knows about the 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 attitude, 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/clergy, and those need to be anticipated, recognized, and managed. This is especially critical if the caregiver/clergy 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.

SUGGESTION:

Obtain the DVD or video of the excellent documentary aired on San Francisco's KRON TV entitled *Lost Childhood: Growing up in an Alcoholic Home*. 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 17 years later and shared 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 is itself 30 minutes in length.

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 a 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 three cases illustrate how clergy may respond to an individual or family member impacted by addiction in their congregation.

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 about 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 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 the pastor in the scenario above 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 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 Carl's teenage children and had alerted 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.

Carl's experience illustrates a different and more positive pastoral experience. The 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 of his own 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 (below) illustrates an understanding but a more directive role of a pastor. This pastor shows open and honest respect for his parishioner while taking the initiative in encouraging her to find help. She experiences him as a caring and trustworthy person and follows his lead. He is 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 is not threatened by other options for help. In this case, the congregation became a supportive and caring community for her, complementing her AA group in a positive way.

THE CASE OF PATRICIA

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 transforming spiritual experience that gave her a new openness to change, the pastor encouraged her to attend an AA meeting. Because she was not comfortable going by herself, the pastor called a congregant who was in recovery and persuaded Patricia to accompany her to a meeting where she could be introduced to other AA members. Patricia found genuine acceptance in the group and became an active AA member, moving into recovery. She continued to have a good relationship with her pastor and maintained her church relationship.

The first case – Sally -- is an example of pastoral ineffectiveness. The pastor was too absorbed with himself and too unaware to provide sensitive pastoral care for her. 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 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.

CHAPTER IV

TREATMENT AND RECOVERY

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 in the Diocese of New Jersey 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. Clergy 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 (intake process, range of treatment services, availability of support services) is extremely important.

See Appendix F for an extensive listing of resources. Also see the material further on in this chapter which describes and discusses the various “12-step” programs available to alcoholics and drug addicted persons and their families.

One strategy often successfully used in getting a person into treatment is the process called “intervention.”



THE BENEFITS OF EARLY INTERVENTION

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 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.”

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, in order 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 training from an experienced professional, and confront the person with his/her self-defeating and destructive behavior.

The goals of intervention are twofold: 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 "tough love" kind of approach that was introduced by Vernon E. Johnson, a recovered alcoholic, an Episcopal priest 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 her/him, 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.

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.

THE FAMILY SYSTEM AND TREATMENT

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 of addiction 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 his/her 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 members of the clergy have become familiar with the family systems work of psychiatrist and family therapist Murray Bowen, M.D., and Rabbi Ed Friedman, pastoral counselor and marriage and family therapist. Fundamental points in Bowen's theory are:

- the family as a system is more than the sum of its parts;

- changes in any part of the system affect the entire system;
- subsystems are embedded throughout the larger family system;
- families exist within a larger social environment context and interact with other social systems; and
- 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., 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 co-dependent behavior 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 is 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 also 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.

GENERIC RESOURCES: “12 STEP” SUPPORT GROUPS

[For specific resources within the Diocese of New Jersey, see Appendix F]

For the alcohol addicted person, there is no better community support than Alcoholics Anonymous. Knowledge of the location 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 teenagers in the family are valuable resources for support, feedback, information, and guidance.

Besides knowing the range of assistance that is available, a clergy person’s familiarity with the “philosophy” of the various treatment agencies may allow for a successful matching of congregants’ needs and service providers.

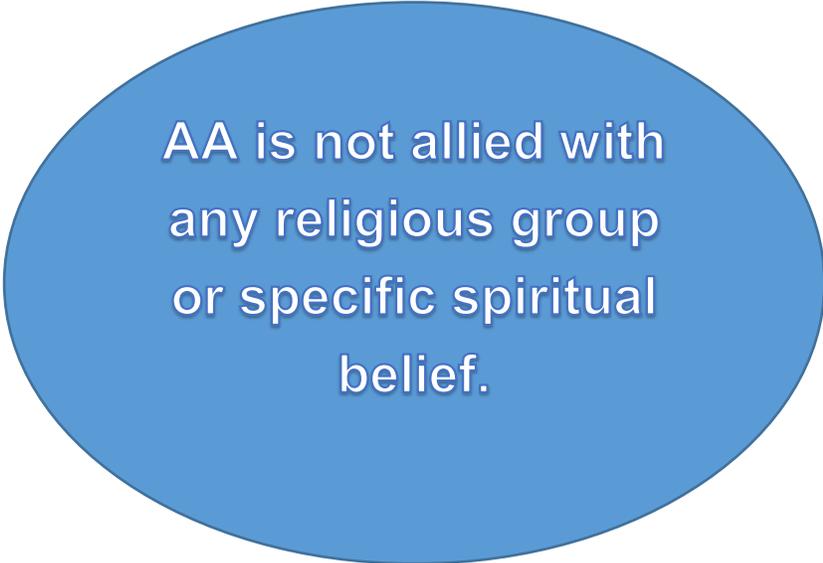
ALCOHOLICS ANONYMOUS

Practically everyone has heard of Alcoholics Anonymous (AA), yet surveys conducted by AA’s General Service Office indicate that only one (1) percent of those in AA were referred by a member of the clergy. This is one 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.

AA is not for everyone, and does not claim to be, however, AA's role in helping people overcome alcoholism cannot be overstated. Although AA does not take or keep attendance records, it has enabled millions of people to achieve sobriety and gain recovery in its many years of activity since being founded by two recovering alcoholics, Bill Wilson and Dr. Bob Smith, in 1935 in Akron, Ohio. The concept for AA grew out of the Oxford Group Movement which was popular in many churches in the 1930s and 1940s.

The Oxford Movement 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 separately from the Oxford 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.



AA is not allied with
any religious group
or specific spiritual
belief.

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. 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 the 12 Steps and the 12 Traditions of AA.

While the spiritual dimensions of the 12 steps and traditions are obvious, AA is NOT a religious program. Although 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 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. This has been successful because, while many people have found recovery through spirituality, they have felt hurt and “turned off” by religion institutions. 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.

The 12 steps and the 12 traditions of AA are presented at the end of this chapter.

Many AA and other 12 step groups end their meetings with the “Serenity Prayer.” The origin of this familiar prayer, shown below, 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. It has been used for many years as an integral part of the AA experience. It reflects a very basic, simple, 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.

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.*
- 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 to 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.*

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 are related: wives, husbands, lovers, sisters, brothers, parents and friends. 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 (NA), 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 (ACoA)

ACoA was formed as a support and educational group for those who grew up in families with an alcoholic. The ways in which their dysfunctional family system impacted the personality and relationships of the adult child are shared and explored, with the goal of transcending them.

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 those delineated above, pastoral caregivers need to be aware of professional treatment resources available in the community. Treatment options available in the Diocese of New Jersey are listed in Appendix F.

Inpatient Treatment – For persons who are physically addicted to alcohol or drugs, treatment in a setting connected to a hospital or hospital-type setting where a person stays a few days or weeks.

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

Residential Treatment – Treatment in a setting in which both staff and peers 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. Commonly called “rehab.”

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 a person’s 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.

CHAPTER V

RECOVERY, PREVENTION AND THE LARGER COMMUNITY

RECOVERY AND THE FAITH COMMUNITY

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." 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.

Jesus said:

*When you
have done it
to one of the
least of
these my
brethren,
you have
done it unto
me.*

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 this 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 a number of dynamics that impact and define the meaning of "caring congregation."

1. Isolation vs. 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 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 support groups 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 vs. 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 comfortable and accepted. In *The Wisdom of Christ*, 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 vs. 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 defines grace in the following way:

Grace is 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.

PREVENTION 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.



There is another aspect to engaging in prevention efforts, however, 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.

- Integration of alcohol/drug education into the ongoing educational programming in the church. Invite other religious communities to attend or co-sponsor. Addiction is truly an interfaith and ecumenical concern.
- Invitation to 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.
- Making creative uses of the “tract rack” by providing informational material on addiction and the impact on families and children.
- Including addiction-related illustrations and information in occasional sermons and teaching sessions.
- Incorporating questions and guidance regarding addiction and the general use of addictive substances in pre-marital pastoral counseling. Including 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.

- Assuring 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.
- Presenting reality-based programs to the youth group on the serious effects of addiction in young persons.
- Presenting 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.
- Sponsoring 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.
- Creating a library of information and materials about alcoholism and drug dependence.
- Developing a discussion working group on alcohol and drug dependence issues, possibly viewing current or past Recovery Month web sites.
- Identifying organizations working on Recovery Month initiatives 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.” 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.
- Incorporating information about substance use disorders, treatment, and recovery into a sermon during September.
- Facilitating your parish’s participating in “Alcohol Awareness Month” which is held in April in the Diocese of New Jersey.
- Encouraging Recovery Month events in your community, such as forums and educational workshops with speakers who are in recovery.
- Offering space in your church for recovery groups (such as Alcoholics Anonymous) to meet.

- Offering opportunities for members of the congregation to tell their personal recovery stories to help in reaching out to others who may need assistance.
- Writing 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.



***O blessed Lord,
You ministered to all who came to you:
Look with compassion upon all who
through addiction have lost their health
and freedom. Restore to them the
assurance of your unfailing mercy; remove
from them the fears that beset them;
strengthen them in the work of their
recovery; and to those who care for them,
give patient understanding and
persevering love. Amen.***

The Book of Common Prayer
Prayer #56,
“For the Victims of Addiction”

REFERENCES

It is not our purpose in this Resource Guide to further the advance of science or research into the subjects surrounding alcohol, drugs or addiction. We merely seek to compile into one document all the basic information a clergy person in the Episcopal Diocese of New Jersey needs to identify and respond to apparent instances of misuse of these substances in parishioners and family members.

Therefore, since this is not a research document, nor do we believe the users of this Guide are particularly concerned about that aspect of these subjects, we have not documented our sources in a scholarly manner. Rather, we list below those agencies and organizations, many of which are governmental and nonprofit, from whose materials we have drawn. Many attributions are included directly in the text and a number of authors and their works are listed. Finally, much of this document has been written by the members of the Recovery Commission themselves, drawing upon their years of experience on these subjects.

Agencies of the Federal Government

- ❖ Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services (HHS). SAMHSA produces periodic bulletins on various aspects of drug and alcohol abuse. <http://www.samhsa.gov/data>.
- ❖ National Institute on Alcohol Abuse and Alcoholism (NIAAA), an agency of the National Institutes of Health (NIH) which is itself a part of HHS. NIAAA publishes periodic bulletins on various aspects of alcohol abuse and alcoholism. [use samhsa website above]
- ❖ National Institute of Drug Addiction (NIDA), an agency of NIH. NIH conducts an annual survey entitled *National Survey on Drug Use and Health* (NSDUH.) [use samhsa website above]
- ❖ Center for Substance Abuse Prevention (CSAP), an agency of SAMHSA/NIH. [use samhsa website above]
- ❖ National Center on Addiction and Substance Abuse (CASA) at Columbia University is a national nonprofit research and policy organization focused on improving the understanding, prevention and treatment of substance use and addiction. www.centeronaddiction.org.
- ❖ Centers for Disease Control / Kaiser Permanente Health Maintenance Organization. Further references are to be found in the SAMHSA “Handbook for use by Pastoral Counselors in Clergy Education.”

- ❖ Center for Behavioral Health Statistics and Quality (CBHSQ). (2015) *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration. HHS Publication No. SMA 15-4927, NSDUH Series H-50.

Non-Governmental Entities

- ❖ Al-Anon helps friends and families of problem drinkers to find understanding and support. Alateen is the arm of Al-Anon that focuses specifically on teenagers. www.al-anon.alateen.org.
- ❖ Alcoholics Anonymous (AA) is a nonprofessional, self-supporting, multiracial and apolitical international fellowship of men and women who have a drinking problem. www.aa.org.
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- ❖ National Association for Children of Alcoholics (NACoA) was established to provide information, education and advocacy for children of alcoholics. www.nacoa.org.
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APPENDIX A

EPISCOPAL CHURCH OF THE UNITED STATES

POLICIES ON ALCOHOL AND DRUG ABUSE

The 78th General Convention of the Episcopal Church, held in Salt Lake City, Utah, from June 25 to July 3, 2015, adopted two resolutions dealing with the subject of alcohol and drug abuse. These resolutions represent the finalized text and are shown below in their entirety.

* * *

A158: Task Force to Review and Revise Policy on substance abuse, addiction and recovery

Resolved, the House of Bishops concurring, that the 78th General Convention acknowledge The Episcopal Church's long-standing tolerance for the use of alcohol which, in some cases, has contributed to its misuse, and has undermined a climate of wholeness and holiness for all; that our Church culture too often avoids hard conversations about alcohol use, and the role of forgiveness and compassion in healing and recovery; and that The Episcopal Church now commits to create a new normal in our relationship with alcohol. We aspire to be a place in which conversations about alcohol, substance abuse, or addiction are not simply about treatment but about renewal, justice, wholeness, and healing. We affirm that Recovery Ministries of The Episcopal Church has long been and continues to be a valuable resource for this work; and be it further

Resolved, that the 78th Convention adopt the following policy on alcohol and other substance misuse and encourage dioceses, congregations, seminaries, schools, young adult ministries, and affiliated institutions to update their policies on the use of alcohol and other substances with the potential for misuse. These policies should consider the following:

1. The Church must provide a safe and welcoming environment for all people, including people in recovery.
2. All applicable federal, state and local laws should be obeyed, including those governing the serving of alcoholic beverages to minors.
3. Some dioceses and congregations may decide not to serve alcohol at events or gatherings. Others may decide to permit limited use of alcoholic beverages at church-sponsored events. Both can be appropriate if approached mindfully.
4. When alcohol is served, it must be monitored and those showing signs of intoxication must not be served. Whenever alcohol is served, the rector, vicar, or priest-in-charge must appoint an adult to oversee its serving. That adult must not drink alcoholic beverages during the time of his or her execution of his or her responsibilities. If hard liquor is served, a certified server is required.

5. Serving alcoholic beverages at congregational events where minors are present is strongly discouraged. If minors are present, alcohol must be served at a separate station that is monitored at all times to prevent underage drinking.
6. Alcoholic and non-alcoholic beverages must be clearly labeled as such. Food prepared with alcohol does not need to be labeled provided the alcohol is completely evaporated by the cooking process; however, it is recommended that even in this case the use of alcohol in cooking be noted on a label.
7. Whenever alcohol is served, appealing non-alcoholic alternatives must always be offered with equal prominence and accessibility.
8. The serving of alcoholic beverages at church events should not be publicized as an attraction of the event, e.g., “wine and cheese reception,” “cocktail party,” and “beer and wine tasting.”
9. Ministries inside or outside of congregations will make certain that alcohol consumption is not the focus of the ministry and that drinking alcohol is not an exclusively normative activity.
10. Food must be served when alcohol is present.
11. The groups or organizations sponsoring the activity or event at which alcoholic beverages are served must have permission from the clergy or the vestry. Such groups or organizations must also assume responsibility for those persons who might become intoxicated and must provide alternative transportation for anyone whose capacity to drive may be impaired. Consulting with liability insurance carriers is advised.
12. Recognizing the effects of alcohol as a mood-altering drug, alcoholic beverages shall not be served when the business of the Church is being conducted.
13. Clergy shall consecrate an appropriate amount of wine when celebrating the Eucharist and perform ablutions in a way that does not foster or model misuse.
14. We encourage clergy to acknowledge the efficacy of receiving the sacrament in one kind and consider providing non-alcoholic wine.

And be it further

Resolved, that, mindful of the emerging legalization of other addictive substances and the increasing rise of addiction, the Executive Council of The Episcopal Church provide for the ready availability, implementation, and continuing development of this policy church-wide, in consultation and coordination with Recovery Ministries of The Episcopal Church.

July, 2015

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A-159: Promote a Healing Ministry to Those Affected by Addiction

Resolved, That the 78th General Convention recognize that the field of substance use disorders and addiction has advanced substantially since 1985 when the 68th General Convention passed the current policy, acknowledging that alcohol use, addiction and recovery all involve biological, psychological, social and spiritual dimensions; and be it further

Resolved, That as holy Baptism is the entrance to the life of wholeness and holiness and addiction disrupts relationships with God, others, and ourselves, impairing body, mind and spirit, the Church, respecting the dignity of every human being, has a moral and ethical responsibility to:

1. Confront and repent of the Episcopal Church's complicity in a culture of alcohol, denial and enabling,
2. Speak to cultural norms that promote addiction,
3. Promote spiritual practices as a means of prevention and healing,
4. Advocate for public funding and health insurance coverage for prevention, intervention, treatment and recovery, and collaborate with qualified community resources offering these services, and to respond with pastoral care and accountability, and be it further

Resolved, That The Episcopal Church affirms the need for exercising a healing ministry to all whose lives are affected by addiction and encourages all members of The Episcopal Church to pursue healing in their personal, professional, relational and vocational lives, and to seek help at the first sign of the disease of addiction; and be it further

Resolved, That The Episcopal Church acknowledge that the epidemic of addiction has a severely adverse social, economic, environmental, and spiritual impact on all communities, and presents particular challenges to communities of marginalized people at home and abroad; and be it further

Resolved, The Episcopal Church directs dioceses to work in partnership with The Episcopal Church Medical Trust, Recovery Ministries of The Episcopal Church, and community-based organizations in order to address most effectively prevention, intervention/diversion, education, advocacy, treatment, and recovery, including developing a list of trained therapists and consultants who are available to assist clergy and laity in this education process.

July, 2015

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APPENDIX B

DIOCESE OF NEW JERSEY:

POLICY ON THE USE OF ALCOHOL AT CHURCH FUNCTIONS

- Alcohol should not be served prior to worship or business meetings.
- All beverages and food containing alcohol must be clearly and distinctly labeled. This guideline is most often forgotten where food is concerned. It must be remembered that the flavor of liquor (in food where the alcohol has been cooked out) is something that many persons in recovery wish to avoid.
- Food must be available at all functions where alcohol is served.
- Equally attractive, non-alcoholic alternatives must be offered as conspicuously as alcoholic beverages. Persons who wish to abstain from alcohol must be able to do so comfortably. It is critical that alternatives to alcoholic beverages be of equal quality as those containing alcohol. It is inappropriate to serve a good bottle wine in a crystal glass when the only alternative is a can of pop in the back of the refrigerator or a pot of coffee on the stove.
- The promotion of church functions must not use alcohol as an enticement to participation. No announcements, advertisements or promotional material should imply that drinking alcohol is a social requirement.
- Alcoholic beverages should not be part of the identification of church events; e.g., Bratwurst Festival, not Beer and Bratwurst; Reception with Hors d'oeuvres or Reception with Light Refreshments, not Wine and Cheese Reception.
- Alcohol should not be served in such a way as to teach children that growing up necessarily implies alcohol consumption.
- All federal, state and local laws and ordinances must be observed. This includes regulation requiring licenses for the sale of alcohol, prohibiting the distribution of alcohol to minors, and serving alcohol to intoxicated persons. Serving alcoholic beverages entails incurring oral as well as potential legal and financial liability for those who become intoxicated. It is expected that responsibility will be taken for the safety of persons who become intoxicated at church functions (up to and including transportation for those whose driving might be impaired.)

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APPENDIX C

RECOVERY MINISTRIES OF THE EPISCOPAL CHURCH, INC.

Recovery Ministries is an independent, nationwide network of Episcopal laity and clergy, dioceses and parishes, schools, agencies, and other institutions – all with a common commitment to address the effects of addiction, in all its forms, in relation to the church’s mission.

The Recovery Ministries network serves as a voice of conscience to Episcopalians throughout the world, building awareness of pastoral and spiritual ministry to those addicted. The original concept for Recovery Ministries’ mission dates from the landmark 1979 General Convention resolution on alcohol.

Recovery Ministries of the Episcopal Church is an organization with a mission to those who, through addiction, have lost their health and freedom. The ministry seeks to:

- Help the addicted and those who love them connect with spiritual resources and find lasting recovery.
- Witness to Christ’s unfailing mercy by welcoming unchurched members of Alcoholics Anonymous and other 12-Step programs into an Episcopal faith community.
- Raise the awareness of bishops, and other clergy, about the disease of addiction and the redemption and grace found in recovery.
- Strengthen recovering Episcopalians in the work of their recovery and help proclaim the Gospel in the world and carry their recovery into the Church.

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APPENDIX D

DIOCESE OF NEW JERSEY

RECOVERY MINISTRIES OF THE DIOCESE OF NEW JERSEY

Commission Members

*The Reverend Cathy Brunson, Dcn., Chair
(732) 778-7685
c.brunson01@comcast.net

*The Rev. Dr. Judith Krom, Dcn., Co-Chair
(732) 330-4949
jsk13@comcast.net

*The Rev. Dr. Hugh Brown III
(609) 921-2420
hughandelly@AOL.com

*The Rev. Dot Hospador, Dcn.
(732) 406-8551
dnhospador@gmail.com

*Lucy Proctor
(609) 865-5576
LBPSCAR71@yahoo.com

Catherine Regan-DeCicco
(609) 693-0215
mkdecicco@comcast.net

*Harriet S. Stuart
(609) 921-9543
pugsrule6@gmail.com

The persons listed above shown with an asterisk (*) are available to assist local clergy in establishing a Recovery Sunday. They are also available to speak on the subject of alcohol addiction at other times, when invited.

APPENDIX E
COMPENDIUM OF
MOST COMMONLY MISUSED SUBSTANCES

The following pages delineate the street names, commercial names, common forms, common ways taken, possible health effects and treatment options for the specific substances. An outline is provided here for the reader's convenience.

A. ALCOHOL

B. DRUGS

1. Marijuana
2. Anabolic Steroids
3. Bath Salts
4. Cocaine
5. Hallucinogens
 - a. MDMA (Ecstasy, Molly)
 - b. LSD
 - c. PCP
 - d. Psilocybin
6. Heroin
 - a. Fentanyl
7. Inhalants
8. Ketamine
9. Over-the-Counter Cough/Cold Medicines
 - a. Dextromethorphan (DXM)
9. Prescription Drugs
 - a. Opioids
 - b. Sedatives
 - 1) Tranquilizers
 - 2) Depressants
 - c. Stimulants

A. ALCOHOL

1. Alcoholics often start out with wine and beer because they are inexpensive and readily available.
2. The fact that “it’s only beer” makes no difference when a person uses beer or wine to excess. Excessive and continued use of beer or wine can lead to alcoholism.
3. Because alcohol is legal to purchase in the US, providing one is old enough, it is commonly available throughout the Country.
4. Sometimes adults will purchase alcoholic beverages for underage individuals.

B. DRUGS

1. Marijuana

Marijuana refers to the dried leaves, flowers, stems and seeds from the hemp plant, *Canabis sativa*. The plant contains the mind-altering chemical *delta-9-tetrahydrocannabinol* (THC) and other related compounds. Extracts with high amounts of THC can also be made from the cannabis plant.

As documented in the SAMHSA 2014 National Survey on Drug Use and Health, marijuana is the most commonly used illicit drug in the United States. Its use is widespread among young people. According to a yearly survey of middle and high school students, rates of marijuana use have steadied in the past few years after several years of increase. The Institute for Social Research at the University of Michigan, however, found that the number of young people who believe marijuana use is risky is decreasing. Legalization of marijuana for medical uses or adult recreational use in a growing number of states may affect these views.

People smoke marijuana in hand-rolled cigarettes (joints) or in pipes or water pipes (bongs). They also smoke it in blunts—emptied cigars that have been partly or completely refilled with marijuana. To avoid inhaling smoke, more people are using vaporizers. These devices pull the active ingredients (including THC) from the marijuana and collect their vapor in a storage unit. A person then inhales the vapor, not the smoke. Users can mix marijuana in food (edibles), such as brownies, cookies, or candy or brew it as a tea. A newly popular method of use is smoking or eating different forms of THC-rich resins.

When a person smokes marijuana, THC quickly passes from the lungs into the bloodstream. The blood carries the chemical to the brain and other organs throughout the body. The body absorbs THC more slowly when the person drinks it. In that case the user

generally feels the effects after 30 minutes to an hour. Short term effects include: altered senses (for example, seeing brighter colors); altered sense of time; changes in mood; impaired body movement; difficulty with thinking and problem-solving and impaired memory.

Marijuana also affects brain development. When marijuana users begin using as teenagers, the drug may reduce thinking, memory, and learning functions and affect how the brain builds connections between the areas necessary for these functions.

???

Is Marijuana a gateway drug?

Some say Yes; some say No.

Marijuana's effects on these abilities may last a long time or even be permanent. For example, a study showed that people who started smoking marijuana heavily in their teens and had an ongoing cannabis use disorder lost an average of eight IQ points between ages 13 and 38. The lost mental abilities did not fully return in those who quit marijuana as adults. Those who started smoking marijuana as adults did not show notable IQ declines. Other health effects include breathing problems, increased heart rate and problems with child development during and after pregnancy

Is marijuana a gateway drug? Some research suggests that marijuana use is likely to come before use of other drugs. Marijuana use is also linked to addiction to other substances, including nicotine. In addition, animal studies show that the THC in marijuana makes other drugs more pleasurable to the brain. Although these findings support the idea of marijuana as a "gateway drug," the majority of people who use marijuana do not go on to use other "harder" drugs.

2. Anabolic Steroids

Anabolic Steroids refers to synthetic variants of the male sex hormone testosterone. The proper term for these compounds is anabolic-androgenic steroids (abbreviated AAS—"anabolic" referring to muscle building and "androgenic" referring to increased male sexual characteristics.) Steroids can be prescribed for certain medical conditions; however, they are often abused to increase muscle mass and to improve athletic performance or physical appearance. Anabolic steroids are usually either taken orally or injected into the muscles,

although some are applied to the skin as a cream or gel. Doses taken by abusers may be 10 to 100 times higher than doses prescribed to treat medical conditions.

Anabolic steroids work very differently from other addictive drugs; they do not have the same acute effects on the brain. However, long-term steroid use can affect some of the same brain pathways and chemicals—including dopamine, serotonin, and opioid systems—that are affected by other drugs. Thus, they may have a significant impact on mood and behavior. Other serious consequences of steroid abuse can include heart disease, liver problems, stroke, infectious diseases, depression, and suicide. Less serious side effects include severe acne and changes in sex characteristics, like shrinking of the testicles in men and growth of facial hair in women.

3. Bath Salts

The term “bath salts” refers to an emerging family of drugs containing one or more synthetic chemicals related to cathinone, an amphetamine-like stimulant found naturally in the khat plant. Reports of severe intoxication and dangerous health effects associated with the use of bath salts have made these drugs a serious and growing public health and safety issue. Some users experience paranoia, agitation, hallucinatory delirium, psychotic and violent behavior. Deaths have also been reported.

These synthetic cathinone products—marketed as “bath salts” to evade detection by authorities—should not be confused with products such as Epsom salts for bathing. Bath salts typically take the form of a white or brown crystalline powder and are sold in small plastic or foil packages labeled “not for human consumption.”

4. Cocaine

Cocaine is a short-acting stimulant, which can lead users to “binge”—take the drug many times in a single session. Cocaine use can lead to severe medical consequences related to the heart and the respiratory, nervous, and digestive systems. Cocaine users can also experience severe paranoia, in which they lose touch with reality.

The powdered form of cocaine is either inhaled through the nose (snorted), where it is absorbed through the nasal tissue, or dissolved in water and injected into the bloodstream. Crack is a form of cocaine that has been processed to make a rock crystal (also called “freebase cocaine”) that can be smoked. The crystal is heated to produce vapors that are absorbed into the bloodstream through the lungs. (The term “crack” refers to the crackling sound produced by the rock as it is heated.)

5. Hallucinogens

The effects of hallucinogens—perception-altering drugs—are highly variable and unreliable, producing different effects in different people at different times. This is mainly due to

differences in the amounts and chemistries of active compounds within the drugs. Because of their unpredictable nature, the use of hallucinogens can be particularly dangerous. Examples of hallucinogens include:

a. [MDMA \(Ecstasy, Molly\)](#)

(3,4-methylenedioxymethamphetamine) produces both stimulant and mind-altering effects. It can increase body temperature, heart rate, blood pressure, and heart-wall stress. Ecstasy may also be toxic to nerve cells. It is taken orally, usually as a capsule or tablet. Its effects last approximately 3 to 6 hours, although it is not uncommon for users to take a second dose of the drug as the effects of the first dose begin to fade. Ecstasy is commonly taken in combination with alcohol and other drugs.

Molly—slang for “molecular”—refers to the pure crystalline powder form of ecstasy. Users may seek out Molly to avoid the adulterants or substitutes known to be commonly found in ecstasy, but those who purchase what they think is pure ecstasy may actually be exposing themselves to the same risks, since Molly often contains toxic additives. In fact, Molly is often nothing more than repackaged ecstasy.

b. [LSD](#)

LSD is one of the most potent hallucinogenic drugs. Its effects are unpredictable, and users may see vivid colors and images, hear sounds, and feel sensations that seem real but do not exist. Users also may have traumatic experiences and emotions that can last for many hours. Some short-term effects can include increased body temperature, heart rate, and blood pressure; sweating; loss of appetite; sleeplessness; dry mouth; and tremors.

c. [PCP](#)

PCP (phencyclidine) was developed in the 1950s as an intravenous anesthetic. Its legitimate use has since been discontinued due to serious adverse effects.

d. [Psilocybin](#)

Psilocybin is obtained from certain types of mushrooms that are found in tropical and subtropical regions of South America, Mexico, and the United States. These mushrooms typically contain less than 0.5 percent psilocybin plus trace amounts of psilocin, another hallucinogenic substance.

6. [Heroin and Fentanyl](#)

Heroin is a powerful opioid drug that produces euphoria and feelings of relaxation. It slows respiration and can increase the risk of serious infectious diseases, especially when taken intravenously. Regular heroin use changes the functioning of the brain, causing tolerance

and dependence. Other opioid drugs include morphine, OxyContin®, Vicodin®, and Percodan®, which have legitimate medical uses; however, using them in ways other than prescribed (or using them without a prescription) can result in the same harmful consequences as heroin use.

A currently popular but deadly cousin of heroin is Fentanyl. In a front page article in the *Asbury Park Press* [part of the *USA Today* network] on Sunday, November 20, 2016, writer Ken Serrano wrote the following:

It's a weapon of mass destruction that comes in a package smaller than a brick.

Just 2 milligrams, about the size of a pinch of salt, will kill you.

It's heroin's much deadlier cousin, fentanyl. Dealers put it into heroin to intensify the high.

A kilogram of the synthetic opioid could, theoretically, kill 500,000 drug users.

It's cheap. It's powerful. And it's been nearly impossible to stop.

DEA agents seized 37 kilograms of pure fentanyl – about the size of a wheel barrel of bricks – in the state [New Jersey] this year. It was enough to kill 19.9 million people. That's double the population of New Jersey. Each brick costs as little as \$2,700 from illegal producers in China.

The potential profit a drug dealer could have made from those 37 kilos once sold to users? \$740 million.

7. Inhalants

These are volatile substances found in many household products (such as oven cleaners, gasoline, spray paints, and other aerosols) that induce mind-altering effects. Inhalants are extremely toxic and can damage the heart, kidneys, lungs, and brain. Even a healthy person can suffer heart failure and death within minutes of a single session of the prolonged sniffing of an inhalant.

People tend to abuse different inhalant products at different ages. New younger users (ages 12–15) most commonly abuse glue, shoe polish, spray paints, gasoline, and lighter fluid. First-time older users (ages 16–17) most commonly abuse nitrous oxide, or “whippets.” Adults most commonly abuse a class of inhalants known as nitrites (such as amyl nitrites, or “poppers”).

8. Ketamine, Rohypnol, GHB

These have come to be known as “date rape” drugs because they can cause someone to lose their memory of an assault. Rohypnol® and GHB can easily be added to beverages and ingested unknowingly. Any of these drugs can also cause some to lose consciousness. Ketamine and GHB are predominately central nervous system depressants whereas Rohypnol® is a benzodiazepine.

9. OVER-THE-COUNTER COUGH/COLD MEDICINES

(Dextromethorphan or DXM)

NAMES	
Street Names	Robotripping, Robo, Triple C
Commercial Names	Various (many name brands include “DM”)
Common Forms	Syrup, Capsule
Common Ways Taken	Swallowed
POSSIBLE HEALTH EFFECTS	
Short term	Euphoria; slurred speech; increased heart rate, blood pressure, temperature; numbness; dizziness; nausea; vomiting; confusion; paranoia; altered visual perceptions; problems with movement; buildup of excess acid in body fluids
Long Term	Unknown
Other Health-related issues	Breathing problems, seizures, and increased heart rate may occur from other ingredients in cough/cold medicines
In combination with alcohol	Increased risk of adverse effects
Withdrawal symptoms	Unknown
TREATMENT OPTIONS	
Medications	There are no FDA-approved medications to treat addiction to over-the-counter cough/cold medicines
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to over-the-counter cough/cold medicines

10. PRESCRIPTION DRUGS

a. OPIOIDS

Pain relievers with an origin similar to that of heroin, opioids can cause euphoria and are often used non-medically, leading to overdose deaths.

A Street Names	Commercial Names	Common Forms	Common Ways Taken
Captain Cody, Cody, Lean, Schoolboy, Sizzurp, Purple Drank <i>With glutethimide:</i> Doors &Fours, Loads, Pancakes and Syrup	Codeine (various brand names)	Tablet, capsule, liquid	Injected, swallowed (often mixed with soda and flavorings)
Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, Tango & Cash, TNT	Fentanyl (Actiq, Duragesic, Sublimaze)	Lozenge, sublingual, tablet, film, buccal tablet	Swallowed, snorted, injected
Vike, Watson-387	Hydrocodone or dihydrocodeinone (Vicodin, Lortab, Lorcet, and others)	Capsule, liquid, tablet	Swallowed, snorted. injected
“D,” Dillies, Footballs, Juice, Smack	Hydromorphone (Dilaudid)	Liquid, Suppository	Injected, rectal
Demmies, Pain Killer	Meperidine (Demerol)	Tablet, liquid	Swallowed, injected
Amidone, Fizzies <i>With MDMA:</i> chocolate chip cookies	Methadone (Dolophine, Methadose)	Tablet, dispersible tablet, liquid	Swallowed, injected
“M,” Miss Emma, Monkey, White Stuff	Morphine (Duramorph, Roxanol)	Tablet, liquid, capsule, suppository	Injected, swallowed, smoked
O.C., Oxycet, Oxycotton, Oxy, Hillbilly, Heroin, Percs	Oxycodone (OxyContin, Percodan, Percocet, and others)	Capsule, liquid, tablet	Swallowed, snorted, injected
Biscuits, Blue Heaven, Blues, Mrs. O, O Bomb, Octagons, Stop Signs	Oxymorphone (Opana)	Tablet	Swallowed, snorted, injected

POSSIBLE HEALTH EFFECTS	
Short-term	Pain relief, drowsiness, nausea, constipation, euphoria, confusion, slowed breathing, death
Long-term	Unknown
Other Health-Related Issues	<ul style="list-style-type: none"> • Pregnancy: miscarriage, low birth weight, neonatal abstinence syndrome. • Older Adults: higher risk of accidental misuse or abuse because many older adults have multiple prescriptions, increasing the risk of drug-drug interactions, and breakdown of drugs slows with age; also, many older adults are treated with prescriptions for pain. • Risk of HIV, hepatitis, and other infectious diseases from shared needles.
In combination with alcohol	Dangerous slowing of heart rate and breathing leading to coma or death
Withdrawal Symptoms	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps (“cold turkey”), leg movements
TREATMENT OPTIONS	
Medications	Methadone; Buprenorphine; Naltrexone (short- and long-acting)
Behavioral Therapies	Behavioral therapies that have helped treat addiction to heroin may be useful in treating prescription opioid addiction

b. SEDATIVES

The following medications (tranquilizers and depressants) slow brain activity, making them useful for treating anxiety and sleep problems.

Street Names	Commercial Names	Common Forms	Common Ways Taken
Barbs, Phennies, Red Birds, Reds, Tooies, Yellow Jackets, Yellows	Barbiturates: pentobarbital (Nembutal), phenobarbital (Luminal)	Pill, capsule, liquid	Swallowed, injected

Candy, Downers, Sleeping Pills, Tranks	Benzodiazepines: alprazolam (Xanax), Chlorodiazepoxide (Limbitrol), diazepam (Valium), lorazepam (Ativan), triazoam (Halicon)	Pill, capsule, liquid	Swallowed, injected
Forget-me Pill, Mexican Valium, R2, Roche, Roofies, Roofinal, Rope, Rophies	Sleep Medications: eszopicione (Lunesta), zaleplon (Sonata), zolpidem (Ambien)	Pill, capsule, liquid	Swallowed, injected

POSSIBLE HEALTH EFFECTS

Short-term	Drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing
Long-term	
Other Health-related Issues	Sleep medications are sometimes used as date rape drugs; risk of HIV, hepatitis, and other infectious diseases from shared needles
In combination with Alcohol	Further slows heart rate and breathing, which can lead to death
Withdrawal Symptoms	Must be discussed with health care provider; barbiturate withdrawal can cause a serious abstinence syndrome that may even include seizures
Medications	There are no FDA-approved medications to treat addiction to prescription sedatives; lowering the dose over time must be done with the help of a health care provider
Behavioral Therapies	More research is needed to find out if behavioral therapies can be used to treat addiction to prescription sedatives



c. STIMULANTS

Prescription stimulants are medications that increase alertness, attention, energy, blood pressure, heart rate, and breathing rate.

Street Names	Commercial Names	Common Forms	Common Ways Taken
Bennies, Black Beauties, Crosses, Hearts, LA Turnaround, Speed, Truck Drivers, Uppers	Amphetamine (Adderall, Benzedrine)	Tablet, capsule	Swallowed, snorted, smoked, injected
JIF, MPH, R-ball, Skippy, The Smart Drug, Vitamin R	Methylphenidate (Concerta, Ritalin)	Liquid, tablet, chewable tablet, capsule	Swallowed, snorted, smoked, injected, chewed
POSSIBLE HEALTH EFFECTS			
Short-term	Increased alertness, attention, energy; increased blood pressure and heart rate; narrowed blood vessels; increased blood sugar; opened-up breathing passages. High doses: dangerously high body temperature and irregular heartbeat; heart failure; seizures		
Long-term	Heart problems, psychosis, anger, paranoia		
Other health-related Issues	Risk of HIV, hepatitis/other infectious diseases from shared needles		
In combination with Alcohol	Masks the depressant action of alcohol, increasing risk of alcohol overdose; may increase blood pressure and jitters		
Withdrawal Symptoms	Depression, tiredness, sleep problems		
TREATMENT OPTIONS			
Medications	There are no FDA-approved medications to treat stimulant addiction		
Behavioral Therapies	Behavioral therapies that have helped treat addiction to cocaine or methamphetamine may be useful in treating prescription stimulant addiction		

APPENDIX F

TREATMENT OPTONS WITHIN THE DIOCESE OF NEW JERSEY

In the Diocese of New Jersey, many resources are available to the clergy seeking help for a hurting parishioner. These resources are outlined below.

EMERGENCIES

If an addicted person is in physical distress and in imminent physical danger, the person must be admitted to a Hospital Emergency Room immediately. Treatment of the addiction will begin when the person's health is stabilized and a course of action is thoughtfully determined.



NON-EMERGENCY SITUATIONS

For the non-emergency cases, there are multiple treatment centers in any given geographic area. If a person is in need of treatment, a careful search should be done to meet the needs of the individual.

Usually, as the first step toward sobriety, the addicted person undergoes detoxification. "Detox" is the term generally used to help people initially cleanse their bodies of the substance(s) to which they are addicted. Detox usually is a 5-7 day in-patient program, done in a medical setting in order to carefully monitor and treat the symptoms which a person may experience during this time. Most times after a period of detox, the person will go directly into rehab. Very few rehab centers will take a client directly into their program without first going to detox.

When searching for a detox facility for an alcoholic, it is best to start by calling Alcoholics Anonymous. The Drug Addiction emergency help line shown below will help with drug-related issues.

AA Hotline 1-800-245-1377

Drugs Help Line 1-800-601-7202

AA's 24/7 toll-free hotline number in New Jersey is 1-800-245-1377. For calls outside of New Jersey, the number is 908-687-8566 (not toll free). For drug addiction, call 1-800-601-7202 or go to www.drugstrategies.org on line. Another helpful site is www.recovery.org. These are not the only resources, however, and an internet search can yield many good resources using the key words "addiction rehabilitation."

Treatment is generally based on the substance/behavior to which the person is addicted, his/her ability to enter long term care (typical length of in-patient treatment is generally 28-30 days), and his/her insurance coverage. A careful internet search using “addiction treatment” as a key word search will help you uncover many resource numbers. An option to in-patient care would be Intensive Outpatient Care or IOP. These programs generally are attended three times a week at a local treatment center. Again, the choice is based on the same criteria of time and payment options.

OTHER PROFESSIONAL RESOURCES

- New Jersey Department of Human Services / Hotlines
 - www.nj.gov/humanservices/dmhas/home/hotlines/
 - 1-844-276-2777 (free)
 - Incident Reporting within Mental Health Community Agency Settings
 - Assists in locating programs for alcohol and drug abuse treatment and related services
 - Provides information and referral to substance abuse treatment agencies statewide

- Central Jersey Intergroup – Alcoholic Anonymous in Central New Jersey
 - www.centraljerseyintergroup.org
 - 24-hour emergency hotline: 609-298-7785
 - Made up of the AA groups in the Trenton and surrounding areas
 - Will provide meeting locations and phone numbers

- South Jersey Intergroup Association, Inc. – Alcoholics Anonymous in South Jersey
 - www.info@aasj.org
 - Telephone: 856-486-4444 (or 4446) (free)

- Substance Abuse Treatment Facility Locator (nation-wide)
 - <http://findtreatment.samhsa.gov>
 - 24-hour free hotline: 1-800-662-HELP (4357)
 - In Spanish and English
 - Maintained by the federal government (SAMHSA)
 - Provides referrals to local treatment facilities, support groups and community-based organizations
 - Receives nearly 28,000 calls per month

LIST OF COUNTIES WITHIN DIOCESE TO CONTACT FOR DRUG AND ALCOHOL PREVENTION:

- Atlantic – 609-645-5932 - (Public Health)
- Burlington – 609-265-5000
- Camden – 856-427-6553
- Cape May – 609-522-5960
- Cumberland – 856-451-3727 – (“First Step”)
- Gloucester – 856-384-6886 – (Disability Dept.)
- Hunterdon – 908-782-3909 or 908-788-1253
- Mercer – 609-396-5874
- Middlesex – 732-254-3344
- Monmouth – 732-431-6451
- Ocean – 732-367-5515
- Somerset – 908-704-6300
- Union – 908-527-4844

OTHER DIOCESAN RESOURCES

1. Recovery Ministries of the Diocese of New Jersey – “Our sole purpose is the wholeness of all who are affected by the disease of drug and alcohol dependency. We seek to be proactive in the diocese and responsive to the medical and pastoral needs of parishes and persons through education, intervention, advice and referral.”
2. Commission members’ expertise – Several members of the Commission are recovering alcoholics and/or have belonged to AA/AI-Anon. They are willing to provide assistance to any clergy person who wishes to avail him/herself of their services, including in-person visits, private consultations and meetings with other clergy. They will help with the planning of activities within the church that deal with alcohol and drugs.

3. Parish Recovery Sunday Services -- Individual churches hold recovery services in their own facilities. Speakers from the Commission are often featured. Information on alcohol and drug recovery is available. Consultation on how to set up a Recovery Sunday is available through this Commission.
4. Diocese-Recovery Sunday 12 Step Service -- This is a Diocesan-wide Eucharistic celebration of those in recovery who have found a new freedom and a new happiness in sobriety. Family and friends are invited to this joyous and wonderful celebration and 12 Step Recovery Service. There is a reception following the Service. It is a joy to celebrate our release from bondage and our happiness in a new life in Christ. The service is sponsored by the Diocesan Recovery Commission.

SUGGESTIONS TO CLERGY

- Attend open meetings of AA and NA to understand purpose and function; meet local people who can help.
- Understand the language of sobriety which is different from the usual, sometimes negative, common usage of words and concepts like “surrender,” “powerlessness,” “humility,” and others.
- Read and collect AA, NA and other pamphlets; make available to congregation.
- Review Diocesan alcohol policy to determine your church’s compliance.
- Read biographies and other books of recovering people.

- James Brown: [*The Los Angeles Diaries: A Memoir*](#) (2011)

A wrenching chronicle of loss and reaffirmation from novelist James Brown. Plagued by the suicides of both his siblings, heir to alcohol and drug abuse, divorce and economic ruin, James Brown lived a life clouded by addiction, broken promises and despair.

- Jim Carroll: [*The Basketball Diaries*](#) (1987)

The original classic story about growing up with drugs and sex and about learning to survive on the streets of New York. An urban classic of coming of age.

- Bill Clegg: [*Portrait of an Addict as a Young Man: A Memoir*](#) (2011)

Author had a thriving business as a literary agent, a supportive partner, trusting colleagues, and loving friends when he walked away from his world and embarked on a two-month crack binge. He had been released from rehab nine months earlier, and his relapse would cost him his home, his money, his career, and very nearly his life.

- Mary Karr: [*Lit*](#) (2010)

Story of a self-professed black belt sinner's descent into the inferno of alcoholism and madness—and to her astonishing resurrection. *LIT* is about getting drunk and getting sober; becoming a mother by letting go of a mother; learning to write by learning to live

- Heather King: [*Parched*](#) (2006)

A powerful memoir of King's life on the lam, telling how she became her drinking self, spending over twenty years in a cycle of drinking and self-loathing. From highly functioning alcoholic to living in dive bars, King's painful and poignant story tells how she evolved, and how, suddenly and dramatically, she stopped, and changed her life.

- Caroline Knapp: [*Drinking: A Love Story*](#) (1997)

Author started drinking in her early teens and began to use alcohol as "liquid armor," a way to protect herself against the difficult realities of life.

- Ann Lamott: [*Imperfect Birds: A Novel*](#) (2011)

The life of this "perfect" seventeen-year-old isn't nearly as perfect as her mother believes. Disturbing signs indicate that Rosie is not immune to the dark impulses towards drugs and alcohol. Gradually her mother and alcoholic step-father are forced to confront the fact that Rosie has been lying to them and that her deceptions have profound consequences.

- Bill W.: [*Bill W.: My First Forty Years: An Autobiography by the Co-Founder of AA*](#) (2005)

Told in his own words, this is the story of the man who would come to be known as Bill W., a man who, for his part in founding the fellowship of *Alcoholics Anonymous*, would be celebrated as one of the important figures of the twentieth century.

- David Lee Westfall: [*My Name is Dave*](#) (2005)

The journey of one man as he gives insight into his life. From humble beginnings in rural West Virginia, through self-destructive emotions and behavior, to triumph over alcoholism and gambling.

- Watch movies which tell the story of addiction.

- [*Days of Wine and Roses*](#) (1962)

Jack Lemmon, Lee Remick

The pressures of business lead Joe to seek solace in liquor. Kirsten joins him and before long both are confirmed alcoholics. After several frightening episodes, Joe is able to shake the habit thanks to AA, but Kirsten is not. The two split up, although Joe clings to the hope that someday he and Kirsten will be reunited, if for no reason other than the sake of their young daughter. Henry Mancini's title song won an *Oscar* for Best Song in 1963 while Lemmon was nominated for Best Actor and Remick was nominated for Best Actress.

- [*Lost Weekend*](#) (1945)

Ray Milland, Jane Wyman, Philip Terry

Searing portrait of an alcoholic features Ray Milland as Don Birnam, a writer whose lust for booze consumes his career, his life, and his loves. "One's too many and a thousand's not enough." The film won four Oscars in 1946: Best Picture, Best Director (Billy Wilder), Best Actor (Milland), and Best Screenplay.

- [28 Days](#) (2000)

Sandra Bullock, Dominic West, Steve Buscemi, Viggo Mortensen

In this romantic comedy, a journalist who's become too much the life of the party finds a new lease on life in a drug and alcohol treatment center. Legendary rock band NRBQ performs at the wedding reception.

- [Leaving Las Vegas](#) (1995)

Nicolas Cage, Elisabeth Shue,

Grim drama documents a romantic triangle of sorts involving a prostitute and a failed Hollywood screenwriter, and the constant flow of booze which he loves more dearly than life itself. A darkly comic tragedy, it charts the brief romantic convergence of two desperately needy people who together find a brief flicker of happiness. Nicolas Cage won an *Oscar* for Best Actor and Ms. Shue was nominated for Best Actress.

- [The Rose](#) (1979)

Bette Midler, Frederic Forrest, Alan Bates

In her debut role, Bette Midler stars as Rose in this somber drama loosely based on the life of the late Janis Joplin. She plays an ill-fated singer who succumbs to the pressures of performing by indulging in drugs and alcohol. Her sweetheart is the former chauffeur who naively tries to save her from self-destruction, while her British manager is ultimately blamed for not preventing her inevitable fall. Midler and Forrest were nominated for Oscars for their performances. *The Rose* was a box office smash and was the plum role that elevated Midler to star status in the eyes of the public and Hollywood.

- [Clean and Sober](#) (1988)

Michael Keaton, Morgan Freeman, Kathy Baker

Intense, gritty drama was received as one of the best-ever cinematic treatments of substance abuse. A hustling, successful Philadelphia real estate agent, who has become addicted to cocaine, embezzles from his employer and loses on the stock market, wakes up one morning with a young woman dead in his bed

from a coke overdose. He decides to hide out in an anonymous drug treatment program and finds romance with an abused fellow addict. Keaton won the National Society of Film Critics Award for Best Actor in 1988.

- [*When a Man Loves a Woman*](#) (1994)

Meg Ryan, Andy Garcia, Tina Majorino

A dramatic treatment of a family torn apart by alcoholism and recovering from it, the wife hits bottom and goes into a clinic for rehab. When she returns home, she has kicked her addiction and has become independent and strong. Her perfectionist, controlling husband has trouble adjusting. He is used to his wife being weak and helpless, and they end up seeing a marriage counselor to recover from his "co-dependency."

- [*Ironweed*](#) (1987)

Jack Nicholson, Meryl Streep, Tom Waits

Based on the William Kennedy novel of the same name, *Ironweed* is set in the waning years of the Depression. A washed-up ballplayer accidentally kills his infant son. He finds solace in drinking and seeks out his girlfriend and former drinking companion who has begun prostituting herself for drink and lodging. Eventually, a chance for a reconciliation with his wife emerges. The movie won Oscar nominations for both Nicholson and Streep.

- [*My Name is Bill W.*](#) (1989)

James Woods, James Garner

Story of WWI vet Bill Wilson (Woods) who returns from combat with a drinking problem. His drinking continues through Prohibition until 1929 when he suffers financial ruin and he sinks into flat-out alcoholism, losing his family and reputation in the process. While drying out in detox, Wilson strikes up a friendship with Bob Smith (Garner), an alcoholic doctor. Through Smith's influence, Bill Wilson organizes a small band of chronic drinkers into what will eventually become Alcoholics Anonymous. Aired originally on TV as *The Promise*, a Hallmark Hall of Fame TV special, Woods won an Emmy for his portrayal of Wilson.

- [Bill W.](#) (2012)

Blake Evans, Chris Gates

This feature length biographical documentary, directed by Dan Carracino and Kevin Hanlon, chronicles the life of Bill Wilson, co-founder (along with Dr. Bob Smith) of AA. The voices of Bill W. and Dr. Bob are heard as themselves. The movie received very good reviews.

- [Smashed](#) (2012)

Aaron Paul, Mary Elizabeth Winstead

A married couple finds their love affair with alcohol threatening to unravel their relationship. Relationships with family and co-workers deteriorate until Kate realizes she has to get sober in order to pull out of her downward spiral. She finds her husband is reluctant to join her, and she starts to see their relationship in a new light. Meanwhile, once she gathers the courage to set the bottle aside, the real fight begins.

- [Sarah T: Portrait of a Teenage Alcoholic](#) (1975)

Linda Blair, Mark Hamill, Larry Hagman

Sarah begins drinking socially at high school parties because the other kids do it and soon finds that she can't stop, nor can she keep her boozing a secret. After a near-tragic baby-sitting episode, Sarah decides to attend Alcoholics Anonymous, but soon she's back on the hard stuff. Only when Sarah causes the death of a horse does she strengthen her resolve to remain "clean and sober." Not available on video or DVD but can be viewed on *YouTube*.



The Diocese of New Jersey

808 West State Street

Trenton, New Jersey 08618

609 394-5281

www.dioceseofnj.org