Pastoral Care Newsletter

For Member Care Committees, Ministry and Counsel, Overseers, and others who provide pastoral care in unprogrammed Friends meetings

Vol. 11, No. 4 • June 2004

Pastoral Care in Situations of Drug Abuse

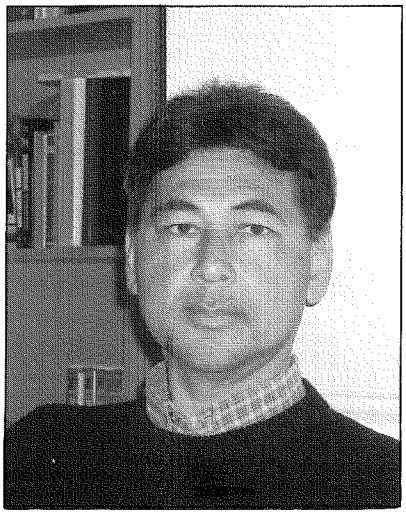
by John J. Blum

Friends, whatever ye are addicted to, the tempter will come in that thing; and when he can trouble you, then he gets advantage over you, and then you are gone. Stand still in that which is pure, after ye see yourselves; and then mercy comes in. After thou seest thy thoughts, and the temptations, do not think, but submit; and then power comes. Stand still in that which shows and discovers; and then doth strength immediately come. And stand still in the Light, and submit to it, and the other will be hastened and gone; and then content comes. George Fox, 1652.

~~~~~

As pastoral care providers, we may find ourselves deeply challenged if we are called upon to give care in a situation involving drug abuse. Friends caregivers seem to do quite well attending to traumatic events like serious illnesses, sudden deaths and the like—what I like to call the "flash fires" of life. We tend to have more difficulty addressing ongoing and complicated traumas—the "smoldering fires." Issues of drug abuse tend to be both: smoldering fires that develop over a period of years and may take a long time to resolve punctuated with flash-fire periods of crisis. Along the way those in our care present us with a wide array of emotions and discord, frustrations and pain, exasperation and resignation.

These challenges and dilemmas will come not only from the drug abuser, but also (and perhaps more importantly) from the immediate family and friends. How can we offer Friendly support and comfort during such difficult times?



John Blum

Understanding Drug Abuse

Since most of us have little or no training or experience responding to addiction, we may feel anxious, even overwhelmed, when confronted with these issues.

It is very important for pastoral care providers to understand that substance abusers and distressed family members are not mean or evil people. They are children of God who are struggling, often very desperately, with a disease process that has altered their basic brain chemistry. Drug abusers suffer from tremendous guilt and shame about hurting themselves and those around them, yet are often unable to express those feelings, continuing to use substances while engaging in various forms of denial to avoid facing the exact nature and extent of the problem.

As a result of substance abuse, their physical, psychological and spiritual well-being has been compromised, resulting not only in assorted medical problems, poor impulse control and judgment, moodiness, social isolation and withdrawal, but also in a distancing from the Spirit.

For the purpose of this discussion, we shall define a "drug" to include all addictive substances, including alcohol, licit and illicit drugs, and nicotine. Similarly, we shall use the words "drug" and "substance" interchangeably to mean the same thing.

Defining "drug abuse" is a bit more complicated. How does drug *use* differ from drug *abuse* and from drug *dependence or addiction.* The distinction is a matter of degree:

Drug use refers to occasional and limited consumption of a drug (licit and illicit) *without significant negative consequences.* An example might be the occasional glass or two of beer or wine.

Drug abuse is characterized by struggles with fulfilling important roles (school/job attendance, child care, etc.); risky or dangerous substance use that is ongoing (drunk driving, purchasing illicit drugs); continued use despite recurrent legal problems (drunk driving arrests, disorderly conduct, domestic violence, drug possession, etc.), and/or
~~~~~

continued use despite social or interpersonal problems (estrangement from family and friends, social isolation).[1]

Drug dependence or addiction includes physical, emotional, and social dysfunctions such as: substance tolerance (needing increasing amounts due to the body's habituation to previous levels of use, i.e. "holding one's liquor"); withdrawal symptoms when stopping substance use (anxiety, sleeplessness, irritability, cardiovascular changes, physical shaking and tremors, nausea, vomiting, diarrhea, chills, etc.); loss of control (consuming more alcohol or drug than originally intended); previous failures to control, reduce or eliminate substance use (relapses); more time spent on substance-related activities (thinking, planning, using, recovering from substance use) than non-substance-related activities (family, work/school, social, leisure, spiritual); and continued substance use despite knowledge of its relationship to physical or psychological distress.

A drug abuser's physical, psychological and spiritual well-being has been compromised.

This progression from use to abuse to dependence/addiction does not happen to everyone, since most people either don't use addictive substances at all or, if they do, use them infrequently or in low-to-moderate doses without negative consequences.

Still, pastoral care providers may find themselves called upon by family members who are worried or distressed by casual use. They may bring concerns about adolescent experimentation or about occasional risk-taking behaviors involving alcohol or illicit drug use. While this article deals mainly with supporting individuals and families dealing with drug *abuse* and *addiction*, it is important for the meeting to be responsive to the very real concerns families might have about casual use. There is always a role for caregivers to listen with compassion and to assist the concerned person in discerning next steps.

Effects on Family and Friends.

The causes [of addictive behavior] go deep and may not be fully understood; but the resulting pain, fear, desperation, and denial, damaging the abuser and all around that person, need to be supportively recognized. Faith & Practice, Baltimore Yearly Meeting.

As pastoral care providers, we are more likely to be approached by a concerned family member or friend than the substance abuser. In contacting the caregiving committee, the family member may bring a wide range of strong emotions—shame, guilt, sadness, confusion, anger. They may have worked at holding the family together, being tolerant and supportive, caretaking, rescuing, ignoring, concealing, placating, walking on eggshells. They may feel deceived, belittled, blamed, and abused (verbally, emotionally, or physically). By the time they approach us, they may be at wit's end with the substance abuser and feeling trapped with few or no options. They may have already become sick themselves (emotionally and physically), if not well on the road to it. They may even feel guilty about the intensity of their feelings towards the abuser. And they are likely to be angry because they have felt the brunt of the harsh consequences of substance abuse.

Just as the addicted is substance dependent, family and friends, and even the meeting's caregivers, may become "codependent" on that person. *"A codependent person is one who has let another person's behavior affect him/her, and who is obsessed with controlling that person's behavior."*[2]

It is often easier to ignore the behaviors of a substance abuser, to avoid confrontation, or even cover up for the abuser when obligations and appointments are neglected, than to confront the reality of the situation. Family members and F/friends may find themselves enabling the addiction by shouldering the responsibilities of the substance abuser when that responsibility should lie with the person herself or himself. Missed committee meetings, unfulfilled promises and commitments, drifting away from meeting (or threatening to do so), even smelling of alcohol or behaving as if intoxicated—all are possible cries for help as well as tests for our individual and corporate patience and tolerance. Addictive behaviors often are permitted to continue, even enabled, until collective pain and suffering become too great to ignore or to bear—or until a wise and loving person sees the pattern of addiction and codependency and helps to create conditions for change.

What a Meeting Can Do

A meeting community should be ready to listen non-judgmentally, offer information about sources of help, refuse to enable people to continue in harmful practices, and continue to offer an environment free from addictive practices. Faith and Practice, Baltimore Yearly Meeting.

Building trust and safety is a fundamental part of pastoral care, especially in the area of drug abuse. The guilt and shame of the drug abuser, the often unintentional yet insidious conspiracy of silence that envelops and subsumes family and friends, the layers of denial and evasiveness that help to deflect any attention to problem areas, the perceived stigma of being a drug abuser (or a family member of one)—all work together to hinder outside access to inside issues, to maintain what ultimately becomes a chaotic and destructive lifestyle and family/social system. We need to be very mindful of these powerful forces, accept them as basic, albeit desperate,

[1] These definitions are based on the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (1994), pages 181-183.

[2] M. Beattie, *Codependent No More & Beyond Codependency.* New York: MJF Books. (1992), p. 36

human reactions to handling difficult situations, and refrain from hasty generalizations or judgments that would get in the way of building and nurturing a trusting and safe pastoral care relationship.

At the same time, as pastoral caregivers we must be mindful of the feelings that are elicited in us. We may have a strong desire to ease pain and suffering and a willingness to be of service. We may be tempted to get caught up in the family member's side of the story and to be judgmental of the substance abuser. Or in trying to be helpful to the abuser we may inadvertently get caught up in enabling and codependent behaviors ourselves. We need to pay attention to how dealing with addiction may test both our skill and our energy, and we need to set appropriate boundaries, find knowledgeable support, and hold the situation in the Light, seeking Divine guidance at each step along the way.

Trying to tease out the difference between loving, supportive behaviors and "enabling" behaviors may be the most difficult work for any of us. When is helping out helping too much? When do we draw the line between caregiving and taking care of ourselves? How do we maintain a dispassionate understanding of the challenges of addiction lest we get burned out when the drug abuser doesn't listen and "straighten up"? How do we encourage self-responsibility without abandoning the substance abuser?

Referring to a professional is not an abdication of the meeting's care, but a part of it.

As pastoral care providers, we can best offer support by focusing on the person rather than on the behaviors. We can gently and mindfully attend to the spiritual disconnect or gap between person and God, always recognizing and affirming that of God in everyone, especially those who suffer.

We begin by listening in love. What is the concern that is being brought to us? Does the person need someone just to listen while she or he sorts out what next steps to take? Does she or he need help in identifying possible next steps? Our focus should be:

- to hold the person in love and to assure her or him that we will continue to do so through the ups and downs of recovery;
- to offer comfort and guidance in seeking out solutions based in respect and self-care;
- to encourage the individual or the family members to avail themselves of appropriate professional support and/or Alcoholics or Narcotics Anonymous or other 12 step support group;
- to foster and maintain an environment of tender holding while the family goes through the difficult process of recovery;
- if appropriate and desired, to form a support group for the spouse or family to help them hold firm in breaking the patterns of codependency.

Bringing together members of the meeting who have had similar experiences may further enhance the common understanding that is often needed in such desperate and isolating times. Creating and fostering sacred space allows the Light to bring forth spiritual renewal and guidance as well as opportunities to explore more pragmatic courses of action (interventions, referrals, temporary housing, financial assistance, meals, child care, etc.).

Referring to Community Resources

When a concern regarding substance abuse is brought to the pastoral care committee, the meeting's caregivers should make use of informed resources in the meeting and in the community. If the meeting does not already maintain a listing of community resources, a very early step in supporting someone suffering from addiction is create such a list. It should include professional contacts, inpatient and outpatient, who specialize in substance abuse and codependency issues; information on Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, Nar-Anon, for family members, CoDependents Anonymous (CoDA), and other self-help groups; phone numbers for local crisis centers and domestic violence shelters, and a list of Friends who are willing to offer their own common personal experiences, strengths, hopes, and support. Some yearly meetings have a referral system to identify Quaker counselors. A person might be encouraged to explore the employee-assistance program where he or she works. Even small communities have chapters of AA and NA which can be found in the community service pages of the telephone directory or through the AA or NA website. If you have difficulty finding a nearby chapter, check with the local hospital or mental health center for information.

Referring to a professional is not an abdication of the meeting's care, but a part of it. The meeting's caregivers can help to identify a professional, offer to accompany the individual or family to the first appointment, and provide child care, transportation, or financial support.

Responding in an Emergency

At times pastoral care providers find themselves involved in situations for which emergency medical or psychiatric attention is required. Medical emergencies include acute intoxication with overdose risks, rapid changes in breathing and blood pressure, heart palpitations, and seizures. Psychiatric emergencies (substance-induced or not) can include severe depression, mania, or paranoia, with possible suicidal or homicidal impulses.

In an emergency situation the meeting's caregivers may find themselves in a position of helping a person get emergency medical attention *even against their will.* In order to maintain the caring and trusting relationship, (1) explain

as clearly and lovingly as possible the concerns that you have for any safety and well-being issue, making the decision to call for medical assistance, if at all possible, a consensual one, (2) try to include a family member or close friend in the decision-making process, and (3) be prepared to go along to the hospital or crisis center in order to provide ongoing support during this very difficult and scary time. Chances are, you will be successful in getting the person to voluntarily accept emergency care. If not, and you remain concerned about any imminent dangers to anyone, call 911 immediately and let the emergency personnel take over. You will have time later to resume the pastoral care relationship.

A Spiritual Program.

It is the experience of Friends that these drugs, intoxicants, and practices lead to...inability to listen for the will of God. Avoid in daily work those involvements and entanglements that separate us from each other and from God. Faith & Practice, Philadelphia Yearly Meeting.

The most important role for the meeting may be to support a person in reestablishing a relationship with God. Although estrangement from God is a common dimension of addiction, mental health professionals tend to shy away from this dimension of recovery.

Providing spiritual support could take the form of one or more caregivers meeting periodically with the person for prayer. Or perhaps reading together about guilt and forgiveness in one's relationship with God. If the person has been away from meeting for worship for a period, caregivers can invite him or her back to worshiping with the community and give reassurance that struggling with drug or alcohol abuse need not separate him or her from the loving care of the meeting.

The most important role for the meeting is support in reestablishing a relationship with God.

The AA philosophy focuses on spiritual life changes or "recognizing and turning our lives and our will over to God" as the fundamental principle for breaking the cycle of addictions and obsessive/compulsive behaviors. The compatibility of Quaker beliefs and AA becomes apparent as one explores the 12 Steps and 12 Traditions. Getting and staying in touch with one's Higher Power, central to "working the program," is similar to understanding and nurturing that of God in ourselves and others. Slogans such as "One Day at a Time," "First Things First," and "Keep It Simple" affirm the need to maintain a less impulsive, chaotic, and complex lifestyle. "Giving back" means to perform direct service and outreach to those alcoholics and addicts still suffering.

Family members of alcoholics have 12-Step support groups such as Al-Anon and Alateen, along with Nar-Anon for families of drug abusers and addicts. Many people have benefited greatly from their involvement in these meetings. Many lives have been saved by "working the steps."

If a person is active in AA or NA, pastoral caregivers in the meeting can support the similarities with Quaker beliefs. Knowing something about these self-help alternatives will significantly enhance our ability to be more informed, credible, and effective in the middle of addictive and codependent crises. Taking time to visit various open 12-Step meetings can help pastoral caregivers to better understand how these groups work and how they may be useful as resources in the pastoral care relationship.

Summary

Drug abuse is a very complicated spiritual, physical, mental, emotional, and social phenomenon, involving not only the substance abuser but family members and friends. Understanding basic information regarding medical and psychiatric risks and dangers is important, not only to create and maintain a safe and healthy pastoral care relationship, but also to allow for experienced assistance for the more complicated dimensions. Family members and friends often suffer as much as, if not more than, the abuser and often need specialized help in their own recoveries.

Addiction and codependency are often called diseases of the Spirit. Effective pastoral care means understanding the nature of addiction and codependency, how to help the afflicted reconnect with God and the Spirit, and how to refer for appropriate help when needed. Above all, it means always being mindful of that of God in each of us.

<<<<>>>>

John Blum is a Certified Alcohol and Drug Counselor and Licensed Professional Counselor in New Jersey where he is a member of Rancocas Meeting. He served on the Overseers Committee of Crosswicks, NJ, Meeting when he was a member there.

Introducing PCN's New Editor:

Jessica Bucciarelli

The editorial committee is pleased to announce the selection of Jessica Bucciarelli to edit *Pastoral Care Newsletter.*

Jessica has her own communications firm creating newsletters and brochures for non-profits and socially responsible small businesses. She is a member of Orange Grove Meeting in Pacific Yearly Meeting and on the Ministry and Counsel Committee of Southern California Quarterly Meeting. A Friend for the past ten years, she has worshiped among Friends in California and Indiana.

Her work with *PCN* will begin with the September 2004 issue.

The Experience of Meetings in Situations of Substance Abuse

Below are experiences in three meetings. Two go back over twenty years yet continue right up to the present. Because the situations are so tender, we have agreed to keep the stories anonymous, not even revealing the meeting. We can say that these stories take us from coast to coast and north to south. The one name that is mentioned is a pseudonym.

As you will see, there is no account of a perfect outcome, yet they are the stories of meetings being present and doing what they could do, and they are stories of the Spirit at work.

Held in the Circle of Light

The Circle of Light is a standing group in our meeting under Worship and Ministry. It takes prayer requests from members and holds them in the Light for two weeks. We asked them to hold our whole family in the Light since we had not heard from our son in over six weeks, his phone had been cut off, and he lived too far away for us to check in on him. Almost as soon as we put in the prayer request, he called us to say he had been holed up in his apartment for six weeks after a period of heavy drinking, had run out of food, was in deep debt, and had taken large doses of an over-the-counter medicine one night to try to end his life. He'd woken up the next morning and decided that was a sign he was supposed to stay on earth a bit longer and he asked if he could come home for a visit.

Being held in the Light helped us to consider what was next without anger or guilt, our frequent reaction in past cases when alcoholism and depression have invaded this gentle son's life and thus ours. We contacted a counselor, began to make a plan, talked it over with folks in the meeting in an informal manner, and set in place steps that we are now living into. Our son did come for a visit, during which he observed that he could feel the love in the meeting. Now he has returned to his home to try to pick up his life. Things look good, and though we have not renewed the request to be held in the Light right now we have a renewed sense of the loving power available from our meeting to us in a time of need.

What We Can Do May Not Be Enough

Some years ago a member of our meeting contacted the pastoral care committee about longstanding marital problems and her sense that for her own well-being she needed to leave her marriage and leave her home. A support group from the meeting helped her in finding temporary housing and making plans for next steps. It turned out that a key issue in the marital situation was the husband's chronic and severe alcoholism.

Pastoral caregivers attempted to contact him but failed to reach him. After the wife moved temporarily to the home of friend from the meeting, she became fearful for her husband's well-being. At her request group of men from the meeting, including a mental health professional, went to the home. They found him in a state of intoxication, took him out for a meal and a talk about his situation. Over time they supported him in joining AA, entering a rehabilitation facility, and moving to other housing. His story does not have a happy ending. He went through periods of sobriety and relapse, back to rehab and sobriety and back to relapse. Over time Friends from the meeting became less clear about how to be supportive and had less and less contact with him. He rarely attended meeting for worship. After several years he died, largely from the physical ravages of alcoholism.

The wife, with support from the meeting and elsewhere, was able to establish her independent life. Having gotten out of the codependent living situation, she became able to be supportive to her husband in his attempts to overcome his alcoholism. She helped to care for him in his final illness.

As she looks back on that time she is deeply grateful for the "group of terrific Quaker women who helped me sort facts and find my way to my own best decision for myself." She goes on, "I felt less sure that the meeting supported Jack in the way he needed. Without special skills, it is very, very difficult to deal with alcoholism, so urging the alcoholic to get to AA is truly the best thing to do, and the meeting members did that. His AA sponsor never gave up. He loved and even admired Jack right to the end of Jack's life."

Quakerism and AA: Hand in Hand in Recovery

Twenty years of heavy drinking and drug abuse took me places that I would have never imagined, places like hospitals, psych wards and jails. An intervention by a few friends and family brought me to the realization that death might be the next place I would find myself.

A cold rainy morning in March 1983 found me in a room filled with strangers in the basement of a Presbyterian church, introducing myself as an alcoholic. I wasn't a Quaker, nor a churchgoer when I first stepped into the rooms of Alcoholics Anonymous. I had had enough of "religion" in my youth. I did not want to hear all the talk of a "higher power" or God as some AA's called it. In spite of myself, I gradually came to believe in a power greater than myself; a God of my own understanding. In time I sensed a need to find a spiritual, even religious community to call home. My search took me to a variety of churches, but nothing seemed to fit.

One Sunday morning after giving up on church shopping, I came across a newspaper article about the

Quaker meeting in my hometown. I looked at my watch; I had time to get there. What I found was beyond my wildest expectation. At last the search was over, I was safe at home in the silent assembly of that little Quaker meeting. The wisdom of the AA program had prepared me for this moment. Here I could discover God as I understood God. Here too, I could share my revelation of truth.

I found the twelve queries of my yearly meeting to be like the twelve steps of AA, and Friends' testimonies to fit with AA's twelve traditions—ways to look at how I'm living life; how I relate to God, to myself, and to others and give guidance on how to improve my world.

By the grace of God and the help of my AA friends I have been clean and sober for twenty-one years. That same grace has kept me a Friend for 18 years. I attend meetings (AA and Quaker) on a regular basis; I need both. I have never laid my addiction before the meeting as an issue for their explicit care, since anonymity is the spiritual foundation of the AA traditions. While doing pastoral care, however, I have disclosed my story to those it might benefit. Being a Friend has been an important part of my recovery. Week after week, I come back to my two spiritual homes, AA and Friends. Both are loving, accepting, and caring communities. They are places where I hear the Spirit calling me to be the best that I can be. Being an active alcoholic is not the best that anyone can be.

Questions for Reflection

1. When a member's conduct or manner of living gives cause for concern, how does the meeting respond?
2. Is our pastoral care committee prepared to discuss sensitive topics such as drug or alcohol addiction in a manner that allows openness and honesty, and also firmness and direction?
3. Have there been instances when our committee got drawn into forms of caring that were not helpful? How can caregivers help one another to be mindful of the risks of joining in patterns of denial, codependency, and enabling?
4. Do we know who in the meeting is knowledgeable about matters of substance abuse or addiction whom we could call on? Do we know where to find resources outside the meeting?
5. What do we do as a committee to prepare ourselves to provide spiritual as well as practical support?

Resources

Addiction: Pastoral Responses by Bucky Dann. Nashville, TN: Abingdon, 2002.

Alcohol, Tobacco, and Other Drug Abuse: Challenges and Responses for Faith Leaders. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1997.

Alcoholics Anonymous (3rd ed.). New York: AA World Services, 1976.

"Alcoholism in the Meeting," *Pastoral Care Newsletter,* March 1999.

The Awakened Heart: Living *Beyond Addiction* by Gerald G. May, San Francisco: Harper, 1991.

Blessed are the Addicts: The Spiritual Side of Alcoholism, Addiction, and Recovery by John A. Martin, San Francisco: Harper, 1990.

Codependent No More & Beyond Codependency by Melody Beattie. New York: MJF Books, 1997.

Narcotics Anonymous (5th ed.). Chatsworth, CA: NA World Services, 1988.

FRIENDS COUNSELING SERVICE OF PHILADELPHIA YEARLY MEETING

Marcia Angerman,LCSW
New Hope, PA
215-862-5103

Henry Beck, Ph.D.
North Wales, PA
215-353-2530

Ray Bentman, M.Ed.
Philadelphia, PA
215-985-1314

Terence Carroll, ACSW
Philadelphia, PA
215-829-5525

Deborah Cooper, M.Ed.
Philadelphia, PA
215-248-0489

Teresa Glatthorn, M.A.
Hatboro & Doylestown, PA
215-672-6627

John L. Hall, Ph.D.
Downingtown & Mt. Airy, PA
610-458-5534

Harriet Heath, Ph.D.
(parenting issues only)
Haverford, PA
610-649-7037

Gary M. Johnson, Ph.D.
Wilmington, DE
302-656-1295

Douglas D. Neill, Ph.D.
Kennett Square, PA
610388-2917

Karin M. Sannwald, ACSW, LCSW
Lumberton, NJ
609-518-1057

James J. Saxon, Ph.D.
Swarthmore, PA
610-544-7583

John Scardina, Ed.M.
West Chester, PA
610-696-2153

Diane C. Stowe, LCSW-BCD
Lansdowne, PA
267-253-8308

Fran Van Allen, M.A.
Philadelphia & Media, PA
610-358-3212

Lindley Winston, M.D.
West Chester, PA
610-431-3955

Elaine P. Zickler, MSW, LCSW
Moorestown & Philadelphia
856-234-9117

Pastoral Care Newsletter is published quarterly by the Philadelphia Yearly Meeting Concerns Group on Care and Counsel for Meetings and Members. Annette Bennert, clerk. Editorial Committee: Susan Heath, clerk, Suzanne Day, Carolyn Terrell. Patricia McBee, editor. We are located at 1515 Cherry St., Philadelphia, PA 19102. Comments are welcome. **Please do not duplicate without permission**. To obtain additional copies or to subscribe, contact Steve Gulick, at 215-241-7068 or steveg@pym.org.