



CHRISTIAN **1** VOL. 26 NO. 3  
**counseling**  
TODAY

**Shame, Addiction, and Recovery:  
Patterns, Issues, and Strategies**  
John C. Thomas

**Why They Do What They Do:  
The Connection Between Addiction,  
Attachment, and Child Abuse Trauma**  
Shannae Anderson

**Bondage and Freedom:  
The Heart of the Addiction Journey**  
Jim Cress

# Addiction and Recovery

**The Neuroscience of Addiction and  
Behavior Change: Time Effects of Drugs**  
Brian Kelley and Blake Fraser

**Preventing Future Generations From Harm**  
Heidi Christensen

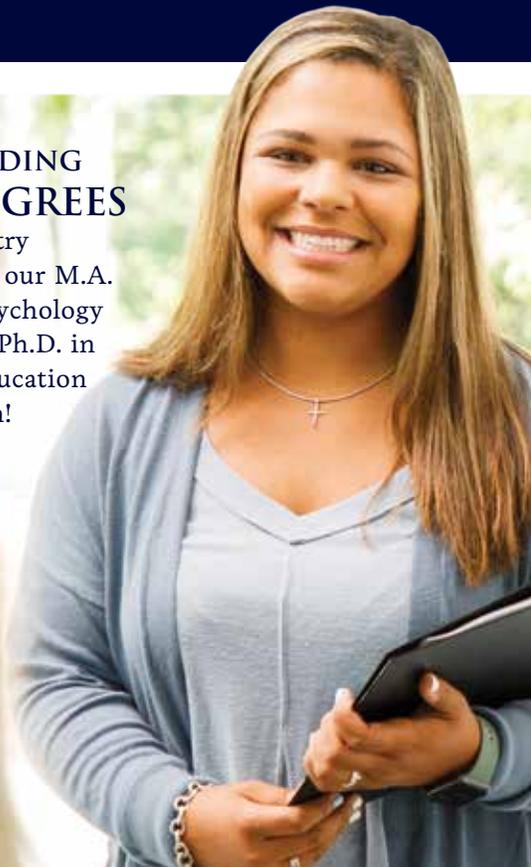
**Spiritual Strongholds and Addiction:  
Patterns, Progression, and Power**  
David E. Jenkins

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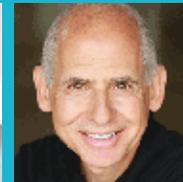
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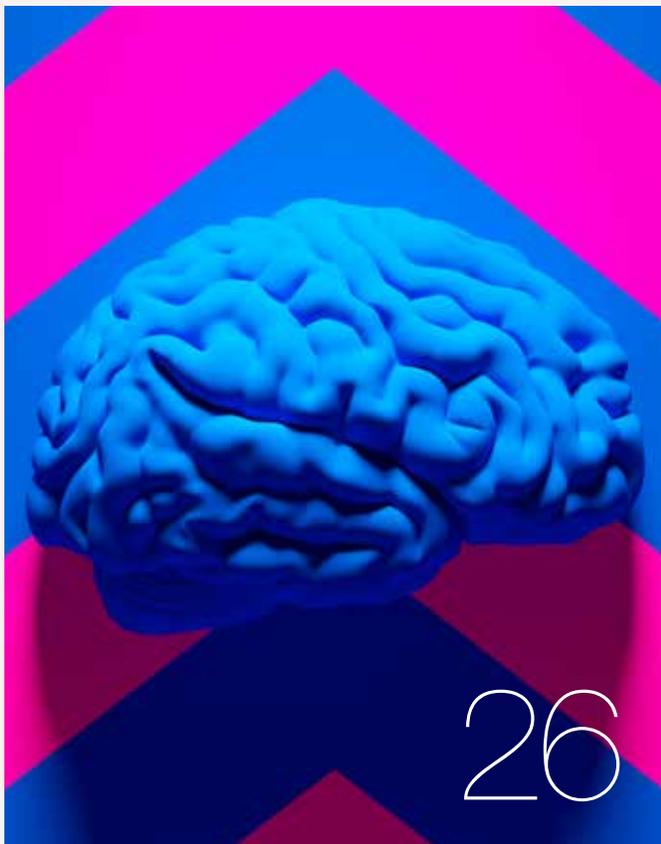
## FEATURES

### **12 Shame, Addiction, and Recovery: Patterns, Issues, and Strategies** *by John C. Thomas.*

Finding freedom from enslavement to shame requires accessing psychological and spiritual resources. Licensed Professional Counselor-Supervisor, professor, and author, John Thomas, analyzes the fallout of shame and guilt involved with addiction and the challenges associated with addressing these issues through effective counseling and God's promises to free those enslaved by shame.

### **18 Why They Do What They Do: The Connection Between Addiction, Attachment, and Child Abuse Trauma**

*by Shannae Anderson.* Clinical and forensic psychologist, Shannae Anderson, describes that various addictions manifest themselves in many ways and how those who struggle with them have difficulty managing everyday life decisions and, as a result, use external means to regulate their overwhelming internal states. She observes how addiction often has attachment insecurity and trauma at its core, so treatment needs to incorporate interpersonal relationships as part of a recovery protocol. Additionally, Shannae offers self-help programs to utilize the power of God to facilitate renewal.



### **23 Bondage and Freedom: The Heart of the Addiction Journey** *by Jim Cress.*

It is no surprise that addictions and various compulsive behaviors are rampant today. Jim Cress, Licensed Professional Counselor, Certified Sex Addiction Therapist, and Certified Multiple Addictions Therapist, recommends an emotional, physical, medical, and spiritual perspective on addiction treatment for those working on this battlefield.

### **26 The Neuroscience of Addiction and Behavior Change: Time Effects of Drugs**

*by Brian Kelley and Blake Fraser.* Professor, Brian Kelley, and instructor of psychology, Blake Fraser, discuss the unfortunate effects of substance abuse on the brain, how drugs work, are absorbed and eliminated from the body, and the resulting rebound effects. They suggest a forward-looking, empathetic approach that focuses on understanding these effects on the path to recovery.



**31 Preventing Future Generations From Harm** by Heidi Christensen. Public Affairs Specialist at the Center for Faith-based and Neighborhood Partnerships at the U.S. Department of Health and Human Services, Heidi Christensen, provides some staggering statistics regarding the opioid crisis among today's generations. She presents several valuable resources for faith and community leaders to strengthen their responses to this critical problem and help prevent future harm.

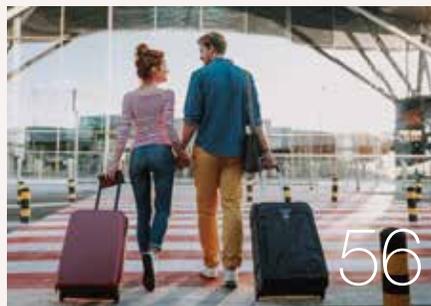
**36 Spiritual Strongholds and Addiction: Patterns, Progression, and Power** by David E. Jenkins. Using key illustrative passages and words from the Bible to clarify terms and concepts, disclose addiction-related information, and explain how spiritual strongholds may be involved, David Jenkins, clinical psychologist and professor, lays out several principles for addressing addiction-related strongholds.

**40 Forgiveness in Addiction and Recovery** by Everett L. Worthington, Jr. Treating substance-use disorders is complex, and there is no single pathway from use to addiction to treatment to recovery. Licensed clinical psychologist and retired professor, Everett Worthington, Jr., uncovers how forgiveness is involved in addiction and recovery. He delivers some evidence-based treatments (EBTs) for addiction recovery and practical advice on how to be effective helpers.

**44 Family Patterns and Generational Dysfunction: Understanding Intergenerational Transmission of Addiction** by Linda Mintle. Licensed therapist, professor, and author, Linda Mintle, sheds light on substance use disorder and how addiction is commonly stigmatized and misunderstood. She reveals that the intergenerational transmission of this disease, in terms of genetics, epigenetics, and behavior, is often overlooked in treatment. However, the cycle of family dysfunction patterns can be broken with a systematic perspective that treats the body, mind, and spirit.

**48 Co-dependency and Dependency: Signs, Issues, and Challenges** by Gregory L. Jantz. Interpreting dependency and co-dependency, psychologist, mental health expert, and author, Gregory Jantz, draws a clear picture of the challenges these disorders pose and conveys how a healthy sense of self can be knit back together through a healing relationship with God.

**52 Catch it, Challenge it, Change it: Cognitive Behavioral Strategies for Recovery** by John Eklund. Licensed Clinical Social Worker, pastor, author, and founder of Recovery ALIVE!, John Eklund, shares a personal experience involving his wife's eating disorder and how cognitive behavioral therapy and Scripture helped him face the shame and guilt he encountered. By confronting his denial and rejecting his false and harmful beliefs, he was able to change his thinking and realize the truth... just like his wife.



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**Shannae Anderson, Ph.D.**, is a clinical and forensic psychologist at the AACC, where she is the Director of Psychology and Co-director of the Ethics and Advocacy Division. She is also the Clinical Director of an Intensive Outpatient Addiction Treatment Program in Southern California. Dr. Anderson maintains a private practice specializing in treating complex trauma, addictions, and personality disorders.

**Heidi Christensen, MTS**, is a Public Affairs Specialist at the Center for Faith-based and Neighborhood Partnerships at the U.S. Department of Health and Human Services. Her efforts focus on strengthening the capacity of faith and community organizations to respond to critical public health issues. Heidi has coordinated coalitions of diverse faith and community-based partners to address issues that have included childhood obesity, access to healthcare, the epidemic of addiction, and COVID-19 prevention, as well as the social and economic issues challenging the health of our nation's communities.

**Tim Clinton, Ed.D., LPC, LMFT, BCPCC**, is president of AACC, the world's largest and most diverse Christian counseling association. Dr. Clinton also serves as the Executive Director of the Liberty University Global Center for Mental Health, Addiction, and Recovery. He is the co-host of "Dr. James Dobson's Family Talk," heard daily on nearly 1,400 radio outlets. Licensed as a Professional Counselor and Marriage and Family Therapist, Dr. Clinton is recognized as a world leader in mental health and relationship issues and spends much of his time working with Christian leaders and professional athletes. He has authored or edited nearly 30 books. Dr. Clinton and his wife, Julie, have two children and two granddaughters.

**Jim Cress, M.A., LPC, CSAT, CPTT, CMAT**, is a Licensed Professional Counselor, Certified Sex Addiction Therapist, and Certified Multiple Addictions Therapist. He is a group leader for Onsite Workshops near Nashville, a national conference speaker with the American Association of Christian Counselors, and a 34-year veteran broadcaster. Jim co-hosts the "Therapy & Theology Podcast."

**Ted Cunningham, MACE**, is the founding pastor of Woodland Hills Family Church in Branson, Missouri. He is a graduate of Liberty University and Dallas Theological Seminary.

**John Eklund, M.S.W.**, is an author, Licensed Clinical Social Worker, ordained pastor, and founder of Recovery ALIVE!, a Christ-centered, 12-step program operating in churches all over the country. For more information about his books and ministry, visit [recoveryalive.com](http://recoveryalive.com).

**Blake Fraser, M.S.**, is an instructor of psychology at Liberty University and teaches research methods and statistics courses. He also directs a research team of undergraduate and graduate students. His main research interests are loneliness, substance abuse, and how health behaviors affect mental health.

**Fernando Garzon, Psy.D.**, is a professor at Regent University in the School of Psychology and Counseling. His research interests focus on investigating spiritual interventions in therapy, multicultural issues, and evaluating psychologist/counselor education practices in spirituality. Dr. Garzon's professional experiences include being in private practice as a clinical psychologist, serving as an associate pastor for a Latino church, and fulfilling a role in pastoral care ministry.

**Gregory L. Jantz, Ph.D.**, is the founder of The Center • A Place of HOPE, a healthcare facility in Edmonds, Washington, which emphasizes whole-person care, addressing the emotional, relational, physical, and spiritual aspects of recovery. He is the best-selling author of multiple books and a sought-after speaker in person and on television and radio.

**David E. Jenkins, Psy.D.**, is Professor of Psychology and Clinical Director of the Psy.D. in Clinical Psychology program at Liberty University. He has served on the Executive Draft Committee for the 2014 and 2023 updates to the AACC's Code of Ethics for Christian Counselors. With more than 30 years of clinical experience, Dr. Jenkins specializes in the integration of Christian faith and clinical practice.

**Brian Kelley, Ph.D.**, is a Professor of Psychology at Liberty University. He completed a Postdoctoral Fellowship in Psychiatry at the Medical University of South Carolina, where some of his research included psychotherapies for alcoholism and alcohol abuse, prenatal exposure to abused drugs, HIV-related dementia, community interventions, and program evaluation. Dr. Kelley's study and service areas include basic, translational, clinical, and community research in most areas of mental and behavioral health. His training also includes concentrations in neuroscience and pharmacology/toxicology, as well as clinical/community research.

**Diane Langberg, Ph.D.**, is globally recognized for her 50 years of clinical work with trauma victims. She has trained caregivers on six continents in responding to trauma and the abuse of power. For 29 years, she directed her own practice in Jenkintown, Pennsylvania—Diane Langberg Ph.D. & Associates. Now, in partnership with Dr. Phil Monroe, Langberg, Monroe & Associates continues this work, which includes 17 therapists with multiple specialties.

**Michael R. Lyles, M.D.**, is a board-certified psychiatrist and has a private practice with Lyles & Crawford Clinical Consulting in Roswell, Georgia.

**Jeanneane Maxon, J.D., Esq.**, has many years of executive-level, non-profit leadership. She is an attorney and nationally-recognized speaker. Jeanneane formerly served as the Vice President of External Affairs and Corporate Counsel for Americans United for Life and as the General Counsel of Care Net.

**Linda Mintle, Ph.D.**, received her doctoral degree from Old Dominion University in Urban Health Services and Clinical Psychology. She has a master's degree in social work and a Bachelor of Arts degree in psychology and communication, both from Western Michigan University. Linda is the author of 20 books; her latest, *Living beyond Pain*, co-authored with physician, Dr. James Kribs, brings hope to chronic pain sufferers.

**Gary W. Moon, M.Div., Ph.D.**, served as the founding Executive Director of the Martin Institute for Christianity and Culture and the Dallas Willard Center for Christian Spiritual Formation at Westmont College and continues to direct their resource development initiatives through serving as the director of *Conversatio Divina: A Center for Spiritual Formation*, [www.conversatio.org](http://www.conversatio.org).

**John C. Thomas, Ph.D., Ph.D.**, is a Professor in the Department of Counselor Education and Family Studies at Liberty University. He is a Licensed Professional Counselor-Supervisor, Certified Sex Therapist, Certified Sex Addiction Therapist, and Certified Substance Abuse Counselor. Dr. Thomas is the editor and contributing author of *Counseling Techniques: A Comprehensive Resource for Christian Counselors*.

**Everett L. Worthington, Jr., Ph.D.**, is Commonwealth Professor Emeritus, where he worked for the Department of Psychology at Virginia Commonwealth University (VCU). He is a Licensed Clinical Psychologist in Virginia.

## CHRISTIAN counseling TODAY

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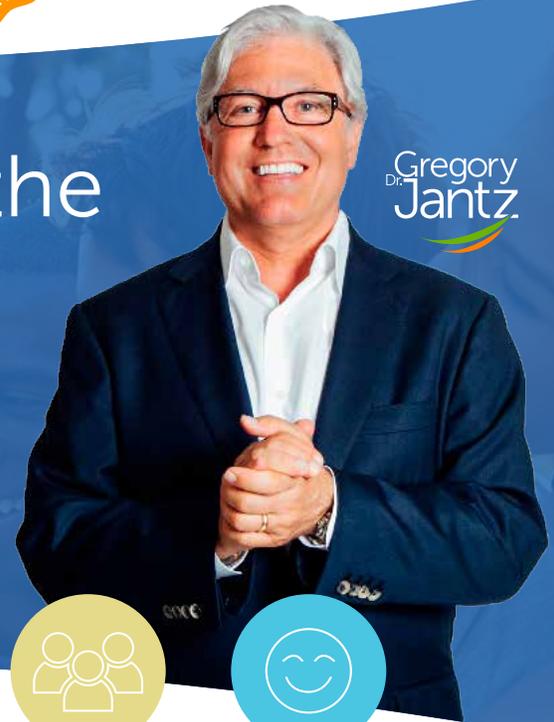




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*“There are six things the Lord hates, seven that are detestable to him: haughty eyes, a lying tongue, hands that shed innocent blood, a heart that devises wicked schemes, feet that are quick to rush into evil, a false witness who pours out lies and a person who stirs up conflict in the community.”*

– Proverbs 6:16-19, NIV

As we look to this year’s AACC “Know Hope” World Conference—which is far outpacing all previous sell-out World Conference events—we are facing unprecedented challenges and issues in culture, including the Church and mental health field, that demand our immediate attention and best efforts.

In my most recent book, *Focus on the Future*, I share how I believe we are on the edge of disaster and in a time of battle and spiritual warfare like we have never seen before. In the book’s opening, I share the story of how the prophet Jeremiah wrote the words that spoke to the destruction of God’s people at that time. He warned that Jerusalem did not consider her future, so “... Her fall was astounding...” (Lamentations 1:9, NIV).

We are in a critical moment in history and must consider what steps to take to fight for our families, faith, and future, including our voice in the mental health professions. Some of the massive concerns on my radar include the fentanyl crisis, the mental health disaster, the disregard for truth in culture, religious liberty infringement, and the increasing obsession with social media.

The fentanyl crisis is a public health emergency that has swept across the globe, particularly in North America. According to the Centers for Disease Control and Prevention (CDC), “... fentanyl is a synthetic opioid that is up to 50 times stronger than heroin and 100 times stronger than morphine.”<sup>1</sup> The CDC reported 106,699 drug overdose deaths in 2021.<sup>2</sup> Fentanyl and other synthetic

opioids are the most frequently used drugs in overdose fatalities.<sup>3</sup> An alarming statistic from a report shared by Fox News from the Families Against Fentanyl analysis of CDC data revealed, “More adults between 18 and 45 died of fentanyl overdoses in 2020 than any other leading cause of death, including COVID-19, motor vehicle accidents, cancer and suicide.”<sup>4</sup>

The fentanyl crisis is a complex issue that requires a multifaceted approach within the U.S., and that is coming in through our borders, including increasing access to addiction treatment and harm reduction strategies and cracking down on the illegal production and distribution of the drug. It is vital to continue raising awareness about the dangers of fentanyl and other opioids and provide resources and support to those who are struggling with addiction.

You have probably heard me say by now that before the COVID-19 pandemic, we were in a mental health crisis; however, since then, we have hit a fever pitch and are witnessing a mental health disaster. The gaping hole between those who need help and those who provide it is massive... and our kids are caught in the middle. Self-injury, depression, anxiety, and other major mental health concerns are soaring.

Christian psychiatrist and AACC Medical Director, Dr. Karl Benzio, has often said we are in this insanity because *“truth is dying.”* I think that statement holds a great deal of weight when you consider that “truth” has become subjective in our culture today. We are told that *your* truth, whatever it may be, is indeed *your* truth. This concept has brought much confusion and made it increasingly more difficult to speak the truth in a culture that does not value what God has given us in His Word. Truth comes from Him and Him alone.

In the midst of this, I am reminded of Psalm 123:1 and the lyrics of the old hymn my mother loved, “Turn Your Eyes Upon Jesus.” When we lift our eyes to the One who is enthroned in heaven, the things of this world grow strangely dim. The late Dr. Archibald Hart shared in a private meeting many years ago that he believed *“... we have run far too ahead of our biblical and theological roots.”*

This discussion reminded me to stay anchored to the undying truth of God and His redeeming work in our lives. To be reminded of that truth—God’s truth—is unwavering and cannot die. It leads us to what we see happening with religious liberty infringement and hatred of the things of Christ. In today’s world, you can practically be anything other than a Christian who holds fast to conservative values.

After the Dobbs decision handed down last summer by the U.S. Supreme Court, there was a direct assault on crisis pregnancy centers and churches with little to no care by the current administration. And now, with the recent attack on The Covenant School in Nashville, faith leaders are finally taking notice of the hate crimes that are beginning to happen against people of the Christian faith. Even more, there is an obsession by some to assault faith leaders with reckless abandon, presuming guilt on issues without the appropriate steps of Matthew 9 and more. In mental health, there are real concerns over challenges to faith-based organizations providing continuing education and program accreditation because of people holding to sincerely held religious beliefs.

Finally, from screen obsession and the insanity of social media news to suppression and censorship, we are being eaten alive. We must gain some type of control, especially for our kids. Josh Hawley, the U.S. Senator

for Missouri, recently introduced a new bill called the Making Age-Verification Technology Uniform, Robust, and Effective Act (MATURE Act) to curb this horrific challenge with our kids, suggesting that social media platforms should enforce a minimum age requirement of 16 years old. He might be on to something. Eradicating the online pornification of our young is a great place to start.

### Good News is on the Horizon

The 2023 AACC “Know Hope” World Conference could not be more critical. This September 13-16, we expect a sell-out crowd of nearly 7,000 counselors and pastors to descend on the magnificent Opryland Hotel in Nashville, Tennessee. Attendees will be joining us from all 50 states and more than 40 countries around the globe.

**Mental Health Coach Training Program:** The Mental Health Coach First Responder Training program is exploding with nearly 12,000 churches and 35,000 students representing all 50 states and over 100 countries worldwide.

**“The Road Forward” Event:** Sponsored by the AACC’s Ethics and Advocacy Division, we are hosting our next religious liberty event, “The Road Forward.” This event is taking place with academic leaders, researchers, legal advocates, and more this July. Stay tuned for more details on this important event.

**The Global Day of Hope:** This event will be held this summer to help influence the Church worldwide to be more aware of mental health issues and become more mental health friendly for such a time as this. The Global Day of Hope, built around 12 mental health themes, will feature mental health and ministry leaders offering hope, help, and encouragement and is focused on reducing the shame, silence, and stigma around mental health.



While these are unprecedented times, I hope you are encouraged that God is at work. This is not a time to be silent but bold, brave, and courageous—a time to unite and stand firm.

**Youth Mental Health Coach Training Program:** Our team is working feverishly to finish our Youth Mental Health Coach Training Program, set to release this summer. Following the release of this program, we will announce a new event focusing solely on the rising issue of youth mental health, which will take place in early 2024.

**AACC Publishing Division:** I am excited to announce the news of a long-awaited development. The AACC has launched AACC Publishing, led by acquisitions editor, Jennifer Cisney Ellers. The first published work is titled, *Bounce: A 60-day Devotional to Jump-start Your Resilience*, by Christian counselor, Donna Gibbs. *Bounce* is a Christian devotional that focuses on supporting people facing challenges, losses, and other setbacks with truth from Scripture and wisdom from a Christian counselor. It is set to release on April 27th.

**Marriage and Family: A Christian Journal:** Another unique endeavor of the AACC is *Marriage & Family: A Christian Journal*. This peer-reviewed journal will be published under the purposes of the sponsoring organization, the American Association of Christian Counselors, led by editor, Dr. Mark Mayfield. Bi-annual issues (May and September, along with an annual special issue in January) include various topics that advance the development and understanding of theory and therapies from, and within, a Christian perspective. The purpose of this journal is not to develop an additional theological exposé but to enhance and deepen the efficacy of the Christian ethic within the realm of clinical therapies.

While these are unprecedented times, I hope you are encouraged that God is at work. This is not a time to be silent but bold, brave, and

courageous—a time to unite and stand firm. Please pray for all that is happening and that we will bring honor to the Lord. I hope to see you in Nashville this September for the World Conference. ✝



**TIM CLINTON, ED.D., LPC, LMFT, BCPC**, is president of AACC, the world's largest and most diverse Christian counseling association. He also

serves as the Executive Director of the Liberty University Global Center for Mental Health, Addiction, and Recovery. Tim is the co-host of "Dr. James Dobson's Family Talk," heard daily on nearly 1,400 radio outlets. Licensed as a Professional Counselor and Marriage and Family Therapist, he is recognized as a world leader in mental health and relationship issues and spends much of his time working with Christian leaders and professional athletes. Tim has authored or edited nearly 30 books. He and his wife, Julie, have two children and two granddaughters.

### Endnotes

- <sup>1</sup> Centers for Disease Control and Prevention. (2022, February 23). *Fentanyl facts*. Retrieved April 4, 2023, from <https://www.cdc.gov/stopoverdose/fentanyl/index.html>.
- <sup>2</sup> Spencer, M.R., Minino, A.M., & Warner, M. (2022, December 21). *Products - data briefs - number 457 - December 2022*. Centers for Disease Control and Prevention. Retrieved April 4, 2023, from <https://www.cdc.gov/nchs/products/databriefs/db457.htm#:~:text=From%202020%20through%202021%2C%20the%20age%2Dadjusted%20rate%20of%20drug,15%25%20from%2017.1%20to%2019.6>.
- <sup>3</sup> Centers for Disease Control and Prevention. (2022, February 23).
- <sup>4</sup> Conklin, A. (2021, December 16). *Fentanyl overdoses become no. 1 cause of death among US adults, ages 18-45: 'A national emergency.'* Fox News. Retrieved April 4, 2023, from <https://www.foxnews.com/us/fentanyl-overdoses-leading-cause-death-adults>.

**NEW**

FOREWORD BY DR. GARY CHAPMAN  
Best-selling author of *The 5 Love Languages*

# FOCUS ON THE FUTURE

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THE FIGHT FOR  
OUR FAITH,  
FAMILY, AND  
FUTURE IS  
NOT OPTIONAL.**



**America is at a crossroads...** Anxiety, Depression, and Suicide are at all-time highs. Divorce is prevalent. Children are growing up without fathers in the home, and the family unit as a whole is suffering. Dr. Tim Clinton, one of America's leading voices on faith and mental health sounds the call for people around the country to step into the moment and rise up to Focus on the Future of America.

**What does the future hold for America?** Will the current and coming cultural battles ultimately destroy or preserve our freedoms?

Dr. Tim Clinton, an eminent American counselor and associate of Dr. James Dobson, believes this moment in American history is a reprieve. It is a moment to take stock. We must know the season we are in and prepare both to maximize our opportunities and for the cultural battles that are sure to befall us. It is a moment to prepare. It is a moment to focus on the future.

And it starts with you!

**The future is bright, the victories are destined, and great things await the faithful who prepare.**



**Tim Clinton, Ed.D., LPC,  
LMFT**

President, American Association  
of Christian Counselors



# Shame, Addiction, and Recovery:

## PATTERNS, ISSUES, AND STRATEGIES

3  
Addiction is notoriously resistant to change. It produces a vicious cycle of self-destructive behavior with spiritual, emotional, cognitive, and behavioral fallout. One story of addiction may be, “If I do this, I will stop feeling; if I stop feeling, I won’t have shame,” as shame is the center of any addiction.

It is difficult to characterize shame concisely because it can present as guilt, depression, and disgust. Unlike guilt, which is behavioral-based, shame is identity-based (Tangney & Dearing, 2004), making it a sickness of the soul. Shame is a universal human experience because it is woven into our fallen DNA. Feelings of shame can be healthy when experienced temporarily and deter problematic behavior. It can be used as a motivation toward change (Stricher, 2020) when the desire for a healthier life is leveraged. However, toxic shame, which is excruciating and debilitating, is felt as an inner torment. Shame is undoubtedly the most painful of emotions.

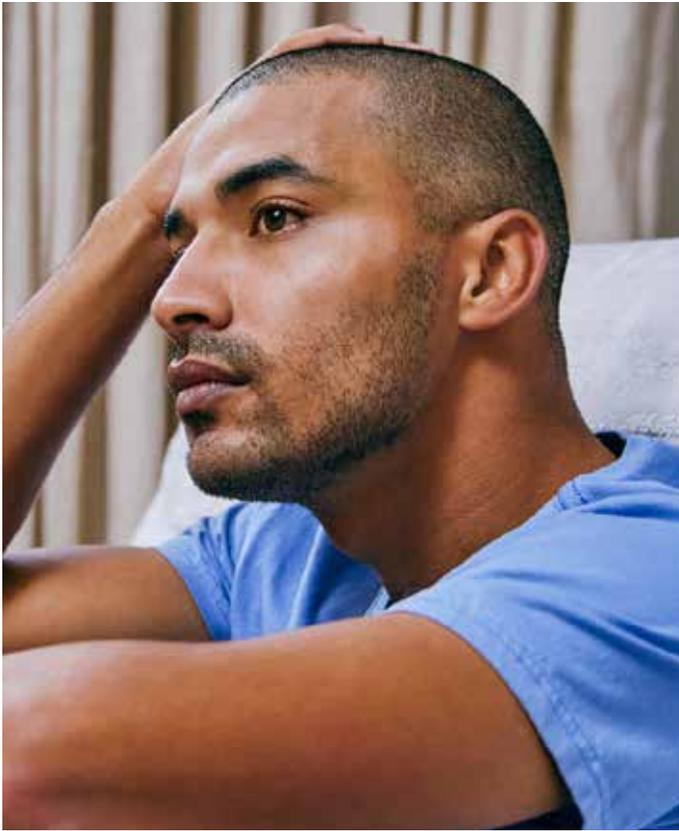
Toxic shame is the confluence of two rivers, the self-devaluation of internal shame and the expected social devaluation of external shame. The internal river of shame is the “dark mirror within” (Gilbert, 2011, p. 328). Addicts are shame-prone people whose self-reflection produces a shame-based identity. The “I am” conclusions (e.g., I’m inadequate, I’m defective, I’m damaged, I’m unworthy, and I’m unlovable) often go unchallenged. Thus, shame becomes stronger and is resistant to change. The most challenging task addicts have is to give up the beliefs they hold about themselves.

According to Bradshaw (2005), shame “... is the source of most of the neurotic and character disordered behaviors” (p. xv), both causing and an artifact of addiction. The internalization of threatening shame messages requires a defense against unwanted and intolerable feelings (Gu & Hyun, 2021). Acting out is the addict’s answer. However, a vicious shame-addiction cycle is generated by striving to escape the haunting feelings and seeking relief from the resulting shame. This cycle paradoxically increases shame, precipitating self-reproach and self-incrimination. Despite the addict’s best efforts, the solution to avoid and escape their shame has become the problem. Soon the aim of acting out is more about reinforcing the shame than escaping it.

The external source of shame involves perceived and actual social judgment. Addicted individuals “know” that others’ thoughts about them are unfavorable and fault-finding. Early life experiences may condition the addict to fear exposure of the real self. Once addicted, social commentary (e.g., Why would they mess up their life? They ought to know better! No true Christian would do that!) reinforces self-incrimination. Though God made us for relationships, the tortuous feelings of shame foster isolation and deception to avoid humiliation. The shamed individual experiences relationships as though there is a vast gulf between being fully known and fully accepted. Subsequently, shame fragments a person’s willingness and capacity for connection, setting the stage for addiction.

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JOHN C. THOMAS



Though shame originated in Adam and Eve's sin, it is perpetuated by Adverse Developmental Experiences (ADEs). Research has clearly linked shame to various forms of trauma (e.g., Plante et al., 2022) and shame-bound interactive patterns in the family of origin (Fossum & Mason, 1986). It is not surprising that most addicts have a history of neglect or emotional, physical, or sexual abuse, which are the breeding grounds for shame. Treating the addict's trauma is essential to recovery.

Shame is a barrier to sobriety (Sawer et al., 2020). Help-seeking is obstructed by shame and addiction's secrecy, self-sufficiency, and deception. When addictive clients present for counseling, they carry their toxic shame into treatment and recovery. Without the anesthetizing activity, the emotions can flood addicts when facing the enormity of their unmanageability. Anxiety, regret, grief, sadness, and self-contempt can be intense. Shame and the tsunami of tormenting emotions may be the catalyst for self-sabotage. Thoughts such as, "I don't deserve a better life," "I'm a horrible person," or "Why try?" impair recovery and foster relapse.

Until the anesthesia of acting out wears off, the depth of shame may not be fully realized. After counseling a sex-addicted client for more than four months, he confessed to holding something back. He agonized for five minutes before hesitantly disclosing a pre-adolescent sexual experience with an animal. He wept uncontrollably and mumbled, "No one else knows this." Shame lives and is fortified in the shadows. It is felt with what is said and what must never be spoken.

In counseling the shame-addiction cycle, confrontational strategies are counterproductive because they reinforce shame—efforts to convince them that they do not need to feel shame discounts their reality. It is of inestimable importance to authentically value the addictive client. Individuals who receive empathetic responses experience an increased sense of power and connection (Brown, 2006). Therapeutic empathy may lead to self-acceptance of past and present behavior and promote self-compassion. For most addictive clients, to be known and valued is a new experience. The hospitality and attunement of the therapist's presence is an antidote for shame. In essence, care is more essential than cure (Kurtz, 2007).

Because of their self-blame and self-hatred, self-forgiveness is a necessary clinical task. However, shame blocks self-forgiveness due to the weight of sinful and harmful choices (McGaffin et al., 2013). Not until addicts internalize God's forgiveness and profound love toward sinners (Romans 5:8) can they release themselves. Having a good God concept is far more impact-

ful than having a good self-concept. His love and delight in us (Zephaniah 3:17) mean that toxic shame is misguided. However, acceptance is a formable task because the shame of addiction erodes one's relationship with God. Addicts must reconceptualize God as the One who abounds in mercy, grace, and love rather than a punitive God who is disgusted with them and their actions. Understanding that each believer is covered in Christ's righteousness, not one's own, reduces shame. Sometimes, I request that my clients envision God looking down on them, clearly seeing their unworthiness. I then cover them with a white cloth, representing Christ's righteousness. Because of His sacrifice, God chooses to see His Son's goodness instead of our sin.

Feelings of shame are not just carried in the head and heart; they are also stored in the body. Creating a safe haven allows clients to turn toward the somatic markers of shame. When addicts gain awareness and label what is happening in their bodies, they can experience what has been intolerable to feel. In some cases, the shame might not abate for those with intense trauma (Wiechelt & Sales, 2001). Therefore, a systematic trauma approach, such as Eye Movement Desensitization and Reprocessing (EMDR) or sensory processing, to target touchstone memories and somatically marked trauma is effective for helping appropriately trained professionals.

Even with effective counseling, shame does not always subside. However, not addressing shame in recovery will stifle treatment. Finding freedom from enslavement to shame requires accessing psychological and spiritual resources. In author John Bunyan's allegory, *Pilgrim's Progress*, Christian and his companion, Hopeful, were captured by the Giant of Despair, who beat them and imprisoned them in the dark and sordid dungeon of Doubting Castle. With no apparent hope, Christian became suicidal. Eventually, Christian realized that he held the key of Promise, which unlocked the dungeon door and set them free. Shame imprisons addicts in a dungeon that seems impossible to escape. However, God has given *promises* that can free those enslaved by shame. Our job is to help them find the key. ✝



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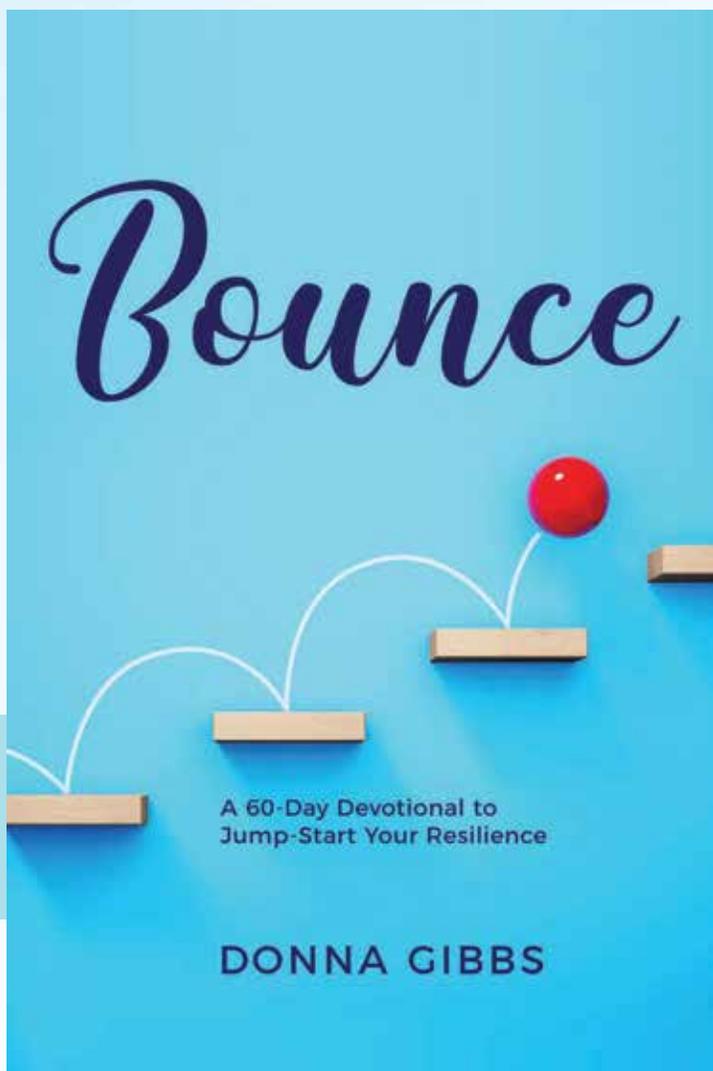
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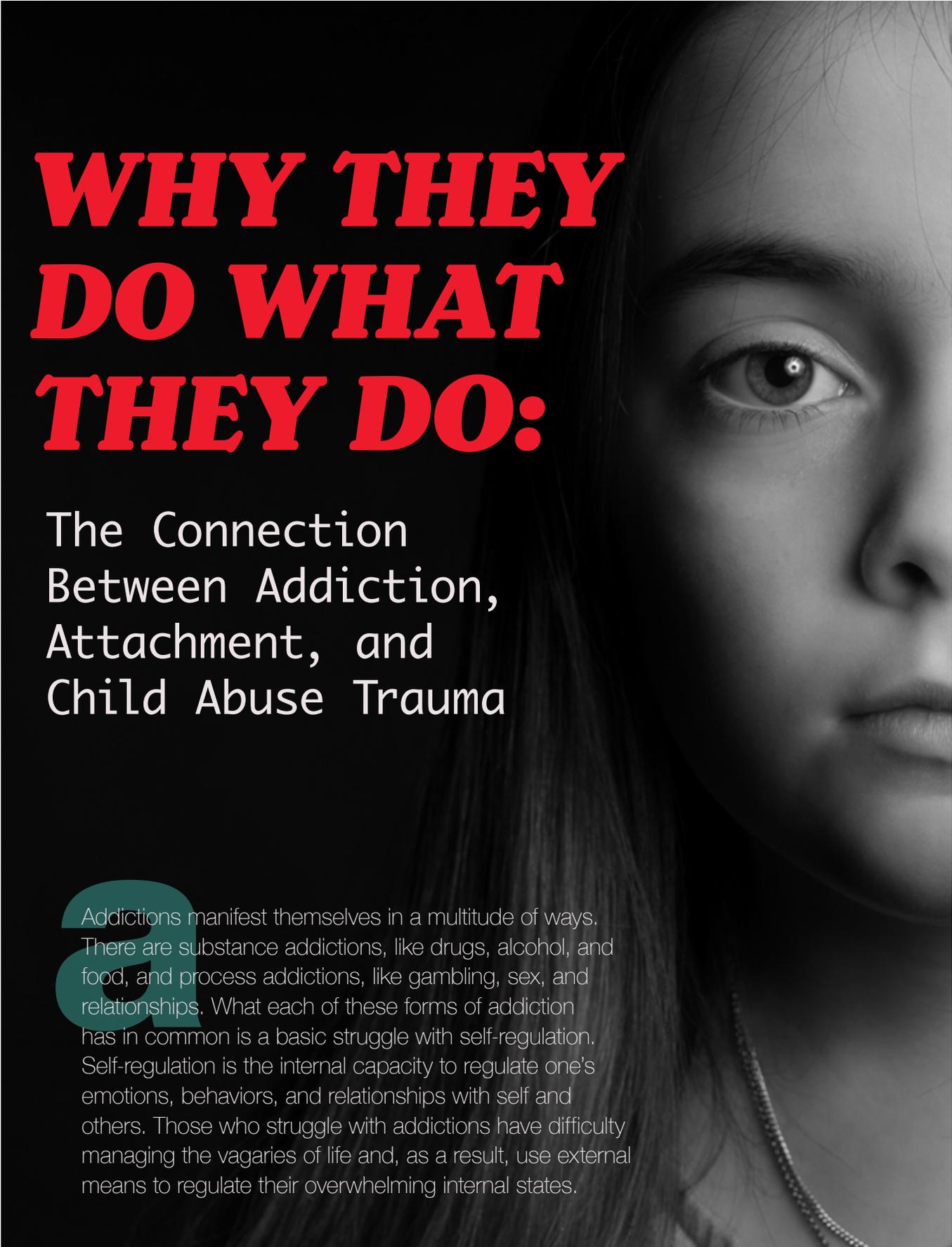


Donna Gibbs is a co-owner of Summit Wellness Centers, PLLC, and provides real hope and practical help for life's hurts through professional Christian counseling, writing, speaking, and consulting. Donna is the author of numerous books, and her blogs, devotions, and articles have frequently

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# ***WHY THEY DO WHAT THEY DO:***

## **The Connection Between Addiction, Attachment, and Child Abuse Trauma**

**A**ddictions manifest themselves in a multitude of ways. There are substance addictions, like drugs, alcohol, and food, and process addictions, like gambling, sex, and relationships. What each of these forms of addiction has in common is a basic struggle with self-regulation. Self-regulation is the internal capacity to regulate one's emotions, behaviors, and relationships with self and others. Those who struggle with addictions have difficulty managing the vagaries of life and, as a result, use external means to regulate their overwhelming internal states.

Problems with self-regulation are often rooted in early developmental and environmental injuries. These wounds frequently combine with biological and temperamental vulnerabilities that render individuals at risk of possibly developing self-regulation difficulties. An insecure attachment with a primary caregiver is one of the most common injuries that produce such impediments. Another is child abuse trauma. This article will explore the etiological manifestations of insecure attachment and childhood trauma on the development of addictions.

Because our God is relational, He created us with an innate and biological need to attach to others. This need is initially seen in early childhood—in the attachment relationship between an infant and its primary caregiver.

British psychologist and child development pioneer, John Bowlby, was the first to explore this phenomenon of attachment. While working with hospitalized children, he observed three predictable stages of separation that children would experience when separated from their parents. These stages included one of *protest*, where children objected to separation by crying out for their caregivers; one of *despair*, where children expressed despondency in response to prolonged separation; and one of *detachment*, where children emotionally disengaged from their parents to protect themselves from the pain of protracted separation.

Bowlby believed that children have a biological instinct to attach to their caregivers to protect them from harm and provide a secure base from which they can safely explore the world around them. When this attachment bond is disrupted, children will respond with

certain prescribed behaviors to preserve this connection and their self-integrity.

Attachment bonds are created through recurring interactions and mutual exchanges between a primary caregiver and a child. Because infants are born speaking a non-verbal language of emotion, it is the caregiver's responsibility to bond with the child by attuning to that emotional language. Through *attuned communication* with the infant, the caregiver modulates the child's internal state through a process called *dyadic regulation*. For example, when a baby cries, the caregiver will emotionally soothe the child's inner state by using a sympathetic tone of voice, congruent facial expressions, and tender, calming behaviors. Through such repeated experiences with a sensitive caregiver, the infant develops an *internal working model* of how relationships work. Over time, the child begins to internalize this process as the basis for self-regulation.

When contingent communication between the caregiver and child is absent, erratic, or frightening, an insecure attachment style is created, and the developing child is left without the means to soothe emotions or control behaviors adequately. As a result, the child erects primitive defenses to protect from overwhelming internal states. These maladaptive coping strategies often predispose individuals to develop addictive behaviors. For example, a child who has a neglectful and unavailable caregiver may develop an anxious-avoidant attachment style, where attachment needs are denied and external objects are used to soothe. Many anxious-avoidantly attached children are at risk of later becoming dependent on various substances or experiences in an attempt to regulate internal feelings externally.

When contingent communication between the caregiver and child is absent, erratic, or frightening, an insecure attachment style is created, and the developing child is left without the means to soothe emotions or control behaviors adequately.

SHANNAE ANDERSON



Like insecure attachment, child abuse trauma can also render one at risk for addiction. When children experience the terror and powerlessness of child abuse, it takes a heavy toll on their developing brains. Powerful neurochemicals flood the brain, which can affect both its structure and function. In fact, because a child's brain is so malleable and vulnerable to environmental stressors, the impact of child maltreatment may leave an indelible imprint upon the entire nervous system. This abuse then produces a highly reactive nervous system that is difficult to regulate.

Because a child's developing mind cannot tolerate the emotional intensity and overwhelming consequences of child abuse, maladaptive psychological defenses are created to survive. For example, many individuals who were sexually abused as children used the psychological defense of *dissociation* to cope with the extreme physical and emotional assault on their minds and bodies. During the abuse, they learned to split off and essentially fracture their consciousness to cope with the devastating onslaught on their bodies. In adulthood, many continue to use dissociation as a primary coping strategy which hinders their ability to manage any emotional experience in a healthy manner. As such, they are at significant risk for addictions to numb their internal pain further.

Sadly, many victims of child abuse trauma suffer from an insecure attachment as well. These joint experiences create an even greater risk for later struggles with addiction. This is especially true for those abused by an attachment figure who was supposed to protect and care for them. When this occurs, it places a child in a dilemma of *fright without solution*. The person who is supposed to offer protection is harming them. As a result, normal attachment strategies fail, and the child is confused about where to find safety. Relationships become dangerous as these experiences of insecure attachment and child abuse trauma ultimately distort one's sense of self and understanding of others. Then, this interferes with interper-

sonal relationships that can have the power to heal these wounds. The most critical relationship that may be damaged is the one with Jesus Christ.

As Paul, Augustine, and Paschal identified centuries ago, there is a place inside each of us that only God can fill, like a specific *God attachment*. Unfortunately, many who struggle with addictions are searching to fill that place by external means rather than using God as the ultimate attachment figure who can facilitate internal self-regulation. Individuals with addictions who never have a secure attachment experience with their caregivers become attached to their "drug" for soothing and self-regulation.

Because addiction often has attachment insecurity and trauma at its core, treatment of addiction needs to incorporate interpersonal relationships as part of a recovery protocol. Self-help programs, such as Alcoholics Anonymous, Recovery ALIVE!, and Celebrate Recovery, provide such a system of interpersonal connection and accountability. In early recovery, people struggling with addictions are like young children who need an attachment figure to help them manage and regulate their internal emotional states. These programs utilize the power of God, and Jesus Christ specifically, in Christ-centered programs like Recovery ALIVE! and Celebrate Recovery to facilitate renewal. Similarly, finding a counselor with whom one can attach and feel safe can also establish healing. For complete healing, connecting to and creating a secure attachment with Jesus Christ is the ultimate mode of recovery. ✠

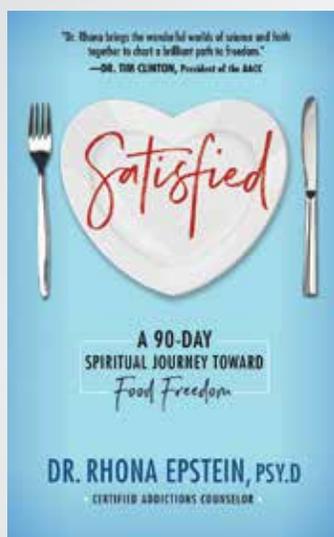


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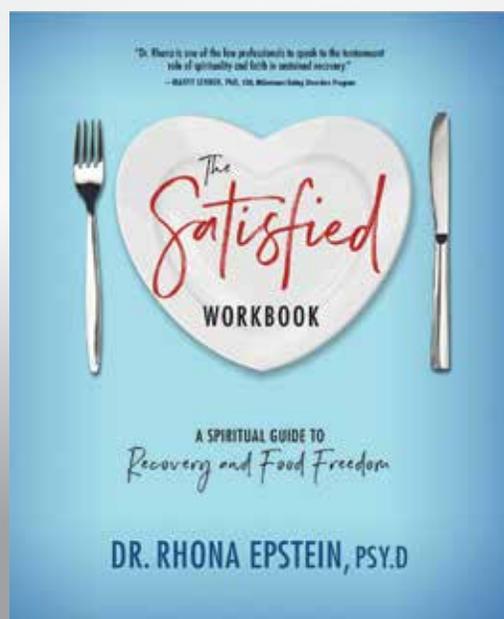
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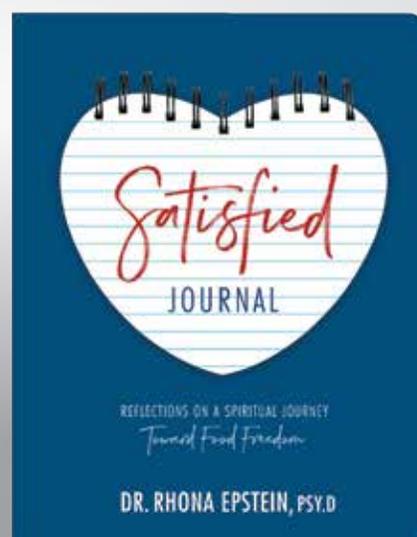


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# BONDAGE AND FREEDOM:

## *The Heart of the Addiction Journey*

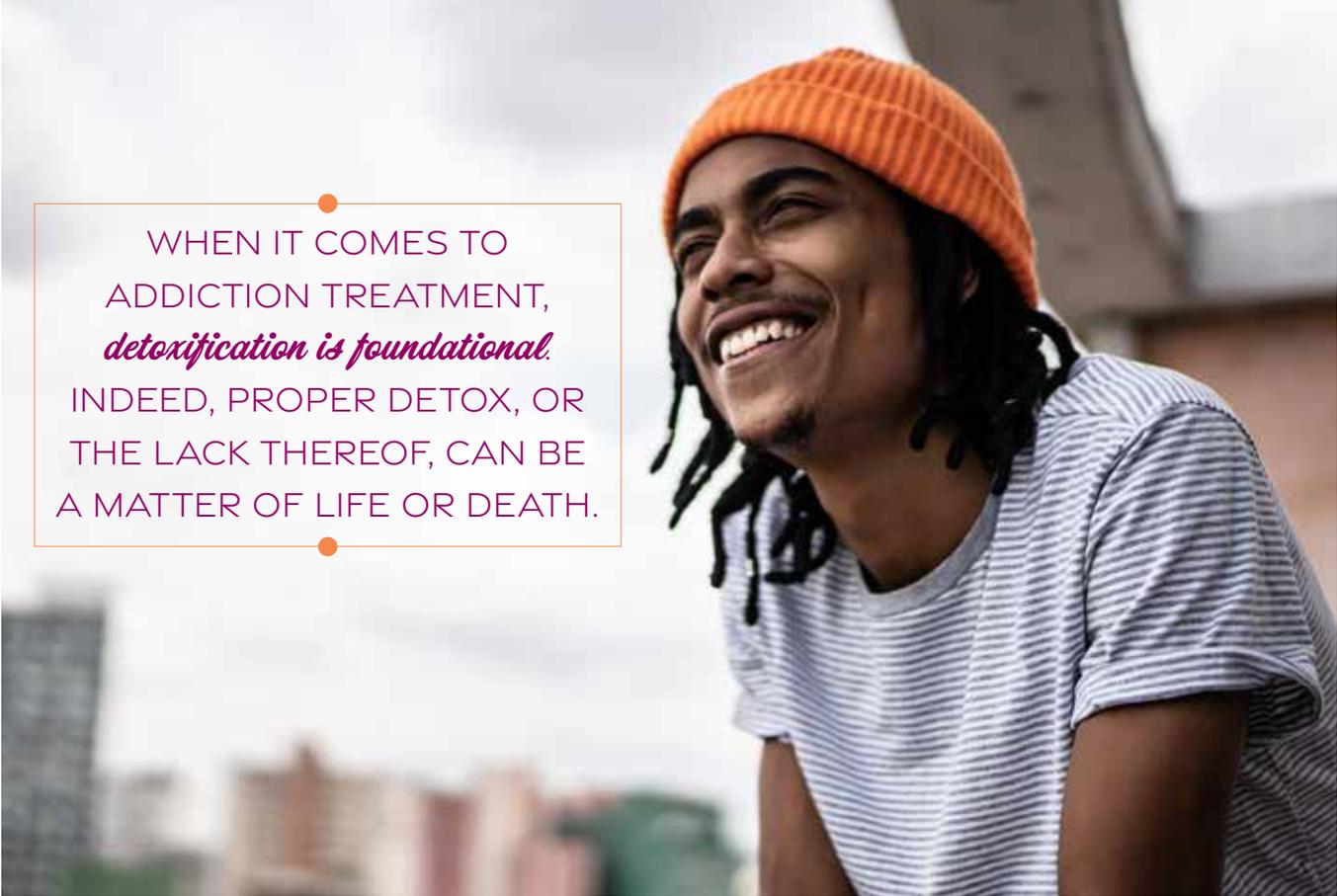
Amid the current global mental health pandemic, it is no surprise that addictions and various compulsive behaviors are rampant. These numerous addictions are all multifaceted problems that need a multi-layered treatment plan for detox, stabilization, and sobriety. This is true whether the diagnosed problem concerns alcohol, drugs, or the process addictions of gambling, financial disorders, or sex addiction. Of course, these addictions are often complicated even more by poly addiction, addiction interaction, and comorbidity with a plethora of accompanying mental health or mental illness conditions or diagnoses.

The mental health, mental illness, and addiction landscape is littered with individuals and their families under stress, financial impact, chronic fear, and concern about what the future holds with this bondage to out-of-control behavior. Those of us working on the battlefield of addictions and compulsions must continue to “curse the darkness” and “light a candle” every day for those experiencing bondage and not walking in the freedom and abundant life promised by God and His Word. And, yes, the fields of medicine, thera-

py, psychology, and solid addiction treatment professionals offer a path from these bondages to true freedom.

I encourage and remind those I work with in therapy and coaching who are battling strongholds, compulsions, and addictions of the following: “*We have more help and hope than you have problems.*” In Christian counseling, we are privileged, called to, and must be equipped to always present a biblical foundation of addictions and, yes, even addiction treatment.

JIM CRESS



WHEN IT COMES TO  
ADDICTION TREATMENT,  
*detoxification is foundational.*  
INDEED, PROPER DETOX, OR  
THE LACK THEREOF, CAN BE  
A MATTER OF LIFE OR DEATH.

Genesis chapter three is always a good place to start. Man and woman shifted traumatically from being “naked and unashamed” to “naked and ashamed.” When they made a volitional choice to take matters into their own hands, their eyes were immediately opened to see this world’s shocking vulnerability. So, they made a futile attempt to hide from each other and God. Grabbing fig leaves to try to cover their perceived inadequacies, anxiety, and fear, these original humans set in motion generations of people taking desperate measures to do whatever it takes to numb the pain, confusion, and realities of living in this fallen world.

Jeremiah 2:13 (NIV) appropriately describes addictions this way: “*My people have committed two sins: They have forsaken me, the spring of living water, and have dug their own cisterns, broken cisterns that cannot hold water.*” This passage is a vivid picture of the lives of people I have counseled struggling with various addictions and compulsions. While these addictions are indeed “muddy waters” from broken cisterns, they are at least available and accessible on demand whenever an addict wants to escape reality. We live in such an “on-demand” world today that our brains continue to be wired to abandon all patience and emotional sobriety. To escape, we scroll on social media, use search engines, and demand from people, places, and

things what we think we are entitled to by insisting that we obtain it immediately!

The brain’s reward center has been taken hostage—the prefrontal cortex is offline as the brain continues to be rewired, making stopping the use of addictive agents seem nearly impossible. We have become a nation of dopamine addicts, which has impacted our relationships with God. I often tell people I counsel that “G-O-D does not stand for ‘God-On-Demand!’”

When it comes to addiction treatment, detoxification is foundational. Indeed, proper detox, or the lack thereof, can be a matter of life or death. Detox is necessary to help clean the body from the chemicals the addict has used, whether alcohol or drugs. A medically supervised detox aims to help the alcoholic or addict safely go through withdrawal symptoms from these agents. These withdrawal symptoms may be mild or can be severe. Assessing the data regarding which drug of choice was used, how much of it was used, the method of usage, and the length of usage are critical factors in a medically supervised detox. One of the “life or death” issues surrounding detox is the fallacy of alcoholics or drug addicts who try to stop taking their drugs of choice by “going cold turkey.” These attempts can produce delirium tremens (DTs) for alcoholics and be fatal if not treated appropriately with medical supervision and care.

After appropriate medical detox, alcoholics or addicts will begin experiencing parts of their brains recovering. Again, each detox, concerning the type, amount, and frequency of usage, will have variances in the time of recovery and restoration of brain and body health and sobriety.

During the period of stabilization in alcohol and drug treatment, a steady state, or homeostasis, will involve emotional, physical, medical, mental, and spiritual components. The individual will typically attend 12-step meetings (or the like), group therapy sessions, and individual therapy. Ongoing psychoeducation about addictions, recovery, and a new life post-treatment is central to recovery. Examining the history of addictions in their family of origin, the impact of trauma in childhood, and the etiology of addiction in their own lives are central to recovery. The ongoing medical condition of the alcoholic or drug addict, and any comorbidity with mental health or mental illness, will be continually assessed and treated.

This persistent continuum of care is an absolute must for anyone coming out of treatment for alcohol, drugs, or any process addictions. Nehemiah chapter three is all about having people next to you as you are rebuilding “the walls” of your life. In this epic biblical narrative, we see the words, “*Next to him,*” repeated over and over again. In life, we are wounded from toxic relationships—often acting out in our addictions or becoming isolated—and then need to be healed and recover with healthy, supportive interactions and connections.

Ongoing individual therapy, group therapy, and 12-step or Celebrate Recovery meetings are a must for recovery. The Bible instructs us in 1 Peter 5:8 (NKJV): “*Be sober, be vigilant; because your adversary the devil walks about like a roaring lion, seeking whom he may devour.*” Those walking a solid recovery path need to continue working on *all* levels of sobriety. Emotional, physical, medical, and spiritual sobriety are all facets of a successful recovery plan. Stopping the use of alcohol or drugs is crucial, but living an overall healthy lifestyle increases the likelihood of ongoing sobriety and recovery success significantly.

I regularly recommend 2 Corinthians 10:3-5 (NIV) to those I am working with in counseling, whether they struggle with addictions or not. The Apostle Paul gives us one of the more powerful resources and counsel for dealing with any strongholds in our lives. Paul challenges, “*For though we live in the world, we do not wage war as the world does. The weapons we fight with are not the weapons of the world. On the contrary, they have divine power to demolish strongholds. We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ.*” Let’s go help set some captives free! ✠



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# THE NEUROSCIENCE OF ADDICTION AND BEHAVIOR CHANGE: TIME EFFECTS OF DRUGS

*“Brothers, if anyone is caught in any transgression, you who are spiritual should restore him in a spirit of gentleness. Keep watch on yourself, lest you too be tempted. Bear one another’s burdens, and so fulfill the law of Christ.”*  
– Galatians 6:1-2, ESV

The United States is, unfortunately, experiencing unprecedented substance use and mental health problems.<sup>1</sup> No ages, races, income levels, or geographical locations have been spared.<sup>2</sup> Significant increases in loneliness, mental health, and substance use were noted during the last several years, with the worst outcomes noted in teens and young adults.

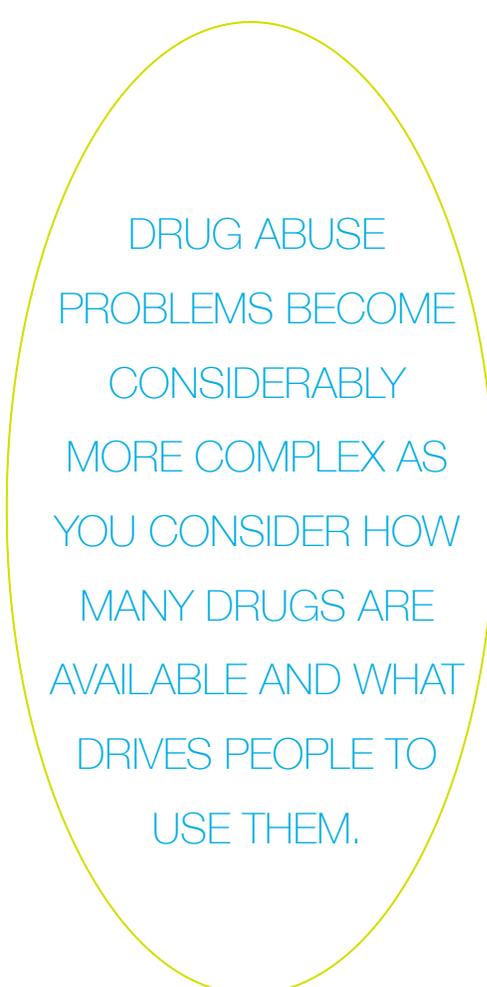
Such problems have caused immeasurable harm through increased homelessness, hospitalizations, crimes, violence, and deaths. More specifically,<sup>3</sup> among people aged 12 or older, 57.8% used tobacco, alcohol, or an illicit drug in the past month, including 47.5% who drank alcohol, 19.5% who used a tobacco product, and 14.3% who used an illicit drug. In 2021, the percentage of people aged 12 or older with a substance use disorder (SUD)

was highest among young adults aged 18 to 25 (25.6%), followed by adults aged 26 or older (16.1%), then by adolescents aged 12 to 17 (8.5%). Similarly, 5.5% of adults aged 18 or older had a serious mental illness (SMI) in the past year. The percentage of adults aged 18 or older with SMI was highest among young adults aged 18 to 25 (11.4%), followed by adults aged 26 to 49 (7.1 %), then by adults aged 50 or older (2.5%). Given these alarming statistics, it should be no surprise that parents' number one concern is their children's mental health, followed by fears around substance use.<sup>4</sup> Understanding these issues is of paramount importance, and probably one of the least understood factors is how drugs actually work, especially across time.

Let us start with an *easy* question: What is the most addictive drug available today? Almost everyone answers from a purely drug-focused point of view, often ignoring the complex biopsychosocial risk factors associated with addiction. The answer is the most readily available drug with the highest reward value self-administered at a vulnerable point in time. All three factors (readily available, reward value, and vulnerable age) influence each other, creating a unique risk profile.

Drug abuse problems become considerably more complex as you consider how many drugs are available and what drives people to use them. People use drugs to produce an altered state, such as to elevate mood, decrease anxiety, alleviate boredom, reduce pain, increase energy, or focus attention. Moreover, people also use drugs, often unknowingly, to modify the effects of drugs, including consuming alcohol to reduce anxiety associated with amphetamine use or smoking marijuana to induce sleep after taking too much Ritalin. Using one or more drugs to modify the consequences of another is often the start of, and transition to, abuse and, consequently, withdrawal from important daily activities.

The relationship between the time course (i.e., absorption, half-life, and rebound) and adverse consequences of drug use is poorly understood, often misunderstood, or simply underestimated, partly because few people know how drugs work. Drugs do not have any magical or mystical properties; rather, all drugs work solely by increasing or decreasing existing biological processes. As an individual becomes dependent on a drug, neurons within the brain's reward system change at the epigenetic level (i.e., the interaction between environment and gene expression) during repeated drug exposure. These drug-induced epigenetic adaptations result in long-lasting changes in brain function and, thus, behavior—generally experienced as tolerance and withdrawal. Consequently, these changes contribute to long-term, drug-related behavioral abnormalities.<sup>5</sup> Furthermore, if the exposure occurs during a critical development period (i.e., prenatal, adolescence, or older adulthood), it could potentially cause permanent problems as the epigenetic changes redirect brain maturation.



DRUG ABUSE  
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BRIAN KELLEY AND BLAKE FRASER

While the nervous system dampens responses to intermittent drug use, other organ systems are less able to adapt, thus, creating a series of unhealthy and cascading consequences (e.g., fatty liver from alcohol exposure or tar and scarring in the lungs from smoking). Combine these problems with changes from co-occurring stress, depression, trauma, fatigue, and pain issues, and you might begin to appreciate how challenging it is to fully understand the initiation and maintenance of substance use disorders.

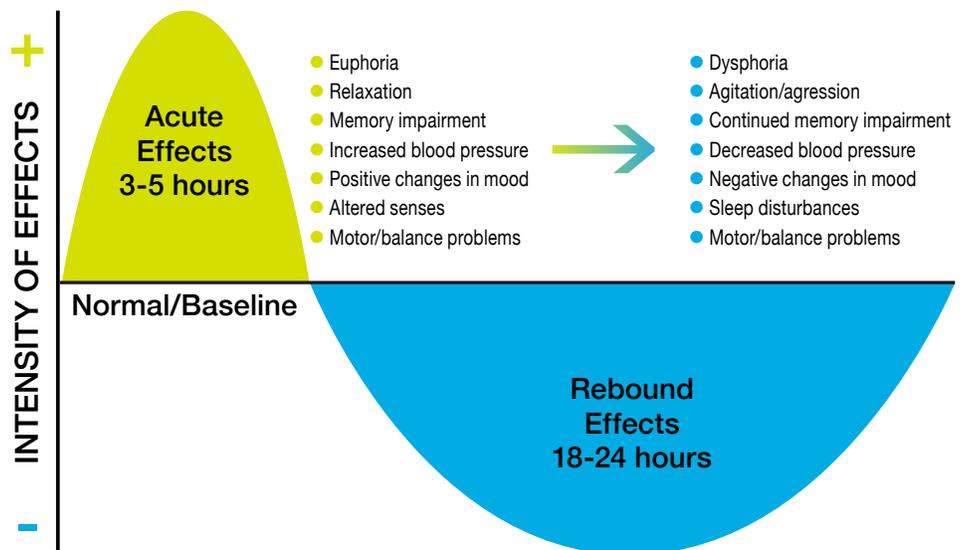
How drugs work across time is complex and confusing, especially considering drug effects are almost always framed around their immediate, acute results. The faster a drug enters your brain, the faster you will be able to learn to associate the psychoactive properties with its desirable outcomes, like euphoria. In contrast, the slower a drug enters your brain, the slower the association. Therefore, the faster a drug enters the brain, the more likely the drug will be abused. This effect is why cigarettes are abused and not nicotine patches, even though both deliver the same drug dose. It is also why most abused drugs move toward injection or inhalation, as those routes produce the most rapid effects.

Drugs with short half-lives (i.e., how long a drug stays active in your body) have higher abuse rates than similar ones with a longer half-life. For example, cigarette smokers like maintaining a steady concentration of nicotine in their bodies, which has a half-life of about two hours. Most smokers find

themselves lighting a cigarette just about two hours after their last smoke but generally have no idea that the rate of absorption and elimination are driving those behaviors. This phenomenon describes an important process called a steady state. A drug is said to be in a steady state when an equal amount is being administered and eliminated. Any drug generally takes five to six half-lives to achieve a steady state. Likewise, it takes that same number of half-lives for a drug to be fully eliminated. People follow drug usage patterns that match the absorption and elimination rate without even realizing it. So, even if someone stops using drugs, it could take many hours, or even days, to be entirely drug-free.

Once all the drug is eliminated, rebound effects will occur and are another unavoidable, time-related effect of drug use. A rebound effect takes place because the body is trying to bring itself back to a normal (pre-drug) level of functioning. It is important to note that the rebound effect tends to overcompensate, thus producing an exaggerated effect, often lasting considerably longer than the initial drug effect. In other words, if a drug activates a particular process (e.g., euphoria) and is removed, that process shows an inverse effect (e.g., dysphoria). The rebound effect will last longer than the initial effect. As with abused drugs, the exact experience or problem the drug user is trying to stimulate or eliminate, like euphoria or fatigue respectively, comes back and is worse than before the drug was taken and lasts longer.

This outcome drives greater drug use—now with a deep sense of urgency (i.e., craving), which is often the case with marijuana and a trigger for daily use. For example, a person who uses marijuana to produce euphoria will experience dysphoria and anxiety upon discontinuation, which feels like depression, potentially up to a week or longer. Those feelings of anxiety and depression, combined with a generally poor mood, are actually a rebound effect. Rarely would a person understand this relationship even a week later, as the poor mood and anxiety, among other complaints, are still part of the overall drug effect, albeit delayed. So, it is not surprising to find this same person saying that (now) *medical* marijuana actually helps them feel normal or better when they are just self-administering the drug to recover from the rebound effects. Sleep aids further exemplify this—if a person discontinues use after just several days, they will often experience numerous nights of debilitating insomnia. This issue is especially problematic today with marijuana (i.e., cannabis), as young people get most of their information on TikTok and Facebook, which is often part of a sophisticated marketing campaign intended to drive experimentation and daily use.





During the rebound phase, even more of the drug will be required because it now must bring the physiology back to normal before it can begin to produce the desired effect. In the case of sleep aids, while one pill may have worked before, it may take two or even three during the rebound phase. Of course, this will create an even bigger rebound phase in the next cycle, which is why the rebound effect plays a significant role in maintaining continued and compulsive drug use.

As more drugs are required, the adverse or side effects become more prominent. Often, this is when use becomes compulsive, followed by the addition of other drugs to help mitigate the now expanding profiles of withdrawal, rebound, and compounding side effects. This entire process is made dramatically more complicated as additional drugs are added, each with its own absorption rate, half-life, rebound, and side effects. Since people are generally unaware of the time effects of just one drug, they will most certainly not understand the overlapping and compounding effects of multiple drugs—which is one of the underlying factors in treatment and recovery. Helping someone understand these effects is an important starting point for harm reduction and recovery.

We need to move more generally from a model of what is wrong with you (not an actual question) or what happened to you to what can I do to help. That is, we need to move away from a backward-looking judgmental approach focusing on why the person is a moral failure to a forward-looking empathetic approach focusing on improving that person's quality of life. Understanding how drugs work is a vital component of this process. ✖



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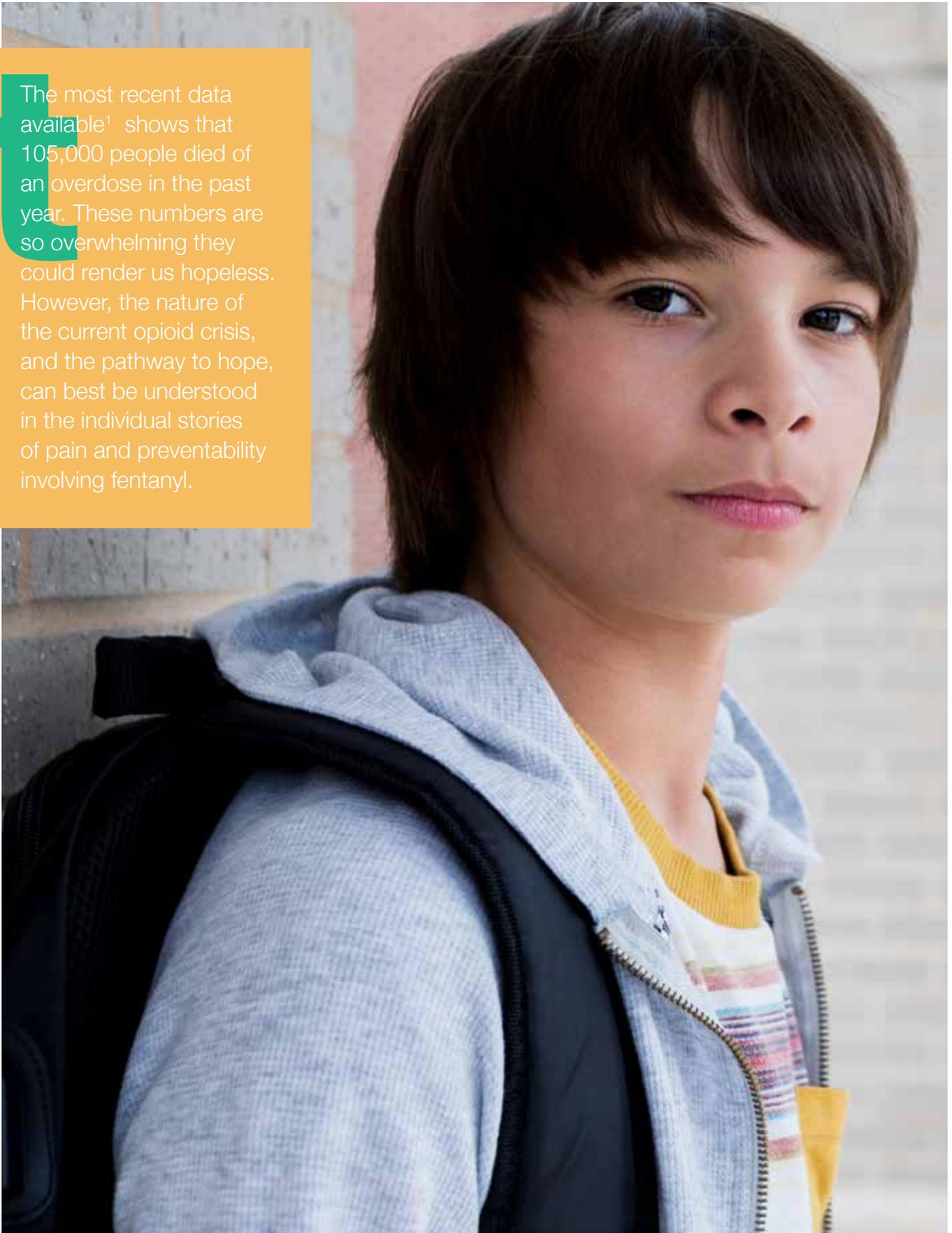


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## Endnotes

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The most recent data available<sup>1</sup> shows that 105,000 people died of an overdose in the past year. These numbers are so overwhelming they could render us hopeless. However, the nature of the current opioid crisis, and the pathway to hope, can best be understood in the individual stories of pain and preventability involving fentanyl.



# PREVENTING FUTURE GENERATIONS FROM HARM

The striking reality is that in the 12 months ending in October 2021, 80,816 deaths were attributed to an overdose of opioids. More than 71,000 of them came from overdoses of synthetic fentanyl.<sup>2</sup>

In 2022, *The Washington Post* shared the tragic story of Zach Didier.<sup>3</sup> Zach was a 17-year-old Eagle Scout, soccer player, and high school musical star. Zach purchased what he thought was Percocet® on the instant messaging app, Snapchat. Tragically, what Zach bought was a “hot pill” or a fake prescription tablet containing a deadly level of illicit fentanyl. According to the Centers for Disease Control and Prevention (CDC), this lethal drug, a synthetic opioid, can be up to 50 times more powerful than heroin and 100 times stronger than morphine. When Zach took this pill, it poisoned him by disrupting his ability to breathe, decreasing the amount of oxygen going to his brain, and ultimately ending his life.

## “The Superhighway of Drugs”

Snapchat and other social media sites have become “the superhighway of drugs,” according to Ann Milgram, who leads the U.S. Drug Enforcement Agency.<sup>4</sup> Social media is being used by drug traffickers to advertise drugs and conduct sales. A drug trafficker can find anyone with a smartphone and a social media account, which also means they can find our kids who have social media accounts.<sup>5</sup> Criminal drug networks mass-produce fake pills and falsely market them as legitimate prescription pills to deceive the American public—especially America’s youngest generations.



HEIDI CHRISTENSEN



### Experimentation for Youth Can Be a Death Sentence

Many young people have never heard of illicit fentanyl or what it might have to do with them. Their lack of awareness increases their risk of death through experimentation.<sup>6</sup>

According to a 2020 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA), “Among people aged 12 or older in 2020, 3.4% (or 9.5 million people) misused opioids (heroin or prescription pain relievers) in the past year. Among the 9.5 million people who misused opioids in the past year, 9.3 million also misused prescription pain relievers...”<sup>7</sup> This misuse makes them vulnerable to deadly substances like illicit fentanyl.

Due to its heroin-like effect, most fentanyl overdoses are associated with being manufactured and distributed illegally on the market. Because of its extreme potency, fentanyl is frequently added to additional drugs making them inexpensive, more powerful, addictive, and incredibly dangerous.

### Working to Get Ahead of the Curve

So how do we get ahead of this perilous movement into the lives of our children and young adults? How might parents, families, congregations, and community leaders increase protective factors that may prevent a young person from misuse in the first place—or help them make healthier decisions and set them up for a more resilient future?

While the challenge is great, faith and community leaders can help to get ahead of the curve through local prevention efforts. At the Center for Faith-based and Neighborhood Partnerships here at the U.S. Department of Health and Human Services (HHS), we have been working with faith and community leaders to strengthen their response to the opioid crisis and other critical health issues and crises.

We recently released the *Practical Toolkit for Preventing Drug Overdose and Supporting Recovery in Faith and Community Settings* (4th Edition) (<https://www.hhs.gov/sites/default/files/preventing-drug-overdose-and-supporting-recovery-in-faith-and-community-settings.pdf>) to guide community leaders in not only supporting those in treatment and recovery from Substance Use Dis-

orders (SUDs) but also to help them lean into strategies that may prevent a young person from future misuse and other long-term harms. The toolkit has also been translated into Spanish (<https://www.hhs.gov/sites/default/files/june-2022-un-kit-de-herramientas-pr%C3%A1cticas.pdf>) for use in Spanish-speaking congregations and communities.

### Help Prevent Future Harm

Faith and community-based organizations can be well positioned to increase protective factors for children and young adults, promote social norms that protect against violence and adversity, connect youths to caring adults and activities, and intervene to lessen immediate and long-term harm.

It starts with strengthening the health literacy of communities as it relates to substance use disorders, addiction, and drug-related deaths. We all need to be educated on the current drug threats to have informed conversations with children and youth in our communities. Tools and resources are readily available that can be shared with family members and posted on congregational and community websites:

- Share the Drug Enforcement Administration’s (DEA’s) One Pill Can Kill initiative ([https://www.dea.gov/onepill?utm\\_medium=email&utm\\_source=govdelivery](https://www.dea.gov/onepill?utm_medium=email&utm_source=govdelivery)) that includes “What Every Parent and Caregiver Needs to Know About FAKE PILLS” (including pictures of legit or fake prescription pills).
- Visit the DEA’s Get Smart About Drugs website (<https://www.getsmartaboutdrugs.gov/illicit-fentanyl-psa>) and post the provided PSA on illicit fentanyl on your social media—it is eye-opening.



*Communities can... participate in trainings... that teach adults the basic skills to recognize and respond in the case of a mental or behavioral health crisis that includes substance use disorders.*

- Share the CDC’s website (<https://www.cdc.gov/stopoverdose/index.html>), designed to educate people who use drugs about the dangers of illicitly manufactured fentanyl, the risks and consequences of mixing drugs, the lifesaving power of naloxone, and the importance of reducing stigma around recovery and treatment options.
- Download the federal resource, Growing Up Drug Free: A Parent’s Guide to Substance Use Prevention (<https://www.getsmartaboutdrugs.gov/sites/default/files/publications/Final%20%28508%20Compliant-Online%29-small.pdf>).
- Learn about emoji codes (<https://www.getsmartaboutdrugs.gov/family/drug-use-internet-social-media>) used on social media to buy and sell counterfeit pills and other illicit drugs.
- Invite local public health experts (<https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html>) to speak directly to your community about current prevention efforts.
- Share Submit a Tip (<https://www.dea.gov/submit-tip>) to the DEA if you suspect illegal prescription drug sales, but in the case of an emergency, *report it to your local police or law enforcement authority.*

### Strengthen Your Community Response

Communities can also build their capacity to support prevention efforts by joining the actions of their local Drug-Free Community Coalition (<https://www.cdc.gov/drugoverdose/drug-free-communities/index.html>). They can also participate in trainings such as Mental Health First Aid and Youth Mental Health First Aid (<https://www.mentalhealthfirstaid.org/population-focused-modules/youth/>) that teach adults the basic skills to recognize and respond in the case of a mental or behavioral health crisis that includes substance use disorders. There is also teen Mental Health First Aid (tMHFA) (<https://www.mentalhealthfirstaid.org/population-focused-modules/>

teens/) teaching teenagers (in 10th-12th grade or between the ages of 15-18) how to identify, understand, and respond to mental health signs and substance use encounters with their friends and peers.

### Be Prepared to Reverse an Overdose

If “one pill can kill,” we want to do everything in our power to prevent a mistake from ending a life. More and more community and school leaders are getting the training they need to administer the opioid-reversal drug, naloxone (<https://nida.nih.gov/publications/drugfacts/naloxone>). According to one study, “bystanders were present in more than one in three overdoses involving opioids.”<sup>8</sup>

Naloxone can be carried by anyone and administered to a person suffering from an overdose. Having the right tools can save lives by preventing overdose deaths. You can reach out to local public health departments, law enforcement, or some pharmacies to train community members. Here are a few helpful links:

- Prevent & Protect Site (<https://prevent-protect.org/>) – Provides help for people to gain access to naloxone. It also offers tools for organizations conducting overdose prevention and naloxone advocacy, outreach, and communication campaigns.
- Drug Overdose Immunity and Good Samaritan Laws Site (<https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws>) – Policymakers are seeking solutions that will help curb use and overdose by expanding Good Samaritan immunity and increasing naloxone access.
- Naloxone Training Video from the Baltimore City Health Department Site (<https://www.youtube.com/watch?v=YyDdMdLvdBc>) – This video explains the dangers of opioid misuse and symptoms to recognize an opioid overdose. It demonstrates how to assemble a naloxone kit and administer naloxone intranasally.

*Friends, there is no sideline when it comes to the overdose crisis. Information in the right hands is a powerful tool and critical safety net against this current trend of drug trafficking to our most hopeful generation.*

### Learn About ACE's Key Principles in the Prevention of Use

We are learning more about why some youths are more susceptible to risk-related behaviors than others. They are often the children who have been exposed to abuse, violence, neglect, mental illness, substance use disorders in their household, or any other Adverse Childhood Experiences (ACEs) (<https://www.cdc.gov/violenceprevention/aces/index.html>).

The greater the number of ACEs a person experiences, the greater the risk that person will develop poor health outcomes, engage in risky behaviors, or be at higher risk for substance use disorders and other long-term harms.<sup>9</sup>

Fortunately, faith and community leaders can play a vital role in creating an environment and fellowship that offer protective factors that will buffer or mitigate ACEs. Learn more about ACEs by sharing and participating in the CDC's newly released Preventing Adverse Childhood Experiences: Training for Faith, Spiritual, and Religious Communities (<https://www.youtube.com/watch?v=OOC5dh4BNZQ>). You and your community members will learn about risk and protective factors, outcomes associated with ACEs, and evidence-based strategies you can use to reduce or eliminate the impact of ACEs and stop them from occurring in the first place.

Friends, there is no sideline when it comes to the overdose crisis. Information in the right hands is a powerful tool and critical safety net against this current trend of drug trafficking to our most hopeful generation. Please let our office know if we can assist your efforts by reaching out to us at [HHSPartnerships@hhs.gov](mailto:HHSPartnerships@hhs.gov). Thank you for being an agent of hope and a beacon of light to those who need you most in your community. ✕

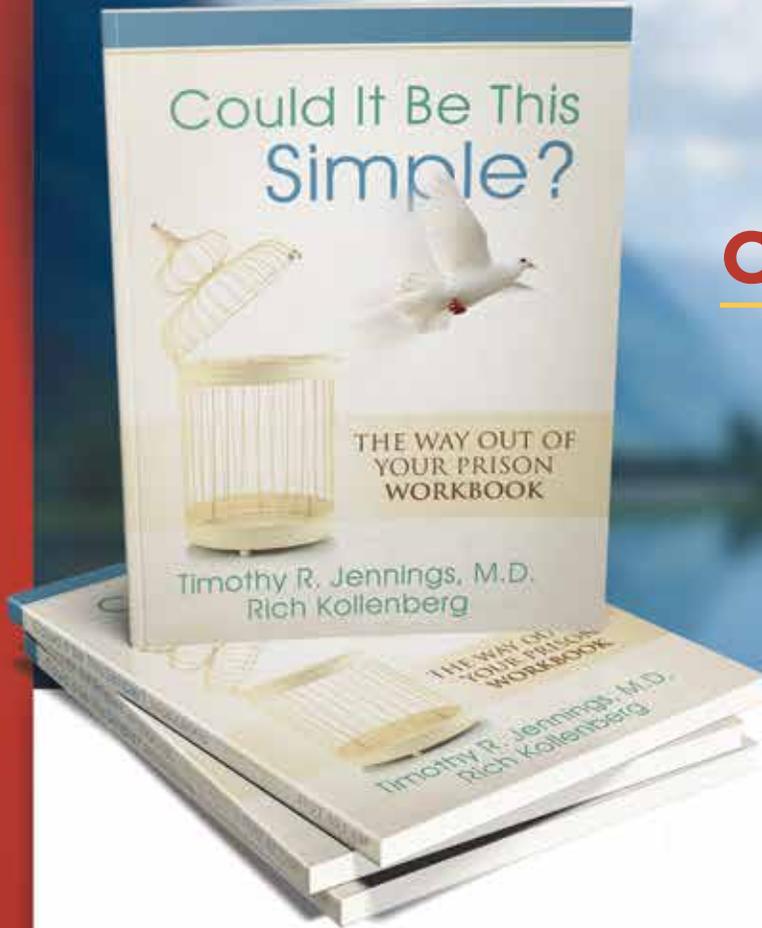


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issues. Heidi has coordinated coalitions of diverse faith and community-based partners to address issues that have included childhood obesity, access to healthcare, the epidemic of addiction, and COVID-19 prevention, as well as the social and economic issues challenging the health of our nation's communities.

### Endnotes

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# Spiritual Strongholds and Addiction:

PATTERNS, PROGRESSION, AND POWER



This article considers spiritual strongholds, their involvement in addiction, and principles for addressing them. Key illustrative passages and words from the Bible help clarify terms and concepts, followed by information related to addiction and how spiritual strongholds may be involved. Several principles for responding biblically and effectively to individuals who struggle, and as those who care, close out the article.

## **BIBLE STUDY<sup>1</sup>**

### **Strongholds**

In the Old Testament, passages such as Judges 6:2 present strongholds as fortified places, often inaccessible, that commonly provide security and refuge. One of the key Hebrew words for stronghold is *masada*, also the name of the famous site in Israel of the final stand of the Jewish revolt against the Romans in 73 B.C. In Psalm 9:9 and Psalm 18:2, Yahweh Himself is a stronghold for the oppressed, those in trouble, and those needing deliverance and refuge.

In the New Testament, the word translated as stronghold is in 2 Corinthians 10:4. The apostle Paul uses military terms of war to teach us that, although we are in physical bodies in a physical world, we do not conduct war according to this world. Instead, the implements of our warfare have divine godly power for tearing down, demolishing, and destroying “strongholds” or fortresses in a context that implies these are spiritual in nature. Paul provides more specificity about the strongholds in verse 5. He uses a Greek word variously translated as “speculations, arguments, or pretensions” to describe hostile, arrogant reasonings and calculations. Paul also describes the destruction of every arrogant, pretentious thing, even in otherworldly, supernatural places raised against the knowledge of God. In addition to destroying these things, Paul also takes every thought captive to obedience to Christ. Interestingly, the next verse (v. 6) links this obedience of thought to the complete obedience of the Corinthians to whom he is writing.

### **Spiritual Struggle**

A second New Testament passage related to spiritual warfare is Ephesians 6:10-17. There, Paul tells us to be strong in the Lord and His mighty strength. Putting on the full armor of God enables us to stand firm against the “schemes, cunning, and craftiness” of the devil because our struggle is not against fleshly, worldly things. In the New Testament, the Greek word translated as struggle is only used in this passage, but in other literature, it also means wrestling or conflict, which implies the struggle can be ongoing. Paul specifies that our struggle is against: 1) rulers with authority that is supernatural; 2) supernatural authorities that rule and judge; 3) rulers supernaturally empowered in a dark, evil abode; and 4) spiritually wicked powers in heavenly places. The acronym, RAPE (rulers, authorities, powers, forces of evil), can help recall these primary objects of our warfare.

DAVID E. JENKINS



Because of this struggle, Paul once again tells us to put on the full armor of God so that we can resist, oppose, and even be hostile toward those forces resulting in us still standing. He details what this armor entails: truth, righteousness, the gospel of peace, faith, and salvation. These implements of spiritual battle should characterize any helping technique.

Strongholds are real. While they can be physical and material, strongholds can also be psychological, relational, and spiritual. Importantly, they can be places of godly refuge, security, and protection; or they can be mental and spiritual types of bondage, oppression, wickedness, and hostility toward God. Thankfully, God has equipped and empowered us to be victorious in this war and endure in the midst of it confidently.

### Addiction

Addiction involves the total person. A common tool for helping us understand it is the bio-psycho-socio-spiritual model. Although this article primarily focuses on spiritual and cognitive aspects, even the biblical findings previously mentioned point to the biological and sociological (relational). Addiction typically results from a progression through stages, including experimental, social, medicinal, and addictive use. Most people who use alcohol, for example, do not have problems related to their use. Those who progress from use to misuse of substances or behaviors, such as gambling, extreme Internet consumption, or sex, begin doing so for the experience itself with increasing disregard for consequences (psychological). Using behavior increasingly occurs in isolation and secrecy from others (relational). Tolerance (needing more to get the same effect) and withdrawal (unpleasant results of not using) increase in intensity and characterize dependence (biological). If progression continues, craving (an intense, urgent, abnormal desire or longing) and loss of control (decreased ability to regulate use) develop and, together with tolerance and withdrawal, characterize addiction.

As you can see, the process of addiction involves distortions in thinking, feeling, and behaving that become increasingly rigid, entrenched, and difficult to change. The nature of addiction itself closely mirrors the nature of spiritual strongholds. In fact, addiction is often considered a “worship disorder” (i.e., a form of idolatry) since strong desires can have God or “lusts” as their object. Is it possible (likely?) that spiritual strongholds related to addiction have progressed to become places of refuge, security, and protection for the enemy of our soul? Freedom from addiction involves wrestling, conflict, and the will to ultimately be victorious. It is much more like a 15-round boxing match with Rocky than a 90-second knockout with Mike Tyson!

## Conclusion

“There are two equal and opposite errors into which our race can fall about the devils. One is to disbelieve in their existence. The other is to believe, and to feel an excessive and unhealthy interest in them. They themselves are equally pleased by both errors, and hail a materialist or a magician with the same delight.”<sup>2</sup>

– C.S. Lewis

Several key principles for addressing addiction-related strongholds emerge from our biblical study and reflection on addiction.

- Those struggling should be lovingly reminded to focus on God (the Person) as their Stronghold rather than any spiritual strongholds (the pretensions) that may be involved.
- In 2 Corinthians 5:6-8, Paul provides more context for his teaching on strongholds and emphasizes he is more focused on “building up” than “destroying” the believers in Corinth. Those we care for can be responded to in such a way, especially when being confronted or challenged, that they know their coach or counselor has their best interests in view. Tearing down strongholds is much different than tearing down people!
- Those in current bondage to strongholds should be disciplined in such a way that their obedience of self to Christ is the key to making their thoughts about God, self, and others obedient. Remember, freedom “from” is more likely if freedom “to” is more salient.
- Captives should be encouraged that war can be victorious even when some battles are not won. Fostering their ability and willingness to stay in the fight will help them “stand firm,” especially when they are experiencing hostile opposition.
- Those struggling should be shown they are not in this fight alone and that honesty and vulnerability are also required from those helping them. Helpers, too, should have the “air support” of prayerful partners in this conflict.
- In 2 Corinthians 2:10-11, Paul identified forgiveness as a primary means of defeating the devil’s schemes. “... *Father, forgive them, for they do not know what they are doing...*” (Luke 23:34, NIV) was spoken by Jesus from the cross, not before or after. Those in the grip of strongholds should be supported in genuine, Christlike forgiveness of those who have wronged them, including themselves.

Demolishing strongholds is about truth more than power. It is important to remember that the Truth of Jesus Christ brings freedom (cf. John 8:31-38 where Jesus instructs on truth, freedom from bondage, and the devil). May God, our stronghold, find us faithful as we fight the good fight of faith! ✠



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# Forgiveness

## IN ADDICTION AND RECOVERY

Substance-use disorders seem omnipresent... just Google “addiction stories in the news,” as Christian clinical psychologist, Jon Webb (2021), suggested in his excellent, recent book, *Understanding Forgiveness and Addiction*. I did on January 17, 2023, and there were nearly 93.1 million hits... and those are just the ones in the news.

Treating substance-use disorders is complex. There is no single pathway from use to addiction to treatment to recovery. Counselors have tried many ways to help people recover from addictions, but too often, we have failed.

### **How is Forgiveness Involved in Addiction and Recovery?**

Basic research on how forgiveness (or not) might be an issue in addiction and recovery has blossomed. Webb excellently digests that research. Here are a couple of points to consider.

Many people struggling with substance misuse have histories of hurt with significant people in their lives. Scherer et al. (2012) found that most people with alcohol-use problems

report unforgiveness of at least one family member and often blame work supervisors, God, or stress for their substance misuse. However, many with substance-use disorders also wrestle with self-condemnation. Early treatment is typically littered with blaming others, but as treatment progresses, people often better understand their disorder’s impact on those around them. Guilt, regret, remorse, and shame can replace the unforgiveness of others. Also, suicidality can accompany self-condemnation.

### **Evidence-based Treatments (EBTs)**

To improve your odds of successful treatment of people in addiction and recovery, recognize that unforgiveness plays a role—perhaps, for many, a significant one. If you can treat that, you can help more people.

## EBTs for Addiction

Many EBTs can be used to treat substance-misuse disorders in inpatient and outpatient settings. I will list only a few. There are some medication-based treatments (see McKay et al., 2015), but I will focus on psychological therapies. For extended summaries, see Webb (2021).

The 12-step Model is an effective community-based treatment for addiction and recovery (see Kelly et al., 2020, for a Cochrane systematic review of its effectiveness). Especially important in the 12-step Model is its insistence that an active Higher Power can help. Step 8 (forgiving others, seeking forgiveness from others, and forgiving oneself) and step 9 (making amends wherever possible and appropriate) directly promote forgiveness and reconciliation. Twelve-Step Facilitation Therapy (Nowinski, 2012) is *the* program for therapy.

Motivational interviewing is a conversation about change. It seeks to draw out, direct attention to, and empathize with the values and desires of the person struggling with addiction. This approach can be combined with the Transtheoretical Model's stages of change to motivate people to move from stage to stage. Cognitive-behavioral (CB) coping skills models can also help people deal with substance misuse, including relapse prevention methods. Miller (2004) has combined the 12-step Model, motivational interviewing and stages of change models, and CB models into the COMBINE treatment, which has strong research support. Other treatments, too numerous to describe in a brief article, have begun to accumulate effectiveness data.

## EBTs for Unforgiveness

For helping people forgive, both the Worthington (2020) REACH Forgiveness Model (see Worthington, 2020) and Enright's Process Model of Forgiveness (Freedman & Enright, 2020) have more than 30 randomized controlled trials (RCTs) supporting their effectiveness. The next most frequently studied approach has only six such studies.

Worthington's model ([www.EvWorthington-forgiveness.com](http://www.EvWorthington-forgiveness.com)) is aimed mostly at changing emotions of unforgiveness into more forgiving ones, which are the focus of the REACH steps to R=Recall the hurt, E=Empathize with the offender, A=give an Altruistic (undeserved) gift of forgiveness, C=Commit to the forgiveness experienced, and H=Hold onto forgiveness when you doubt and make a motivated decision to forgive. Decisional forgiveness is treating the offender as a more valued and valuable person. This model also seeks to help people become more forgiving in general. It is available in explicitly Christian (six RCTs) and secular (more than 25 RCTs) forms for both psychoeducational groups and do-it-yourself workbooks. Also, it has been applied to self-forgiveness with inpatients for addiction (Scherer et al., 2011). Griffin et al.'s (2015) six-step model advocates first taking the problem to God, then seeking to make amends, and then trying to deal with psychological troubles like rumination and moral injury (i.e., injuring one's own sense of morality by what one has done, observed, or willingly ignored). After those steps, the REACH Forgiveness Model can be applied to the self to promote emotional self-forgiveness and a decision to forgive oneself. Then, the person works on self-acceptance while committing not to relapse.



EVERETT L. WORTHINGTON, JR.

If you modify an EBT, do not assume your changes will necessarily help. Assess your patients carefully. Collect data on several. Humans are masters at what social psychologists call self-enhancing bias, which includes looking selectively for evidence that supports our modifications.

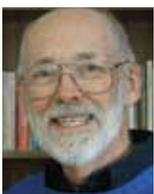
The Enright Process Model of Forgiveness ([www.internationalforgiveness.com](http://www.internationalforgiveness.com)) comprises 20 steps, arranged in four phases (uncovering, decision, work, and outcome/deepening). It seeks to help people change their affect, behavior, and cognition regarding the wrongs they have experienced. Enright has written about Christian applications but has not specifically adapted them for Christians.

In a meta-analysis, Wade et al. (2014) showed that both were equally effective per hour of intervention. The most significant driving force in helping people forgive is the time they spend trying seriously to forgive. Webb (2021) showed how EBTs for addiction relate to forgiveness treatments—particularly the REACH Forgiveness and Process Models.

### Practical Advice

Find a treatment for addiction and recovery that fits your values. Adopt one of the EBTs for promoting forgiveness. (Naturally, I recommend REACH Forgiveness, and the research shows it to be equivalent to Enright's Process Model.)

Consider modifications to those protocols carefully. Research shows that you can weaken outcomes by making changes—like leaving out portions or mixing two or more together. If you modify an EBT, do not assume your changes will necessarily help. Assess your patients carefully. Collect data on several. Humans are masters at what social psychologists call self-enhancing bias, which includes looking selectively for evidence that supports our modifications. Rather, embrace Christian humility. Apply it to your own practice. There is nothing wrong with making changes to EBTs. In fact, changes might improve the outcomes. Although we can boldly make changes, determining a wise modification requires spiritual discernment, prayer, interaction with specific patients with particular needs, collecting hard data to make informed judgments, and having a humble approach to our own effectiveness as helpers. ✨

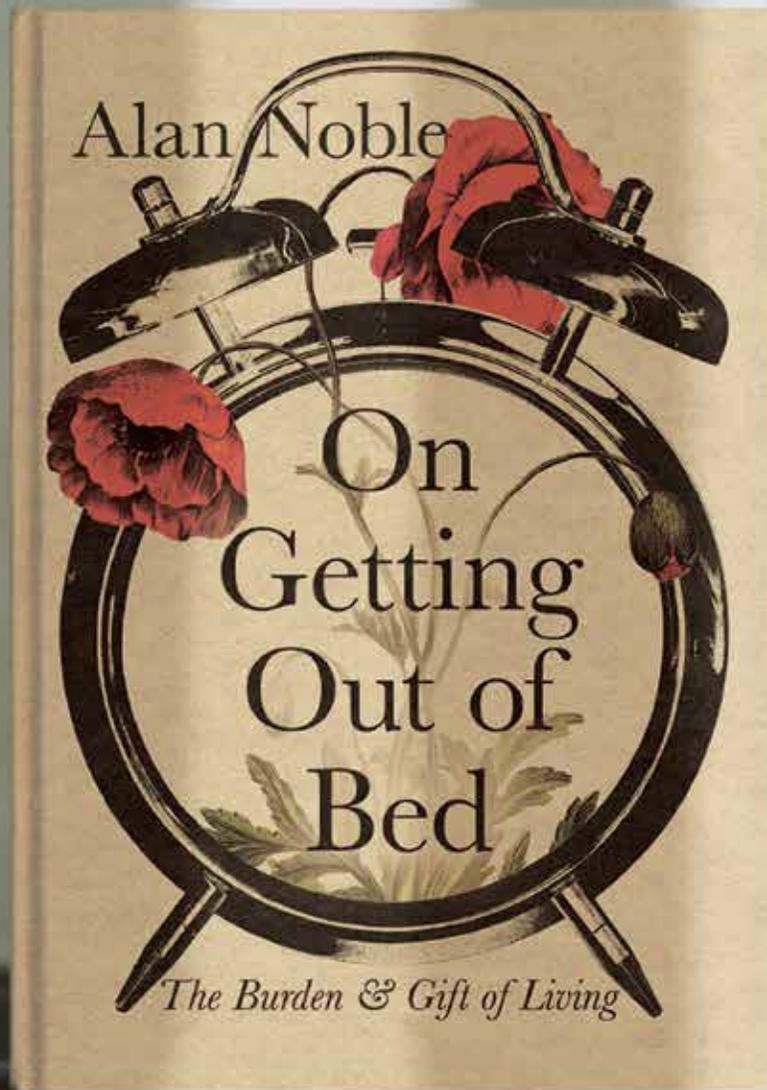


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# Meditations on why life is worth living



For most people, sorrow, anxiety, and mental illness are everyday experiences. The burden of living comes down to mundane choices that we each must make—like the daily choice to get out of bed. In this deeply personal essay, Alan Noble considers how carrying on amid great suffering is a powerful witness to the goodness of life, and of God.



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“To be human is to suffer. And to suffer is, in its essence, to continually bear our pain in isolation with no imagined future in which our pain will cease. With *On Getting Out of Bed*, Alan Noble enters with us into. . .suffering as the fully embodied thing that it is, occupying as it does every single one of us. Most importantly, our guide does not simply come in and sit with us. He speaks—by his own authoritative experience—of a way not so much to rid ourselves of our suffering but to open ourselves to God and each other in its midst, so that we may be transformed.”

—CURT THOMPSON, MD, author of *The Soul of Desire* and *The Soul of Shame*



# Family Patterns and Generational Dysfunction:

## Understanding Intergenerational Transmission of Addiction

Addiction is one of the most misunderstood diseases in the Church. For years, we have stigmatized those with substance use disorder with little understanding of this chronic, relapsing brain disease. Along with brain changes, the cycle of family dysfunctions that presents with addiction generationally repeats if patterns are not broken. Recognizing and identifying these patterns are needed for whole-person care.

Understanding the intergenerational transmission of substance use in terms of genetics, epigenetics, and behavior is often overlooked in treatment. Today, renewed interest in intergenerational transmission has emerged in the areas of substance use and trauma. In this context, intergenerational transmission refers to the complex interaction of environmental variables and family legacies.

My training as a family therapist included the study of intergenerational family treatments, which provide a way to think systemically over the generations. This field emphasizes the importance of family of origin and early life experiences to fully understand an individual, couple, or family system regardless of the presenting problem. Bowen's Family Systems, Boszormenyi-Nagy's Contextual Therapy, Framo's Intergenerational Family Therapy, and Scharff and Scharff's Object Relations Therapy are theoretical models used to explain the intergenerational transmission of behavior. As a result of this training, my client intake includes a three-generational genogram tracing the transmission of various problem behaviors through the generations.

Since substance use crosses generational lines,<sup>1</sup> knowing the risks and protective factors informs effective treatment. Numerous factors impact intergenerational transmission. The following are a few of those factors that transmit along generational lines.

### Genetics

Genetics influence the development of substance use disorders (SUDs). While heritability percentages for SUD vary, approximately 50% of the risk is considered genetically influenced.<sup>2</sup> Genes contribute to vulnerability due to the way genetic mutations alter the structure and function of the brain.

To further investigate genetic contribution to SUD, genome-wide association studies (GWAS) have increased in recent years.<sup>3</sup> These studies look for markers across the complete sets of DNA or genome associated with diseases. However, these studies have yet to produce a genetic prediction of SUDs due to the influence of environmental factors. Additionally, most of these studies are conducted primarily with European ancestry samples, which limits their predictive utility.

Another area of research interest is molecular genetic studies aiming to understand better molecular mechanisms and biological pathways underlying SUD. These advances hope to be used in the pharmacogenetics field to inform precision medicine interventions for SUD treatment. Currently, these studies have yielded limited success but may have future potential in substance use treatment.<sup>4</sup>

*Since substance use crosses generational lines, knowing the risks and protective factors informs effective treatment.*

LINDA MINTLE



## Epigenetics

Susceptibility to addiction is believed to have an underlying DNA epigenetic basis. Epigenetics is the study of how genes can be altered by external factors that turn them “on or off,” affecting how cells read genetic material. Certain factors, such as lifestyle/experience, cell type, development/aging, and sex, can trigger changes in gene expression and brain structures. More evidence supports these factors as highly associated with DNA modifications.<sup>5</sup> Other factors, such as poverty, trauma, inadequate parenting, mental and physical health, and social systems, also play a role in addiction development.

## Family Relationships, Attachment, Parenting, and Stress

Family relationships strongly influence a child’s development, perceptions, emotional regulation, and behavior. Children who grow up in families with a parent who uses substances are at higher risk for addiction due to genetic and environmental factors. For example, a child with a first-degree relative with addiction is four to eight times more likely to develop an addiction.<sup>6</sup> Early exposure to addictive substances and shared family beliefs about substances help shape children toward addiction.

Attachment is impacted by parents who misuse substances. Healthy early attachment is marked by security and identity. Object relations theorists, such as London pediatrician, Donald Winnicott, posited that when the mother is alcohol dependent, for example, there is a failure of the maternal introject, which can lead to fulfilling the felt abandonment through substance use. In general, attachment-oriented research findings indicate insecure attachment can develop through substance use and lead to a host of negative behaviors, including self-medicating.<sup>7</sup>



A potential pathway to the intergenerational transmission of substance use and misuse is the parenting styles of individuals with substance use disorder. Positive interactions and engagement may diminish. Discipline skills and the monitoring of children can be problematic. When parents feel their discipline is slipping, they often resort to harsh punishment and coercive control<sup>8</sup> and do not facilitate the child in learning inhibitory control. Additionally, substance misuse impairs executive functioning in the brain and creates problems with self-regulation and impulsivity in parents, disadvantaging them and their ability to teach regulation skills to their children. Deficits in inhibitory control are a potential pathway for intergenerational transmission and are known to be problematic for those with substance use.<sup>9</sup>

In families with addiction, stress is heightened. One response to that stress is to self-medicate with substances, a behavior repeatedly modeled and influenced by a lack of appropriate parental support.<sup>10</sup> Moreover, living daily with someone who misuses substances is often unpredictable and can be accompanied by parental mood swings. Children may also be exposed to trauma and abuse in a stressed and unstable environment. Both are more prevalent in homes with substance misuse.<sup>11</sup>

Spiritually, intergenerational transmission is seen in patterns of behavior passed on through the generations due to original sin. Scripture tells us we have all sinned and fallen short of the glory of God (Romans 3:23). However, when those sin patterns are identified, we are not bound by them, given the work of the Holy Spirit who lives in us. In Christ, there is freedom. Chains are broken, and we are set free. No one is trapped in sin when repentance is sought. Galatians 3:13 affirms that Christ paid the price and covers all curses. Thus, spiritual help is needed to break intergenerational transmission.

In summary, intergenerational transmission of substance use should not be overlooked in assessing and treating clients. A systemic perspective is needed. Intergenerational transmission can be stopped by treating the body, mind, and spirit. ✕



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# Co-dependency and Dependency: *Signs, Issues, and Challenges*

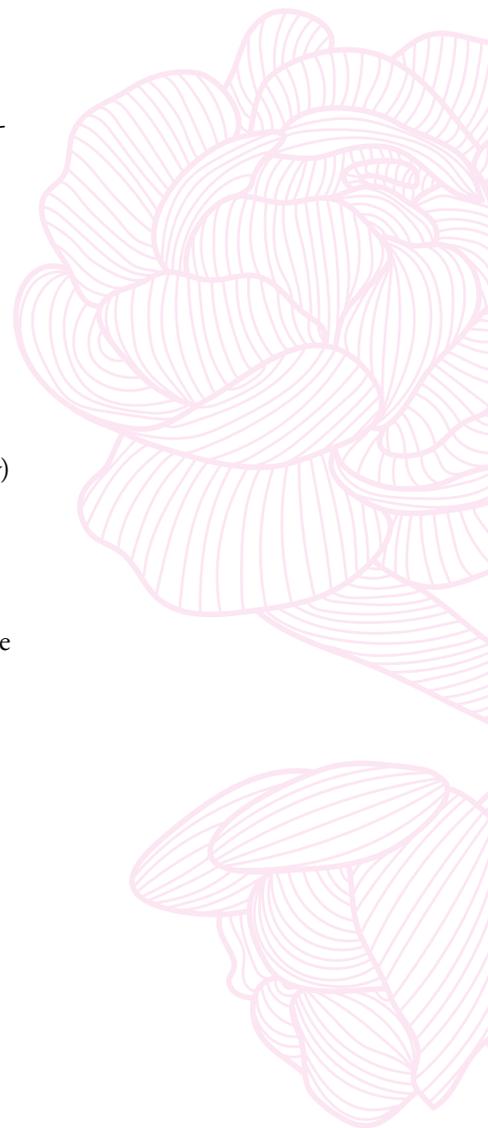


The biblical admonition to “love your neighbor as yourself” presupposes you first know and have the capacity to love yourself.<sup>1</sup> A dependent person, or someone diagnosed with dependent personality disorder (DPD), does not have a healthy sense of self. Instead, they look to other people to tell them who they are. A co-dependent relationship is created when a dependent person enters a dysfunctional relationship with someone else.

Co-dependency, itself, is not recognized in the *Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)* as a distinct disorder but rather linked to dependent personality disorder. DPD is defined as “a pervasive, excessive need to be taken care of, leading to submissiveness and clinging behaviors,”<sup>2</sup> with fears of separation, beginning by early adulthood and indicated by five (or more) of the following:<sup>3</sup>

- Difficulty making everyday decisions without input, advice, and reassurance from others
- Needing others to assume responsibility for most major areas of life
- Difficulty expressing disagreement with others out of fear of loss of support or approval
- Difficulty initiating projects or doing things independently (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- Going to excessive lengths to obtain nurturance and support, to the point of volunteering for unpleasant things out of fear of rejection or disapproval
- Feeling uncomfortable or helpless when alone because of exaggerated fears of inability to care for self
- Urgently seeking another relationship as a source of care and support when a close relationship ends
- Unrealistically preoccupied with fears of being left to take care of self

GREGORY L. JANTZ



The need to be in a co-dependent relationship can be so strong that it mirrors some of the characteristics of an addiction. Sometimes called *relationship addiction*, this type of co-dependency occurs when the dependent person chooses a *relationship*, as opposed to an *individual*, as their drug of choice.

It is important to remember that co-dependency can be between spouses, romantic or sexual partners, siblings, parents/children, friends, or in work relationships. Healthy, independent people ultimately do not tolerate such an unhealthy relationship. By contrast, a dependent person *relies* upon the unhealthy nature of a co-dependent relationship to maintain a sense of control over the connection.

In co-dependent relationships, the dependent person exhibits many of the following unhealthy characteristics, which are actively or passively supported or expected by the other person:

- Focuses attention and effort on solving the problems of the other person
- Takes responsibility for meeting the other person's needs and puts those needs above self
- Feels personally responsible for outside events and circumstances
- Feels responsible for fulfilling the expectations of the other person and a failure if that does not happen
- Hyperaware of the feelings and needs of the other person but unsure of those in self
- Considers the opinions and feelings of the other person as greater in value than self, with a high need for validation
- Adapts behavior and appearance to the desires of the other person
- Has extreme anxiety at the thought of being alone or of separation
- Is unable to create, maintain, or defend appropriate interpersonal boundaries
- Is unfamiliar with, and fearful of, appropriate and healthy intimacy
- Derives positive feelings about self exclusively from the other person
- Harbors unrealistic expectations of self and abilities—will attempt to manipulate and control people and situations to avoid or deny reality

### Co-dependency and Dependency Challenges

The need to be in a co-dependent relationship can be so strong that it mirrors some of the characteristics of an addiction. Sometimes called *relationship addiction*, this type of co-dependency occurs when the dependent person chooses a *relationship*, as opposed to an *individual*, as their drug of choice. Within this type of relationship, it is not enough to convince the dependent person of the unhealthy aspects of a *single* association; the *pattern* of relationships must be addressed. Looking for a healthy person in a relationship is not the long-term answer. The essential person in relationship addiction is not the *other person* but the *dependent person*, who must be gently led through a discovery of how co-dependency is being played out in their *pattern* of relationships.

When working with someone to recover from their dependency patterns, especially within a co-dependent relationship, a challenge may arise when the other person is not sympathetic or helpful toward that goal. The chords of co-dependency may be strong, making the task of untangling *self* from the *other* more difficult. The relationship is *co-dependent* because the other person derives perceived benefit from the unhealthy characteristics of the dependent person.

A person who is dependent already feels worthless and often hopeless. Going into counseling could be viewed as a defeat or further “proof” of the dependent person's worthlessness. Providing encouragement and support, therefore, is vital, as well as calling out and complimenting the person for their



honesty and bravery in working through these issues. It is essential to counter a tendency to be fearful and catastrophizing by consistently focusing on the positive and the possible while being open and honest about a realistic time frame for recovery.

Another important challenge to be aware of is the tendency for the person to exhibit dependency traits within the counseling relationship. The priority of work must first be on healing the person's core sense of self—to strengthen all other relationships. The emphasis should be on what the person is learning and understanding, not what you are instructing or directing.

Recognize there could be the presence of a co-occurring mental health or substance abuse issue. People with DPD may struggle with depression, especially when a co-dependent relationship implodes. Due to their fearful and catastrophic state of mind, anxiety disorders may also be present, including obsessive-compulsive disorder traits. At my clinic, we screen for substance abuse issues because people in pain often find ways to self-medicate.

A sense of self, shredded by dependency and co-dependency, can only be knit back together through a healing relationship with God and Christ. The dependent assumption that they are *not enough* is valid—alone, we are not enough. We are meant for something more and feel it on a visceral and spiritual level. We were not meant

to be alone; we were created for relationship—spiritual relationship. Love, approval, acceptance, validation, assurance, relief, and significance are all human needs found in Christ. As Christian counselors, we are uniquely empowered to spread this very Good News. ✨



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### Endnotes

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# CATCH IT, CHALLENGE IT, CHANGE IT:

Cognitive Behavioral  
Strategies for Recovery



At an eating disorder clinic in Wickenburg, Arizona, I first heard the phrase *catch it, challenge it, change it*. In the cold desert outskirts of Wickenburg, I was there supporting my wife, Jennene, through a 45-day inpatient stay. After battling anorexia and bulimia her entire adult life, she hit rock bottom and courageously agreed to enter treatment.

Though it was my spouse who had endured the ignominy of admitting herself into a facility that was a mix of a retreat center, prison, and hospital, I was the one who felt bitter and angry at having to endure the “family week” the facility had outlined as a prerequisite for her entry into the program. What a sham! I wasn’t the one who needed help. Why in the world did I have to leave our kids, who already were missing their mom, fly across the country, and spend a week in a snake and scorpion-infested wasteland? Did I say I was bitter? In addition to the overall resentment that I was making no effort to hide, I was privately drowning in overwhelming shame and guilt. How had I let this happen? I was a pastor and a therapist, for crying out loud. I had done everything I knew to prevent this, to stop this. I had prayed for her; I had counseled her. Yet, here we were—both of us in rehab. Treating broken people is what I did and who I was. If I could not help my own wife, what good was I? I was a failure and a fraud who had let her, my kids, and God down. This message ran like a ticker tape through my head, and even if I was aware of its toxicity, I wasn’t sure I had the resolve or resources to stop it.

According to the cognitive behavioral therapy (CBT) theoretical model, the type of internal negative self-talk or dysfunctional thought patterns I was experiencing and just described are behind most, if not all, psychological disturbances. CBT opines that behavior change results not from modifying actions or emotions but by aligning one’s thoughts with reality. Simply put, change what you believe, and you will change how you behave.

JOHN EKLUND



Though the origins of CBT are traced back to the pioneering work of psychiatrist, Aaron Beck, the basic tenets of CBT are rooted in principles found in the Word of God. Paul wrote to the Corinthian church, “... *we take captive every thought to make it obedient to Christ*” (2 Corinthians 10:5, NIV). Jesus told His followers that before the truth could set them free, they needed to *know* the truth (John 8:32). Paul advised his readers in his letter to the Roman Christians, “*Do not conform to the pattern of this world, but be transformed by the renewing of your mind...*” (Romans 12:2, NIV). The Bible instructs us that for change to happen and dysfunctional patterns to be broken, we must change how we think. Contrary to what most believe, life change begins not with a change of circumstances or behavior but with a change of mind. English poet, John Milton, wrote, “The mind is its own place, and in itself can make a heaven of hell or a hell of heaven.”<sup>1</sup> The mind is where many of us have been taken captive, where strongholds have been built and fortified.

In CBT, false beliefs that lead to dysfunction are called cognitive distortions. In recovery, we simply call it “stinking thinking.” As a person in recovery myself, clinician, and founder of Recovery ALIVE!, a national Christ-centered 12-step ministry, I have had decades of exposure to suffering minds unchallenged and unchecked by truth. I believe that is why I flung myself into the work of recovery, both personally and professionally. I have found nothing as effective in confronting cognitive distortions as the 12 steps. Courageous and uncompromising honesty is required when working the steps because we think that the war for recovery is won or lost.

As previously stated, Paul tells us we must capture rebellious thoughts and teach them to obey Christ. He wrote that in order to resist conforming to the world, we need a personal transformation that begins internally (2 Corinthians 10:5, Romans 12:2). Recovery is a shift in thinking that equips us to face and live in reality. On the other hand, denial is both the thought and action of

living outside of reality—it is accepting and living the illusion of control. To fully recover, one must confront denial, not through cessation of detrimental behaviors, but by thoroughly rejecting false and harmful beliefs. Our behavior is a byproduct of our beliefs. For recovery to begin, we must confront our beliefs and tell ourselves the truth. Other people can confront our denial, but unless we become acquainted with the truth in an intimate way, the truth is of no use to us.

As for me, I know that was true almost 20 years ago while I was in a dusty hotel outside of Wickenburg, Arizona. I had just left a family therapy session where Kelly, the annoyingly competent and compassionate clinician, had shared that truth with my wife for weeks. The cognitive distortions Jennene had been battling all her life that convinced her to starve, purge, restrict, binge and diet, that told her to just die and be done with it, were amazingly being caught, challenged, and changed. I was amazed! It wasn't magic or a fix-all, but it was working. Jennene was doing it. I listened to her in Kelly's office catch the lies and challenge the ticker tape going through her head—then I listened as she spoke the truth out loud, changing her beliefs, replacing the lies, and reframing the distorted thinking. I was convicted. She had done the work; now it was my turn to man up, confront my own denial, catch it, challenge it, and change it. ✖



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#### Endnote

<sup>1</sup> Online library of liberty. (n.d.). Retrieved January 18, 2023, from [https://oll.libertyfund.org/title/milton-the-poetical-works-of-john-milton/#f0243\\_head\\_119](https://oll.libertyfund.org/title/milton-the-poetical-works-of-john-milton/#f0243_head_119).

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## Companions on the Road to Recovery



I hate traveling alone. I love experiencing new cities, restaurants, and sites with a family member or friend. However, more than that, travel companions help me navigate while driving and keep me organized with the details of airports, rental cars, and hotels. Travel companions also offer a layer of protection and comfort. I feel safer walking down unfamiliar streets at night in new cities. Like my mom always said, “There’s safety in numbers.”

Solomon observed, “*Two are better than one...*” (Ecclesiastes 4:9, NIV). He knew companionship was essential for success in life. A companion makes you more productive, helps when you are down, comforts you when in need, and defends against attacks.

Companionship on the road to recovery is vital in maintaining

sobriety. First, a companion will not get in the way of progress. Two go further together because “... *they have a good return for their labor*” (Ecclesiastes 4:9, NIV).

Second, When you stumble, a companion helps you up. “... *But pity anyone who falls and has no one to help them up*” (Ecclesiastes 4:10, NIV).

This statement is my greatest takeaway from Beth Moore’s book, *Get Out Of That Pit*. Whenever someone decides to get out of the pit, there will always be someone inside who grabs their heels to hold them back. However, a true friend stands above the pit and reaches down to help you out. Your companion on the road to recovery needs to be one who helps you out, not someone who holds you back. This means you may need to walk away from those who feed your addiction.

Third, a companion comforts you when you are discouraged. Solomon speaks of the comfort of a companion in Ecclesiastes 4:11 (NIV), “*Also, if two lie down together, they will keep warm. But how can one keep warm alone?*”

A true friend sticks close and knows what you need when you need it.

Finally, a companion defends you when you are overpowered. This final exhortation of companionship gives the one in recovery room to breathe. A companion is a phone call away when you feel weak and susceptible to the attacks of the evil one. “*Though one may be overpowered, two can defend themselves...*” (Ecclesiastes 4:12, NIV). Like walking side by side down a dark street in a big city, I know I am safer with a friend close by.

We started our church in Branson, Missouri, more than 20 years ago. In

our first year, a man walked into my office to make amends for the harm his addiction caused the church and me. I listened but felt he did not owe the church or me an apology. It was then that I learned he was not apologizing—it was far more than that. We were there for him. He recommitted his life to Christ and wanted the church to walk alongside him in his sobriety. He wanted freedom and accountability. Making amends was a big step on his recovery journey, and it was an honor to join him.

From divorce and job loss to prison and death, we have all seen firsthand the devastating costs of addiction. Mental health professionals, counselors, and pastors offer great tools and help for those seeking recovery, but the road to recovery always begins with a vibrant relationship with Jesus. As a travel companion, I always want to point people to Christ.

Dr. Gary Smalley taught that “people, places, and things are not our source of life.” People, places, and things are limited supplies and make us desperate. Looking to them for fulfillment leaves us empty and unfulfilled. Jesus is *the* unlimited, free refills, priority travel companion. When we stay connected to Him as the Source, we have all we need to walk in freedom.

Many addicts feel hopeless. Ecclesiastes 9:4 (NIV) reminds us, “*Anyone who is among the living has hope...*” If you have breath in your lungs, you have hope. Jesus still breathes life into dead, lifeless souls. A travel companion continually points those on the road to recovery back to Jesus as the Source. If you want to find hope, run to Jesus and never run alone.

I often share with our church family, “If a crisis brought you back to church, stay put, and it may prevent another crisis in your life.” Travel companions are vital in *helping* you out of trouble, but they also aid

in *keeping* you out of trouble. Do not run to them in times of crisis and then walk alone when you think all is good. Journey with them in good times and bad.

At the end of Ecclesiastes 4:12 (NIV), we read, “... *A cord of three strands is not quickly broken.*” In other words, we are better supported by one friend, but two friends make us even stronger. Picture it as though you have a friend on each arm carrying you to safety.

The Apostle Paul exhorts us, “*Carry each other’s burdens, and in this way you will fulfill the law of Christ... for each one should carry their own load*” (Galatians 6:2, 5, NIV). When someone comes alongside you to help carry your burden, that does not free you up to drop your load. You are always responsible for your load, even when someone else offers assistance.

Like my friend who entered my office to make amends, I want to help others get out of that pit. I want to comfort them when they are discouraged and stand with them against the attacks of Satan. Proverbs 27:17 (ESV) says, “*Iron sharpens iron, and one man sharpens another.*” If you want to be iron for those in recovery, pray for and with them. Call them to check in. Tell them they make you proud. Celebrate sobriety milestones and reassure them that you are not going anywhere. Point them to Jesus throughout their journey. In doing so, you will encourage and build them up. ✝



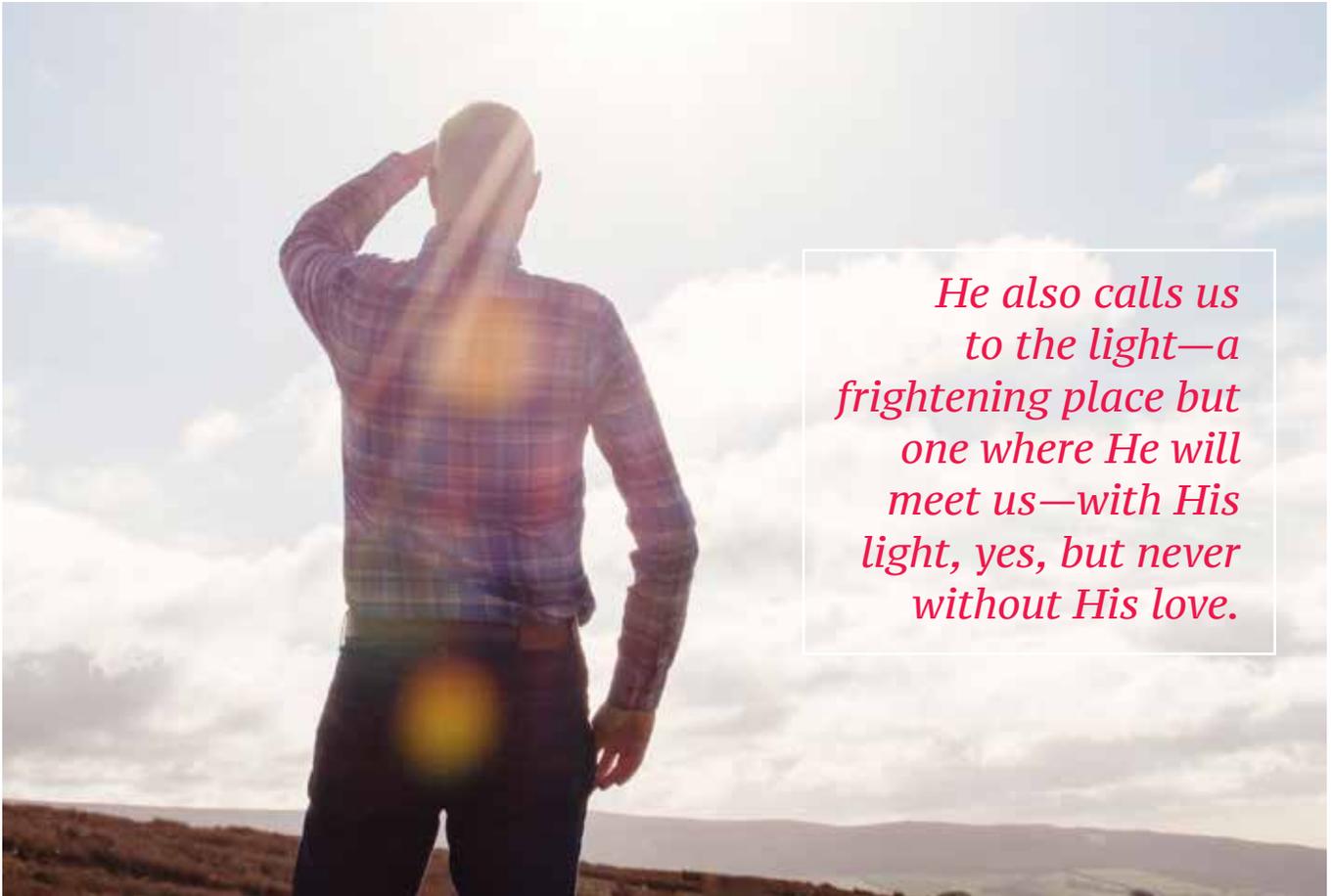
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A travel companion continually points those on the road to recovery back to Jesus as the Source. If you want to find hope, run to Jesus and never run alone.

## Facing the Truth and Finding the Light



*He also calls us to the light—a frightening place but one where He will meet us—with His light, yes, but never without His love.*

**W**hen you hear the word addiction, what comes to mind? A substance? A repeated bad behavior? Being stuck? In the counseling world, we usually think it refers to repeated behavior driven by a craving or compulsion that is destructive. Many people knock on a counselor's door seeking help because the compulsion is destroying them and their lives. When hearing the word, most people think of drugs or alcohol being used excessively and out of control. The use of pornography is also often included in such a list.

Those words are accurate descriptions. However, I would want us to look more deeply into the word

addiction and broaden our thinking about what it is and how we, as human beings, are often controlled and even destroyed by things we cannot manage, change, or stop. We destroy others as well. Let's look at some synonyms for addiction. The word can also mean bent or dependence. It can mean enslavement or fixation. That means someone with a bent toward cruelty, verbal or physical, is destructive and out of control. Like substances, those actions are damaging, crushing, and dehumanizing not just to the one doing so, but also to the recipients. Pride, self-aggrandizing, and an abuse of power destroy both self and others and easily become an engrained pattern with

no stop button. Nor, like addicts of a substance, do they seem to be self-aware of the hideous damage—again, not just to others but to themselves. Leaders who lead by abusive behavior are crushing many souls, including their own. Like alcoholics, they minimize what they do, the damage it causes, and their incapacity to manage themselves.

Think with me about domestic violence. Does the abuser truly see the abused and the damage done? They usually say the harm was necessary because the victim did \_\_\_\_\_ or was \_\_\_\_\_, and if they had not, it would never have happened. Think about sexual abuse. Does not the same response show up? It was

due to the victim's behavior, their lack of something, or their appearance. The damage done to others is immeasurable, and the given reason for that damage is something in the victim. The self-deception is quite staggering.

Note the following quote: "According to your faithless servant, Voltaire, Louis 14th and de Brinvillers went to confession *as soon as they had committed a great crime*. They confessed frequently, he said, '... as a gourmand takes medicine to increase his appetite (a gourmand loves food too much, eats in excess and takes medicine so he can keep eating).' I ask you, in light of such cynicism, would it be improper to suggest that a murderer's confession sometimes serves as a salt to the food of evil?"<sup>1</sup>

Have we ever really thought of these things as salt for the food of evil? Salt is a preservative. Our excuses, renaming, minimizing, and outright lying of such matters are an active cover-up of life-destroying poison. The poison destroys people our God loves and the places we call His house. *We* are His house—not a building or system. Jesus said to the leaders in the temple of His day, "... *You are experts at setting aside and nullifying the commandment of God to keep your [man-made] tradition...*" (Mark 7:9, AMP). We have "salted" many forms of abuse in the name of our God. Like an addict, we are bent toward, enslaved to, and fixated on preserving ourselves, our positions, and our spaces, ignoring the damage to many, including ourselves, and instead maintaining our systems. We have defiled our God's name and ourselves.

In assessing ourselves, we need to listen to Jesus' next word. He said, "*Listen to Me... and understand: there is nothing outside the man which can defile him... the things which proceed out of the man are what defile the man*" (Mark 7:14-15, NASB1995). He continues and says that from

within comes evil thoughts, deceit, sensuality, envy, and pride (21-22). These things come from within—from our circumstances or others—and defile us. To defile is to pollute, debase, corrupt, and destroy. These are very serious words for us today. Our failure to truly understand these effects and bow before our undefiled Lord is breaking the heart of our Father and destroying many lambs for whom He died.

So what must we do? Like any addict, we must face the *truth*. There is *no* recovery without truth. That certainly means speaking the truth with no cover-ups, but it also means bowing before the One who is Truth. Recovery also means return, reconstruction, and restoration. From the very beginning, our God has built His kingdom with human beings who were created in His image and who were to bring His likeness to bear on each other and the world. As a result of our choice of self-rule, we instead live on a ruined planet and, by way of deceit, are creating greater ruin for ourselves and others. Our Lord came in the flesh to rescue us from our slavish addiction to ourselves and has called us to be like Him in this place.

This God we say we worship is light... there is no darkness in Him. Light searches, uncovers, exposes, and brings health. Christ exposes us to ourselves. He shines a light on the rot in our souls yet remains uncorrupted. When He was here in the flesh, He exposed Rome, the political system. He exposed the religious system operating under His name. "*In him was life, and that life was the light of all mankind*" (John 1:4, NIV).

We are His children. He loves us. He also calls us to the light—a frightening place but one where He will meet us—with His light, yes, but never without His love. Let that sink in a bit. *You will never stand in God's light without the presence of His love*. He will accompany us in that place.

He knocks and says, let Me examine you; let Me search your heart and mind together. He longs for us to respond as David did in Psalm 139:1 (ESV), "*O Lord, you have searched me and known me!*"

The call to examine ourselves is a call to a duet. It is you and the Father—the Father who is understood in the life of the Word made flesh. That Word is truth, light, infinite love, kindness, and unerring obedience to the Father. He is the One who enables us to see where we are blind, to call things by their proper name, and to know that whatever we find in ourselves, He is still the lover and transformer of our souls. ✠



**DIANE LANGBERG, PH.D.**, is globally recognized for her 50 years of clinical work with trauma victims. She has trained caregivers on six conti-

nents in responding to trauma and the abuse of power. For 29 years, she directed her own practice in Jenkintown, Pennsylvania—Diane Langberg Ph.D. & Associates. Now, in partnership with Dr. Phil Monroe, Langberg, Monroe & Associates continues this work, which includes 17 therapists with multiple specialties. Dr. Langberg is the author of several books, with her newest being *Redeeming Power: Understanding Authority and Abuse in the Church* and *In Our Lives First: Meditations for Counselors, Volume 2*. She is the recipient of the Distinguished Alumna Achievements from Taylor University, the AACC Caregiver Award, the Distinguished President's Award, and the Philadelphia Council of Clergy's Christian Service Award. Dr. Langberg is married and has two sons and four grandchildren. For more information, visit [www.dianelangberg.com](http://www.dianelangberg.com).

### Endnote

<sup>1</sup> Erdrich L. (2009). *The last report on the miracles at little no horse : [a novel]*. Harper Perennial, an imprint of Harper-Collins Publishers, p. 276.

## Apprenticeship with a Higher Power

**A**re you taking advantage of all the clean energy resources available to you? Do you know how to produce that type of power? I ask these as spiritual health questions, not to start a political fight.

I have a friend who tells a humorous story about someone not taking advantage of their available resources. The setting was the early days of the Rural Electrification Administration (REA). This agency was tasked with bringing electricity to underserved areas. And the effort became one of the most successful government programs ever.

However, there was a farm in a remote area where success was not being found. The farm had become a notorious outlier. And, as you know, politicians hate being out-lied. All the bean counting led to a lot of head-scratching. It was enough to cause one high-ranking bureaucrat to hop in his car to investigate. Why was this one farm using only a few pennies worth of power when unlimited amounts were at hand?

An older woman met the government agent at the front door of the farmhouse. The agent told her he was from the REA and wanted to ask her if she was enjoying having electricity available. She beamed a bright smile and waved for him to come inside. When they were both sitting, she said, "I'm so glad you stopped by. My husband and I just love having electricity. Thank you. Thank you. We use it every day."

"You do?" the agent inquired.

"Certainly," she said, still beaming. "Every day, not long after sundown, we turn on that little light up there. That makes it so much easier to find our matches. Then we light our



candles and turn it off."

The purpose of this story is to raise an important question. How much of the enlightenment and power available all around us, as a result of Jesus' energy distribution program, are we using each day? And how much are we still trusting our own primitive sources? Don't answer just yet. I have another story to share.

I admit that my story will be made up on the spot. It was inspired by my friend's story and the television comedy, *Resident Alien*. But more importantly, something just like it happens every day.

Imagine a small town in a very beautiful rural area. It is located near a gentle river and peaceful lake, about 100 miles from the state capital,

THE PURPOSE OF THIS STORY IS TO RAISE AN IMPORTANT QUESTION. HOW MUCH OF THE ENLIGHTENMENT AND POWER AVAILABLE ALL AROUND US, AS A RESULT OF JESUS' ENERGY DISTRIBUTION PROGRAM, ARE WE USING EACH DAY?

circa the early 1800s. One night, just before dawn, while each of the few hundred residents is sleeping, a bright streak races across the sky and strikes the ground in a nearby pasture. The result is a small crater in a freshly plowed field. In moments a space alien steps out of the shiny, metal, formerly-flying object.

Due to the alien's super-to-earth-natural strength, he is able to hide the craft in a nearby cave and cover the traces of his arrival. And due to his superior intelligence, he can alter his DNA to take on the form and function of a very average-looking human. That's right; he is fully human and fully not.

With the first rays of light in the morning sky, the alien walks into town, enters a country restaurant, and takes up life among the locals. His intentions are benevolent. He desires to vastly improve conditions on earth by sharing some of the secrets from his world. The primary secret he decides to share is how to produce and harness the energy of electricity.

Over time, the alien attracts a small group of friends who love to listen to his stories about another world and the shimmering possibilities for a radically-new way of easy-yoke living right here on earth. Some of these friends become his apprentices and begin learning how to turn his bright vision into practical reality. They learn from the alien about amps and volts, circuits and surges, wiring and resistance, wattage and lumens, grounding, breakers, switches and meters, and what not to put into outlets. They even learn how to harness the power of a nearby river. Eventually, they are able to store energy and build devices that produce light and sound, heat and cold, and mechanical movement.

After their intense training, they go out with their new friend from village to village, town to town, and eventually to the state capital. They

are a movement in motion for providing light in the darkness, vision for what was hidden, the ability to hear across vast distances, and warmth to those who were cold. However, with all this progress and excitement stirring, it is not long before some influential people in the state capital become aware of these miraculous new events. Feeling a threat to their monopoly on power and wealth, they begin plotting to kill the newcomer who threatens their old ways.

One evening, the luminary of electricity gathers a few of his closest friends at the site of his arrival on earth. He shows them the spacecraft that had brought him to their world, and they marvel. And then he reveals his true identity. For a few minutes, he allows them to see him in his true form. As he stands before them, glowing as a beam of light, they fall to the ground in awe.

Not long after that, he tells his apprentices that he needs to return for a while to his world. But before leaving, he gives them a remarkable device, not unlike an iPhone 37. And he says, "Keep this with you at all times. Soon, I will no longer be with you as we are now. But, through this device, I will continue to be able to see you, and you can see me. And I will be able to hear you, and you will hear me. I will keep watching, listening, talking, and teaching. And together, we will do even greater things than you have already seen. Now go out from here and make apprentice electricians everywhere; introduce them to this new knowledge I have given you and teach them to follow all the rules of electricity that I have demonstrated.

After the alien flew away from the field where he landed, his friends were very sad. But then, one day, each of their devices began to buzz and glow. Their teacher's face appeared on the device like a photograph and then in front of them like a hologram. He

began to talk with them and laugh with great joy. He told them many more things and continued to teach them even more.

Slowly at first, and then very rapidly, new lights begin to glow in close and distant lands. If viewed from space, it seems that much of the entire earth is aglow through the night. But over time, centuries of time, many of the lights begin to go out; and darkness creeps back across the landscape. A significant change had occurred in those dark places that had previously seen light. It concerned the process of becoming an apprentice electrician. In the new training models, only two things remained as part of the curriculum.

Those who wanted to become electricians were asked two questions, “Do you believe in electricity?” and “Do you believe that an important

*teacher once came here?”* Anyone who responded “yes” to both questions heard these words from the ones in charge of the guild, “You are now an electrician.” The newly-minted electricians left those ceremonies with great hope for a bright future after they die but without a coherent plan for producing light for themselves or others while living.

So, back to the original questions about producing and using clean energy... and a personal confession. I have been drawn to so many of the resources described in ancient Christian spirituality, Ignatian spirituality, and the writings of Dallas Willard because I find in those sources vision and methodologies for living, as St. Paul describes in Ephesians chapter five, “Children of Light.” I find their descriptions, written from the authors’ personal

experiences, of how to take advantage of clean energy sources all around.

And I know of a fourth source for tapping into the resources of a Higher Power while learning practical steps from knowledgeable practitioners and friends. Their manual is a blue book, and they often meet during “off hours” in the basement of churches. ✦



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for Christian Spiritual Formation at Westmont College. He continues to direct their resource development initiatives by serving as the director of *Conversatio Divina: A Center for Spiritual Formation*, [www.conversatio.org](http://www.conversatio.org).

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## Navigating the Process of Obtaining Psychiatric Help



Obtaining help for mental health challenges has become increasingly necessary and difficult. Mental health systems are overwhelmed with more demand than available resources, resulting in long waits for shorter visits. Thus, help-seeking patients must be equipped as active advocates for their care. The following are practical suggestions that are patient-focused for maximizing positive outcomes as one navigates the process of getting psychiatric help.

The first step is finding a provider. The worsening shortage of psychiatrists has resulted in primary care doctors, including OB-GYNs, being most patients' first point of mental healthcare. Psychiatric nurse practitioners have also increasingly become critical providers of care. One can find potential psychiatric specialists from your primary care physician, local psychiatric hospitals, in-network

referral resources at your insurance company, clergy, and patient support groups such as Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD.org), the Depression and Bipolar Support Alliance (DBSAlliance.org), and the National Alliance on Mental Illness (NAMI.org). Patients in crisis can call the 988 national helpline for direction.

### Preparing for the First Visit

The first visit will focus on gathering critical information needed for diagnostic assessment. A timeline of your current symptom development should be written out and available for in-person visits or e-mailed prior to a virtual visit. Please find a quiet, safe, stationary, private place with good Internet connectivity for virtual visits. Test the virtual platform and get technical help before the visit. Do not waste limited time on technology issues.

The following information should be compiled before the first visit:

1. Previous history of medical and psychiatric problems, treatment, or hospitalizations
2. List of previous and current medications (your pharmacy can assist with this list)
3. Family history of psychiatric issues, treatment, and hospitalizations
4. Collateral observations from therapists, friends, family, and coworkers
5. Recent blood pressure, pulse, and weight readings
6. Past psychological testing
7. Past genetic testing
8. Most recent lab work from your primary care doctor
9. Contact information for your primary care doctor and therapist (with signed releases)
10. Hydrate well, as a urine drug screen may be required

*It is common to become impatient and grieve the effects of these problems on yourself and your family. However, as imperfect as it may be, it is essential to be grateful for having a treatment process to assist you in recovery.*

### First Visit

This visit will consist of extensive data collection about your history and symptoms, which you have documented in your pre-visit preparation. Focus on answering questions truthfully and completely, but briefly.

Once the data is collected, the visit should transition to possible diagnoses and treatment options. Actively participate by discussing the following questions early in this process:

1. What is my provisional diagnosis?
2. What is the treatment that you are recommending?
3. Why this treatment over other options?
4. What side effects may I experience within the first few weeks?
5. Are there safety concerns with this treatment? For example, will it affect any organ systems and require lab tests?
6. Could this treatment affect my pre-existing medical problems and medications?
7. Will this treatment be expensive? If so, are there discount programs?
8. When should I expect to see the beginnings of improvement?
9. How will we measure improvement (e.g., subjective symptoms, rating scales, behaviors, and/or reports from collateral sources such as therapists, family, friends, etc.)?
10. Can dietary changes help promote efficacy or avoid side effects (e.g., caffeine, sugar, alcohol, food, etc.)?
11. Will there be a problem if I become pregnant on this medication?

12. How do I initiate treatment?
13. How often will I need follow-up visits, and who will see me (e.g., nurse practitioner)?
14. Would psychological or genetic testing be helpful?
15. Will I need a more intense level of care (e.g., inpatient, partial hospitalization program, intensive outpatient program, etc.)?

### Subsequent Visits

Write down and e-mail changes in targeted symptoms, behaviors, and rating scales before subsequent visits. If it is a virtual visit, have blood pressure, pulse, and weight available. Be attentive to show rashes or movement problems on the video. Please get any necessary lab work done in time for results to be available at the visit. If labs were done at your primary care doctor's office, please print them off the patient portal and have them available. Try to make one change in medications at a time, on the lowest dose possible, with as few prescriptions used at a time. Be courteous to the office staff, as you will need their help with this process (e.g., appointments, messages, prior authorizations, etc.). The following questions are relevant for follow-up visits:

1. Are there symptoms that may improve quicker than others?
2. When should I expect maximum improvement from this treatment?
3. How long will I need to take this medication?
4. Are there side effects that may emerge later if I take this medication for a long time?
5. How will I stop the medication?

6. What are my risks for relapse when I stop?
7. What should I look for regarding early signs of relapse?
8. If this medication is ineffective, what are my choices for alternative treatment?
9. Are there specific types of psychotherapy that should be partnered with this treatment?
10. What can my family and friends do to help in my treatment process?
11. What are the risks of stopping the treatment prematurely?
12. What is the policy about phone calls, e-mails, texting, or emergency calls?

### Working the Process: Attitude

People tend to get better “little by little” over time. It is common to become impatient and grieve the effects of these problems on yourself and your family. However, as imperfect as it may be, it is essential to be grateful for having a treatment process to assist you in recovery. It takes time and work to get better—therapy, lifestyle changes, spiritual disciplines, and relational work—not just medications. Remember, it will take time for you and others to trust your improvement. Pray for a safe therapeutic community (e.g., family, church friends, support groups, etc.) that will help facilitate the dynamic process of obtaining help, getting better, and rebuilding trust. ✖



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## Developing an Ethical Referral List in Substance Abuse Counseling



“Addiction professionals shall recognize that each client is entitled to the full extent of physical, social, psychological, spiritual, and emotional care required to meet their needs. Providers shall refer to culturally and linguistically appropriate resources when a client presents with any impairment that is beyond the scope of the provider’s education, training, skills, expertise, and licensure.”<sup>6</sup>

### Referrals

Because counseling patients/clients suffering from addiction and/or substance abuse disorders presents unique challenges, referrals are vitally important. Three components should be present when developing a referral list that will protect you and is in the best interests of your patients/clients: 1) legal compliance, 2) qualifications, and 3) avoiding negligent referral.

In short, you should ensure that anyone on your referral list meets their legal obligations and is qualified to perform the service for which they were referred. Also, it is imperative that you present referrals in an even-handed manner to avoid allegations of “negligent referral”—a legal claim that can be made when one professional refers a patient/client to another resulting in an injury.<sup>7</sup> The most common referrals for patients/clients dealing with substance abuse will be to specialists, treatment facilities, and attorneys.

For “legal compliance,” you should independently verify licensure for anyone on your referral list. State licensing boards often provide search-by-name portals, or you can request

**S**ubstance abuse remains an increasingly horrifying problem in the United States. Approximately 21 million Americans suffer from at least one addiction to drugs or alcohol. Every day, we see 36 alcohol-related deaths in the United States and 130 deaths from opioid overdoses. While only 10% of addicted people seek treatment, it is essential for counselors at all levels to be familiar with legal and ethical issues requiring referral of patients/clients suffering from addiction, as well as how to create a referral list that protects both the therapist and client.<sup>1</sup>

### Ethics Codes

There are no provisions specifically related to addiction or substance abuse in either the American Association of Christian Counselors (AACC),<sup>2</sup> the American Counseling Association (ACA),<sup>3</sup> or the American Psychological Association (APA)<sup>4</sup> Code of Ethics. The Association for Addiction Professionals (NAADAC), however, does offer measures in their code of ethics available for download.<sup>5</sup>

Notably, the NAADAC Code does not provide for values-based referrals, but it does specifically require competence-based referrals:

license verification directly from the provider. It is also wise to check on any disciplinary actions taken by a state-licensing board, check your state's sex offender registry, search criminal convictions available through a public records website (such as BeenVerified.com), examine any public ratings or reviews, and ask the provider questions related to additional concerns, such as insurance coverage or treatment philosophy, to ensure it is a good match for your patient/client.

For "qualifications," in substance abuse situations, licensure may not be enough to serve and protect your patient/client adequately; therefore, you should locate counselors who have a certification or specialized training in substance abuse counseling. The AACC<sup>8</sup> and NAADAC<sup>9</sup> offer such programs. Some colleges and universities also offer specific degrees in substance abuse counseling.

For "avoiding negligent referral," you need to appear even-handed and avoid promoting only one or a few providers. A minimum of three referrals per category is preferred. With telemedicine advancements, depending on state law, you may go outside of your jurisdiction as long as the provider is properly licensed. You should also check on the qualifications and reputation of treatment facilities. The AACC offers a list at <https://www.aacc.net/treatment-centers/>.<sup>10</sup> Likewise, not every licensed attorney is qualified to deal with the unique legal questions facing people undergoing addiction recovery, so it is essential to inquire about the specialty of any attorney on your referral list.

### When to Refer

When your patient/client presents problems beyond your scope of education, training, skills, and/or expertise, you must refer to a specialist—another mental health professional more qualified to treat your patient/

While counselors should *never* give legal advice to their patients/clients, knowing when it is appropriate or necessary to refer a patient/client to an attorney is vital.

client with their specific struggles. Likewise, a patient/client may require more extensive care and/or supervision than you can provide. In these cases, referral to a treatment center should be considered.

While counselors should *never* give legal advice to their patients/clients, knowing when it is appropriate or necessary to refer a patient/client to an attorney is vital. The following are a few potential legal issues that may arise while treating your patient/client, in which case, you should provide them with your attorney referral list. Please note that this is not an exhaustive list and generally only applies to people seeking treatment and recovery.

**1. He/She is worried about employment discrimination.** The Americans with Disabilities Act of 1990 (ADA)<sup>11</sup> protects both those who have been successfully rehabilitated from substance abuse and addiction and those who no longer use illicit drugs and are currently participating in a rehabilitation program. Specifically, the ADA would categorize such individuals as "disabled." Protections also include recovering alcoholics.<sup>12</sup> The ADA prohibits employment discrimination in hiring, promoting, and providing benefits unless the condition or disability would unreasonably impact the individual's ability to perform a job. Under the ADA, a disabled person can request a "reasonable accommodation," such as unpaid leave to attend treatment appointments.<sup>13</sup>

**2. He/She is worried about fairly obtaining/maintaining housing.** The ADA also prohibits discrimination in housing, including private and government housing. In addition to

seeking advice from a qualified attorney, your patient/client may also file a complaint with the U.S. Department of Housing and Urban Development (HUD) should he/she face discrimination in a housing situation.<sup>14</sup>

**3. He/She is worried about mandated drug testing by an employer.** Because laws vary state-by-state,<sup>15</sup> the patient/client must consult with an attorney in this situation, especially when the patient/client is taking prescribed addiction treatment medications. In these cases, there are general protections for the employee.<sup>16</sup>

Following this simple direction, along with open and honest communication, will help ensure your patients/clients seeking recovery from substance abuse get the needed care to live a fulfilled life free of the bondage of destructive substances. ✖

*The information contained in this column is provided for educational purposes only. Nothing in this column should be construed as legal advice, and readers should seek advice from a qualified attorney within their jurisdiction for concerns/questions on specific matters. Law varies from jurisdiction to jurisdiction.*

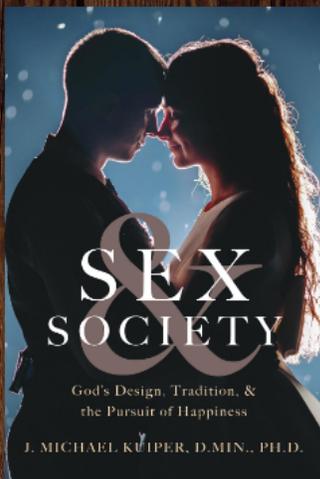


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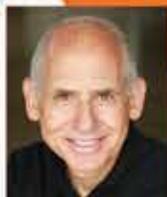
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2 CORINTHIANS 1:3-4, ESV

## Fool Me Twice... Shame on Me

*“Fool me once, shame on you; fool me twice, shame on me.”<sup>1</sup>*

– Anthony Weldon

The Bible is clear that, as leaders, we are subject to the same standards of conduct as everyone else. We do not get a spiritual “pass” on certain behaviors as compensation for our additional responsibilities. God’s bottom line for leadership is not based on placement atop an organizational chart. On the contrary, leaders are to practice forgiveness (Colossians 3:13), be a living example to others (Hebrews 13:7), conduct themselves with humility (Matthew 20:26-27), resist selfish ambition and consider others above themselves (Philippians 2:3-4).

This edition of *Christian Counseling Today* deals with the issue of addiction and recovery. Since leaders are called to forgive, like everyone else, how does forgiveness work when they are confronted with addiction and recovery in those with whom they work? Does the commandment to forgive others automatically mean giving an addict their job or position back? Aren’t there situations when a leader must consider more than one “other?” There is the “other”—the recovering addict—and another “other”—the rest of the leader’s organization. How does a leader balance the potential conflict between these two “others?”

This question would be easier to answer if recovery from addiction was simply a matter of going into treatment. For most people, however, addiction treatment is not a one-and-done; recovery from addiction usually takes multiple attempts. Commonly used numbers are 40-60% of addicts



relapse within 30 days after treatment, and up to 85% relapse within the first year after recovery.<sup>2</sup>

Whichever research study or studies you look at, there is consensus that addiction recovery *includes* the reality of relapse.<sup>3</sup> When it comes to addiction and recovery, for most people, there will—at least—be a “fool me twice.”

Some leaders have no difficulty deciding about an addicted individual in their organization. To avoid “twice-shame” falling on them, they have a one-strike-and-you’re-out policy.

Addiction outweighs recovery every time. If the definition of insanity is doing the same thing and expecting a different result, then their definition of organizational insanity is forgiving someone for addiction because they do not trust a different result, called recovery.

As Christian leaders, how do we reconcile that position with the biblical admonition to forgive? Jesus was not talking about relapse in the parable of the unmerciful

## As a leader, what are your underlying motives when dealing with someone who is addicted or has relapsed? Are those motives pure, or are they tainted by your desire to avoid embarrassment if you are “fooled?”

servant in Matthew 18, but some concepts may apply. This parable starts with the age-old question—*how many times do I have to forgive someone?* (We have all asked ourselves that question about certain people, if not ourselves.) Peter, who is asking, hedges his bets, I think, by going “big.” He offers up the number seven as a possible answer for Jesus—seven is a significant number, and, as a bonus, it is the scriptural number of completeness.

Seven still seems like a lot today, especially with big things that need forgiveness.

However, Jesus does not take the bait and goes even bigger and says, depending upon the translation, *seventy-seven* times or *seventy times seven* (which would be 490). Whatever the number, the point of the parable is that we are to be generous in our forgiveness because God has been generous in forgiving us. We *relapse* all the time, in whatever addiction we are dealing with and what the Apostle Paul calls “... *the sin that so easily entangles...*” (Hebrews 12:1, NIV).

A part of me understands the attractiveness of the one-strike-and-you’re-out strategy; fool me once, and the shame stays with you. Also, there are plenty of scriptural admonitions against operating as fools, but does forgiving someone multiple times make you a fool—or a fool for Christ (1 Corinthians 1:18, 1 Corinthians 4:10)?

Jesus recognized it can be tough on the ground. When He sent out His disciples, He admonished them not to be fools but to be “... *shrewd as snakes and as innocent as doves*” (Matthew 10:16, NIV). I have always liked the juxtaposition of snakes and

doves; they seem like such incompatible companions. However, I believe a “snakes-and-doves” strategy is one that leaders should use when dealing with the complicated question of addiction and recovery in their organizations. Addicts can be highly manipulative. They often will say and do whatever it takes to continue with the addiction. Shrewdness, then, comes into play when determining a genuine cry for help.

Once a genuine cry for help has been established, it is time for the innocence of doves. Innocence can be characterized as pure motives. As a leader, what are your underlying motives when dealing with someone who is addicted or has relapsed? Are those motives pure, or are they tainted by your desire to avoid embarrassment if you are “fooled?” Are you only looking at the situation through the eyes of a leader or employer, or are you looking through the eyes of a fellow sinner, also in need of forgiveness?

I cannot give you answers to those questions; rather, I have given you the questions to ask yourself if, and probably when, you are confronted with this difficult situation. As a leader, I tend to think about Paul’s letters to the Ephesians and Philemon when I have faced such challenges. In Ephesians, Paul addresses the complicated situation of slaves and masters now being Christians together. Paul reminds masters to treat those under them well, saying, “... *Do not threaten them, since you know that he who is both their Master and yours is in heaven, and there is no favoritism with him*” (Ephesians 6:9, NIV). In the letter to Philemon, Paul writes to the benefit of Onesimus, who, in that culture, had wronged Philemon. Yet,

Paul reminds Philemon of the beauty of recovery and redemption in Christ between those of different statuses.

My prayer is for the Spirit to guide you toward answers that avoid human foolishness and reflect on the Cross. ✦



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# Incentives, Videoconferencing, and Homelessness in Substance Abuse Treatment



**T**his edition of Research Digest looks at whether paying someone through various incentives can help with addiction recovery. We will also examine the utility of videoconferencing as a format for 12-step meetings. Finally, we will consider the role faith-related programs play in recovery from addiction with homelessness as part of the experience.

## Incentives

Pfund, R.A., Ginley, M.K., Boness, C.L., Rash, C.J., Zajac, K., & Witkiewitz, K.

(2022). Contingency management for drug use disorders: Meta-analysis and application of Tolin's criteria. *Clinical Psychology: Science and Practice*, advance online publication.

Is it beneficial to pay people recovering from drug use disorders for abstinence? Pfund and colleagues examined the evidence for giving incentives, such as vouchers for goods and services, bus tokens, personal hygiene items, etc., to people with addictions attaining goals like abstinence, treatment attendance,

etc. This is a form of contingency management. To make this determination, Pfund and colleagues applied the most recent criteria for determining empirically supported treatments proposed by the Society for Clinical Psychology. The strategy involved analyzing the quality of meta-analyses (a review of many studies) done on this form of contingency management. There have been five meta-analyses performed on contingency management that together involved 84 studies and 11,000 participants.

Lovett and Weisz wanted to investigate the role faith and spirituality played in addiction recovery for adults who were homeless or had experienced homelessness just prior to treatment.



The researchers found that contingency management “produced clinically meaningful and statistically significant improvements in abstinence at posttreatment, as well as small effects on abstinence at follow-up” (p. 1). Currently, very few publicly funded treatment programs utilize contingency management. Consequently, the authors recommended that contingency management be incorporated more frequently into drug treatment programs. In their view, the benefits appear to outweigh the costs. For Christian therapists, avoiding overspiritualizing solutions to addiction is a good reminder. Sometimes practical rewards, such as those studied in this investigation, can play an essential part in effective treatment.

### In-person vs. Videoconferencing

Barrett, A.K., & Murphy, M.M. (2021). Feeling supported in addiction recovery: Comparing face-to-face and videoconferencing 12-step meetings. *Western Journal of Communication*, 85(1), 123-146.

Twelve-step programs advocate regular meeting attendance to help people dealing with addictions remain clean and sober. In today’s world, these meetings can be attended through videoconferencing and in person. Barrett and Murphy wanted to survey adult participants in Intherooms.com to explore their perceptions of the

helpfulness of both meeting formats. Intherooms.com supports recovery through asynchronous messaging and synchronous videoconference meetings. Members must have had previous or current attendance in Alcoholics Anonymous or Narcotics Anonymous meetings to join.

The researchers sent an online invitation to the organization’s membership base, and 97 adults participated. Thirty-seven were women, 33 were men, and 27 left their gender unreported. The age range was 27 to 72, with an average age of 53 years old (SD = 11.3). Ethnicity data were not reported, but the investigators stated it was a diverse sample. Attendance at in-person meetings varied from 12% daily to 62% attending two to three or more times per week. Videoconference attendance differed. Zero percent attended daily, and 2% attended four to five times per week. Eighteen percent watched meetings two to three times per week, and 4% once a week. Seventy-four percent attended videoconference meetings three times or less per month.

Overall, participants endorsed positive experiences in recovery using both videoconferencing and face-to-face meetings. Face-to-face meetings, however, were rated higher in effectiveness and support quality, and both were about the same in meeting accessibility. The researchers concluded that videoconferencing could

supplement in-person 12-step meetings but should not replace such meetings. Further research is needed. For the Christian therapist, the findings highlight the potential and clear limitations of using technology to replace in-person meetings in addiction recovery.

### Religion and Recovery Among the Homeless

Lovett, K.L., & Weisz, C. (2021). Religion and recovery among individuals experiencing homelessness. *Journal of Religion and Health*, 60, 3949-3966.

Lovett and Weisz wanted to investigate the role faith and spirituality played in addiction recovery for adults who were homeless or had experienced homelessness just prior to treatment. The researchers used grounded theory and conducted extensive interviews with 14 people (five women and nine men, predominantly white) in residential recovery treatment settings. The majority (12) of the residents were in a Christian-focused residential program, while two were in a program requiring 12-step group attendance. Their length of abstinence ranged from about two months to three years, with a median of 11 months. Their time in the residency program ranged from eight weeks to 11 months. All had histories of multiple traumas and loss in addition to homelessness.

The themes discovered during the interviews were consistent with the research on addiction recovery. They supported the value of faith-based services for those going through homelessness as a part of their experience. The interviewees noted positive changes in their outlook, feeling more gratitude, self-worth, and optimism. They stated they acquired new religious coping skills that helped them deal with difficult life situations that might have led them to relapse in the past. Also, they reported that witnessing positive role models in a setting with shared values and beliefs supplied them with chances to rebuild interpersonal trust. The structure and opportunities to participate in numerous religious and nonreligious activities enabled them to do something most of the day that was incongruent with substance

usage. In interpreting their results, the researchers observed that religious coping “may be protective for individuals with a homelessness history by providing future-focused ways of thinking and enhancing an individual’s sense of optimism and control that they may have lost as a result of addiction and homelessness” (p. 3961). The qualitative nature of the study limits generalizability for any specific findings, but the rich narratives support the important role faith can play in homelessness and addiction recovery.

### Conclusion

In this Research Digest, we have seen how paying someone through various incentives may actually help with addiction recovery. We have also recognized the limitations of videoconferencing as a format for 12-step

meetings and the ongoing value of in-person meetings. Finally, we have seen the vital role faith-related programs play in recovery from addiction when homelessness is a part of the experience. ✦



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Answer the following questions from this issue of *Christian Counseling Today* by marking the appropriate circle. Once completed, you may send in this entire page or a photocopy with your payment to the address below. Please do not send cash. The quiz is open-book and you will need a minimum score of 70% to receive a letter of completion.

**Bondage and Freedom... – Jim Cress**

1. Nehemiah chapter three speaks to what aspect of recovery?
  - a. being obedient to biblical teaching
  - b. engaging in healthy, supportive interactions
  - c. fleeing from the temptation to sin
  - d. demolishing strongholds in our lives

**Catch it, Challenge it, Change it: Cognitive Behavioral... – John Eklund**

2. The author says recovery is a shift in
  - a. how we view our relationships with others
  - b. how we accept ourselves and see our limitations
  - c. our thinking that equips us to face and live in reality
  - d. our behavior that creates more positive feelings

**Co-dependency and Dependency: Signs, Issues... – Gregory L. Jantz**

3. Dependent people tend to
  - a. feel worthless and hopeless
  - b. become dependent in the counseling relationship
  - c. struggle with depression or SA issues
  - d. all of the above

**Family Patterns and Generational Dysfunction... – Linda Mintle**

4. Mintle's client intake includes
  - a. a three-generational genogram
  - b. a history of parental substance abuse
  - c. an agreement for genetic testing
  - d. a commitment to attend a 12-step program

**Forgiveness in Addiction and Recovery – Everett L. Worthington, Jr.**

5. Many people struggling with substance abuse
  - a. have histories of hurt from significant people
  - b. wrestle with self-condemnation
  - c. replace their unforgiveness with guilt, remorse, and shame
  - d. all of the above

**Preventing Future Generations from Harm – Heidi Christensen**

6. Bystanders present can reverse an overdose and save a life by
  - a. administering CPR within minutes
  - b. knowing the number of ACEs in a child's history
  - c. administering Naloxone to the overdosed person
  - d. neutralizing the drug's effects with milk

**Apprenticeship with a Higher Power – Gary W. Moon**

7. To tap into clean energy, the author suggests using
  - a. Augustinian spirituality
  - b. Ignatian spirituality
  - c. Puritan teaching and lifestyle
  - d. all of the above

**Shame, Addiction, and Recovery: Patterns, Issues... – John C. Thomas**

8. The author notes that shame blocks
  - a. self-forgiveness
  - b. self-contempt
  - c. the desire for recovery
  - d. a good God concept

**The Neuroscience of Addiction and Behavior Change... – Brian Kelley and Blake Fraser**

9. Drugs with short half-lives have
  - a. lower abuse rates
  - b. higher abuse rates
  - c. longer elimination rates
  - d. increased rebound effects

**Why They Do What They Do: The Connection Between... – Shannae Anderson**

10. Abused children often use the psychological defense of
  - a. rationalization
  - b. projection
  - c. repression
  - d. dissociation

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**LEARNING OBJECTIVES**

Participants will:

1. Increase awareness and content expertise on current trends in mental health practice.
2. Be able to articulate a more comprehensive understanding of this issue's core theme.
3. Be able to integrate spirituality and faith-based constructs into the delivery of care.

**PARTICIPANT EVALUATION**

Please rate the following on a scale of 1–5 (1 meaning **Poor** and 5 meaning **Excellent**):

1. \_\_\_\_\_ This issue of CCT is relevant to my practice as a mental health professional.
2. \_\_\_\_\_ The articles in this issue are comprehensive and well written.
3. \_\_\_\_\_ I would recommend this home-study program to other professionals.

*The American Association of Christian Counselors (AACC) offers some therapists and counselors Continuing Education (CE) credit due to good standing with a limited number of professional organizations.*

- *The training offered through AACC sponsored conferences and training programs meets the ongoing CE requirements for counselors, life coaches, mental health coaches, and crisis responders who are credentialed through the International Board of Christian Care (IBCC) or one of its affiliate boards: the Board of Christian Professional and Pastoral Counseling (BCPPC); the Board of Christian Life Coaching (BCLC); the Board of Mental Coaching (BMHC); and the Board of Christian Crisis and Trauma Response (BCCTR).*

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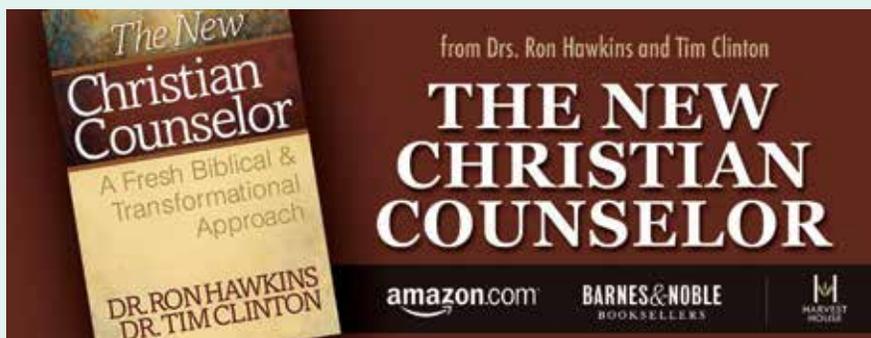
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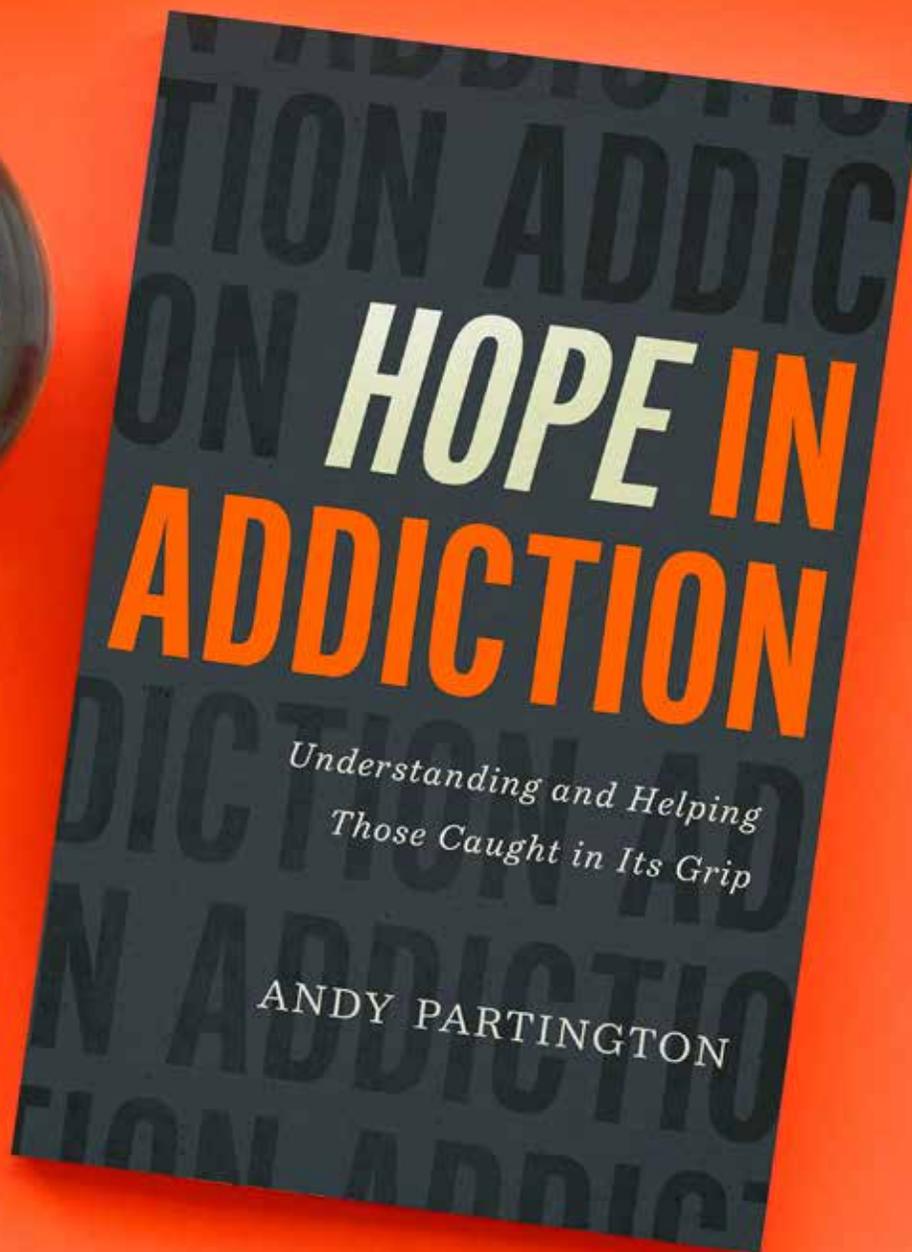
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