The Opioid Crisis: The Spiritual Dimension

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For many of us, the epidemic is personal

By David Lichter
Executive Director

This issue is dedicated to our chaplaincy ministry to victims and families in the opioid crisis. This is most likely a family and friend issue for many of us. If more than 115 people die from overdoses every day in the United States, it’s touching most of us, at least indirectly. As the National Institute of Health notes¹, this is a national crisis that affects not only our social and economic welfare, but our public health also. Should we not also consider spiritual health? We appreciate those who wrote for this issue addressing a holistic approach to this crisis.

In my own family, I came to appreciate how subtle and hidden this addiction can be. One older family member in her late 70s, after knee surgery, was prescribed Percocet (oxycodone and acetaminophen). While it helped reduce pain in the short term, it also came to be used for any ailment, from common cold and feeling sluggish to a headache and sleeplessness. She mentioned, “Percocet has been a godsend.” We only learned of this in a passing conversation, months after the knee rehabilitation. It took time for her to recover.

A more tragic example in my extended family ended in the breakup of a marriage in which the husband hid his addiction to painkillers. It resulted in costly auto accidents (dosing at the wheel), loss of job and home, bankruptcy, divorce, and breakup of their family. Only after all of this did he finally get some treatment a couple of years ago. However, his occasional “flu-like symptoms” sometimes prevent him from seeing his children, leaving them disappointed. This signals that he still uses and tries his own detox to wean himself off.

These are just a couple of personal examples. You have many more that tell the toll of opioid abuse.

While we study the effects of opioid addiction, we are also familiar with Bruce Alexander’s 2008 book, The Globalization of Addiction: A Study of Poverty of the Spirit². He uses a much broader exploration of addiction, utilizing resources from Plato to St. Augustine, and many modern thinkers to expose the power of our human appetites and desires on ourselves and those we love. He argues that our society can create a type of “dislocation or poverty of spirit” that contributes to the draw of addiction.

This term dislocation is helpful, as he sets it off from our need for interdependence and integration, for relationships and belonging — a need that makes life meaningful, enjoyable, and productive. Dislocation reminds me of the term “connectedness” in the definition of spirituality by the consensus conference³ as “the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred.”
Although painkillers, heroin, or other opioids are powerful, we in the chaplaincy ministry probably realize more than most the insidious and pervasive influence of this poverty of spirit, as a dislocation and disconnectedness that underlies most experiences of addiction. My relative who continues to fight his painkiller addiction certainly continues to experience more profoundly the disconnect from himself, his past, his children, and his life. This is a profound poverty of spirit. Would you find this to be the case with those to whom you minister?

Thank you for your ministry.

Notes

¹ https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
Informed hope: Chaplains’ powerful tool in the opioid epidemic

By Fred Rottnek

As a good Catholic kid growing up in St. Louis, and now as a faculty physician at Saint Louis University, I like to know my chaplains. They know stuff — lots of stuff. They usually live at the intersection of people, policy, staff, and administration of the institution. And they almost always have their fingers on the pulse of the institution through relationships they cultivate among all stakeholders. Chaplains wear lots of hats. They translate, they advocate, they normalize seemingly abnormal experiences, and they can promote hope even in the worst of times.

The opioid epidemic now seems like one of those worst of times. And the epidemic rages in most of the institutions in which you’ll find a chaplain, and where a chaplain will be sought to make sense of the suffering and death around the opioid epidemic.

While this is not our nation’s first epidemic, it had hit our society hard — in all ages, all races, and all social-economic levels. The current U.S. landscape of substance abuse is different from past epidemics in several ways.

- The supply of opioids is unlike any supply we have seen before. Opioids — both natural, like heroin and codeine, and synthetic, like fentanyl and oxycodone — have been available for decades on street corners and in physician and dentist offices. Illicit manufacturers and dealers are disguising their products as tablets and capsules. And manufacturing techniques are simpler and distribution networks more extensive than ever.
- With the conveniences of texting, overnight delivery, and social media, deliveries can be made all over the country. No longer are illicit drugs solely an urban issue; suburban and rural communities are also common markets. Previous addiction epidemics were easy to ignore as someone else’s problem and disproportionately affected the poor and those with least access to care.
- These drugs are more potent, purer, and cheaper than ever before. People can drop dead from their first use or from what they think is their standard hit when supplies of heroin are laced with other synthetic opioids such as fentanyl — a synthetic opioid up to 50 times stronger than heroin, gram for gram.

The opioid epidemic is intimidating. It is frightening. But it is not hopeless. And chaplains are in a unique position to keep hopefulness front and center.

Now is a time for chaplains to step forward as change agents by working their systems, reframing situations, and promoting hope through evidence, encouragement, and relationship building.

- Normalize conversations around pain, substance use, and addiction. People with these conditions often feel isolated and diminished. Don’t be afraid to have a conversation. Ask them about their experiences. You don’t need to problem-solve. Just allow space for connection and conversation.
- Remind stakeholders that addiction is a treatable condition, and usually, a highly preventable condition. Know your institution’s resources — as well as some community-based resources separate from your institution — for addiction treatment and behavioral health treatment. You don’t have to be an expert if you know the experts. Too often, people struggling with addiction feel as if they have no alternatives and no resources. That is almost always not the case, but you
can provide hope by suggesting a conversation with people who care. Chaplains often know the back channels, and you shouldn’t be afraid to use them.

• Support people in recovery, in the path that works for them. Advocate for evidence-based practices in your institution. For instance, housing should not be restricted from people who are on medications for opioid use disorders. Likewise, the Americans with Disability Act protects employees on the same medications. Ensure barriers are minimal and policies are accommodating.

• Promote the health of the whole person, and seek assistance when needed. Always promote services — or collaborate with agencies that provide services — to support all your stakeholders. Employees and students might be food insecure—provide a food pantry. Stakeholders might have experienced a disproportionately large share of trauma — provide trauma-informed education and services. Likewise, partner with community agencies to educate stakeholders, their families, and your community about evidence-based models of addiction prevention, addiction treatment, and how to sustain recovery into human thriving.

• Advocate for institutional policies that promote health, well-being, and community among all stakeholders. In addition to promoting services, advocate for sustained change in your institution with policy review about substance use and misuse, access to addiction services, and support for stakeholders in treatment.

Chaplains are visible symbols of history and mission in our Catholic institutions. But they can also be the prophetic voice that we require moving forward in battling the opioid epidemic — and whatever epidemic comes next. Your unique position allows you to occupy the worlds of many stakeholders and bridge the gaps to pursue holistic approaches to healthy communities. Keep us on track, and keep us hopeful!

*Fred Rottnek, MD, is director of community medicine at Saint Louis University Doisy College of Health Sciences.*
My long night's journey into day

By Nicholas Perkins

I am a recovering alcoholic and addict. I understand how my seven-year addiction to tequila and benzodiazepines created unspeakable craziness. The addictive cycle was so intense that I believed the insanity of it was normal; it involved a wanton disregard for responsibilities and participation in risky behaviors. There are moments of my life that remain lost in the haze of blackout drinking.

I began to recover when I surrendered my will to the care of God, which means I gave my addictions to a power greater than myself. Through a solid support system and active involvement in Alcoholics Anonymous, I practice daily spiritual disciplines. Although God and the 12 steps have cleared away the wreckage of the past, a descent into insanity is right around the corner if I ever take another drink or non-prescribed drug. I know today that my sobriety is contingent upon my spiritual condition.

My drinking and using had three phases — fun, fun and problems, and problems. My first Alcoholics Anonymous meeting ruined my addiction because afterward I tried to control it. The energy that I used to convince myself that I could still drink and use — when I knew that I could not — was tortuous. I learned that normal drinkers do not have to manage or count their drinks. I, on the other hand, loved it so much that I could not control it, and I controlled it so much that I could not love it.

I spent six months in a treatment facility after I finished my first year of theology at Catholic University of America. I saw how fellow clients minimized the impact of alcohol and drugs on their lives. Even in a facility that was established to help Catholic clergy, some clients denied and justified the painful effects of their addictions.

I was faced with a very important decision: I could deny my addictions or I could surrender to them. This meant that I had to change everything about my life, especially how I viewed myself and my relationships. If I was going to restructure my sick thinking one day at a time, I had to identify ill-fated character defects and coping mechanisms. These are difficult choices for some alcoholics and addicts to make, because they can want to recover but, at the same time, stay enmeshed in relapse. I did not realize it then, but when I chose to surrender to my addictions, God did something for me that I could have never done for myself. I experienced in that divinely inspired moment a freedom that was comparable to both Paul’s conversion on his way to Damascus and Peter’s breakdown after his denial of Jesus.

The daily inventory that is a part of my sober regimen makes me think about my own recovery, and about the opioid crisis that has gripped the nation — which is a symptom of an economic, social, and spiritual problem. In some cases, physicians overprescribe opioids due to a misdiagnosis and patients’ incorrect rating of pain. In other scenarios, individuals, through no fault of their own, become addicted to opioids to alleviate the discomfort that is associated with a legitimate health problem. We have to remember that people use opioids to ease
sadness, escape hardship, and numb emotional and physical distress. Based on 20 years of sobriety, the odds of recovering from any addiction increase when one identifies why he or she has abused a drug. It is important to regard the opioid crisis as a nationwide public-health emergency, rather than a moral failure.

A spiritual response means we respect how those who battle addiction are created in the image of God. Because we are created in the image of God, an addiction is only one part of a person’s makeup; it does not define their totality. The people whom Jesus healed had a new attitude after they met him. Jesus, instead of just healing the ailment, touched their core. I believe that approach is important for chaplains and other professionals. We acknowledge the problem, but we do not let it undermine the dignity of the person.

The opioid crisis does not discriminate; it affects one socioeconomic class as much as it does another. It ruins the person who has never worked a day in his life; it kills teachers, athletes, pilots, physicians, students, and counselors. It also damages the harmony of body, mind, and soul. The fatigue and nausea of withdrawal can keep one entrenched in addiction for years, while the impaired judgment that follows can change how the person perceives relationships and the world.

Opioid addiction also harms our unique, God-given spirit, which keeps us longing for something that is bigger and more expressive than ourselves. An addiction destroys how the spirit is attracted to the meaningful because it keeps the addict stuck in fixed behaviors. Some addicts have told me how their addiction to opioids destroyed their spirit by locking them in unchangeable behavior patterns. This significant admission recognizes how an addict’s spiritual emptiness has to be healed by a higher power of their own understanding rather than by a substance.

For spiritual care providers who do not grapple with addiction, it is important to listen to the patients who do. Furthermore, it is necessary to understand that this crisis affects family members as much as addicts. Because addiction is a family illness, please consider how codependent and enabling behaviors complicate the problem. Compile a list of healthcare professionals in the area who specialize in treating opioid addiction. Also, ask open-ended questions when you minister to an addict: How does your addiction make your life unmanageable? What concerns you about your use of opioids? What are some of the things that you like about heroin or fentanyl or opioids?

These questions glean crucial information without coming across as judgmental or making the patient feel as if it is an interview. If there is addiction in your family of origin, be open to how you could be triggered when you minister to an addict; the effects of unexplored grief can shift the energy and focus of any encounter. Instead of believing that an addict is a bad person, consider that he or she is sick and has the potential to get healthy.

Nicholas Perkins, BCC, is a chaplain at Franciscan Health in Dyer, IN.
Craving wholeness: The complexity of addiction

By Nina Marie Corona

Most people personally unaffected by addiction probably do not see any correlation with spirituality. They generally assume that spirituality is associated with virtue, and addiction is connected to vice and sin. Or perhaps even more to the unspoken point — that spiritual people are moral, and addicted people are immoral. To add to the confusion, most drug and alcohol treatment facilities utilize the 12 steps (a spiritual program), and their main recommendation upon discharge is ongoing 12-step meetings (usually 90 meetings in 90 days). Without a real understanding of the role of spirituality in addiction, one might falsely assume that the answer is simply to get God and be good. But addiction is far more complex than that.

The nature of addiction is widely debated — from psychological theories of habit, desire, and impulse control, to neurobiological explanations of the intricate brain systems that regulate those desires, to spiritual arguments that describe a God-shaped hole. Amidst all the theories, we have to place our trust somewhere. I choose to place mine in the hands of those associations dedicated to the subject of addiction, such as the American Society of Addiction Medicine. ASAM defines addiction as “a primary, chronic disease of the brain” that affects the brain’s reward, motivation, and memory circuits. They note that “dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations.”

The problem is multifaceted; therefore, it is likely that the solution will be, too. Unfortunately there is often an all-or-nothing mentality in the recovery arena. Some advocate for a spiritual solution and scoff at medication, etc., and others argue for more scientific remedies and discredit the role of spirituality. An integrated approach is necessary — one that acknowledges that spirituality is one aspect of a disorder that affects both the afflicted and their loved ones in various ways (biologically, psychologically, socially, and spiritually).

Believe it or not, it was a psychologist who deemed addiction a spiritual problem! In the 1930s, Carl Jung worked extensively with a patient who suffered from alcoholism, and after about a year of psychoanalysis, the man relapsed. It was then that Jung determined that psychiatry had been ineffective, and that he believed the man’s only hope was a “spiritual awakening” or a “religious experience.”1 Jung later wrote about the man’s condition in a letter to Bill Wilson, the co-founder of Alcoholics Anonymous. Jung wrote that his former patient’s “craving for alcohol was the equivalent ... of the spiritual thirst of our being for wholeness ... the union with God.” Jung’s now-infamous solution was spiritus contra spiritum, which loosely translated means: substitute the spirit of God for the alcoholic spirits. St. Augustine understood this craving long before Jung, and he wrote in his Confessions that this craving or restlessness can be stilled only by God.

1 William L. White, Slaying the Dragon: The History of Addiction Treatment and Recovery in America (Bloomington, IL: Chestnut Health Systems/Lighthouse Institute, 2014), 170.
Jung’s theory was that the spirit of alcohol was a misguided attempt to fill an “unrecognized spiritual need,” a craving for wholeness, and a longing for connection with others. People use substances to fill a need, and usually the need can be categorized as spiritual. For example, if you ask someone why they drink or use substances, some common responses are: “to feel more connected, more creative, more at peace, less afraid, or more loved.” These are spiritual states being sought through substances, because substances temporarily “mimic spiritual states of consciousness.” (see http://slideplayer.com/slide/1564635/) Alcohol, marijuana, heroin, and other substances temporarily fill that spiritual void.

But one of the many problems with this approach is that chemical substances are an inauthentic solution for a spiritual craving. And the biologically and psychologically addictive nature of some substances is a recipe for destruction, especially in those who have a genetic predisposition for addiction. Certainly no one who becomes addicted and loses everything ever thought it would happen to them. No one wants to grow up and be labeled an addict. What for some begins as an attempt to satisfy a spiritual longing sometimes ends up being a prison that even further alienates them from all they were seeking.

Results of a study by the National Institute on Drug Abuse confirm that “stronger spiritual/religious beliefs and practices are directly associated with remission from (most) abused drugs.” (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455957/)

How then do we help those who are suffering discover authentic spirituality? Once addiction has set in, a simple conversation with the person likely will not suffice. There are many other complexities within the brain that stand in the way of healing. Denial and ambivalence are very real attributes of addiction.

A basic education on the nature of the affliction is invaluable in helping us to be more empathetic listeners. Once we can catch a glimpse into the longing, craving, and hungry hearts of others, we can more easily be with them in their struggles. Only then can we be patient and compassionate guides to help them find their way through the darkness and into the “wonderful light.”

Nina Marie Corona is a certified recovery specialist and founder of AFIRE, a faith-based movement for families and communities struggling with addiction. Her website is ninamariecorona.com.
Roots of crisis might lie in spiritual public health

By David Lewellen
Vision editor

Why do people take opioids in the first place?

It isn’t just about mental health or overprescription. One explanation gaining more attention is that the crisis results from a crisis in spiritual health. And spiritual health, rather than spiritual care, might be a promising direction for the future of chaplaincy.

“We’re good at care in a time of crisis,” said the Rev. Frank Mäch, director of chaplaincy at Dartmouth-Hitchcock Medical Center. “But the bigger question is, how do we impact spiritual health?” When he talks in those terms, he said, “people perk up. It fits in with population health and mental health. How do I train students to have an impact on spiritual health? I’m in my mid-50s, and this is a question I hope to engage for the rest of my career.”

It’s a big question, and answers so far are fuzzy. But there are obvious parallels with the medical professions, which excel at patching up sick people but are still laboring to be heard on healthy eating, exercise, safe water, and other preventative measures.

Similarly, Mächt said, recommending that patients meditate and do self-care “doesn’t get at the root of hope and despair.” Where are those roots? Mächt, who grew up in Europe, suspects that part of it is American isolation and self-reliance. “The communal aspect is counter-cultural in American culture,” he said. “Those are bigger philosophical questions that I hope we can engage.” And also, he cited the philosophical question of how we relate to pain and suffering – Americans tend to go for the quick fix, which in the case of pain medication might lead to addiction.

Mindfulness, although an after-the-fact solution, could help some people, but “how do we put these modalities in the community in a setting that could make a difference?”

Mächt is also thinking about how to extend the reach of CPE-trained chaplains. Historically, most police and fire chaplains, ministering to people on the very front lines of the epidemic, have not had that training. But at the moment, Mächt has two CPE students from an evangelical background who minister to fire departments as well as working at smaller hospitals.

Opioid addiction can strike any person from any background, but in Mächt’s hard-hit state of New Hampshire, he has observed that the burden is falling heavily on less educated, lower-income residents. And possibly as a corollary, he has seen that evangelical churches are doing a better job of ministry than either mainline Protestants or Catholics. Too many churches – particularly older, wealthier ones – see addiction as having a moral component rather than being a chronic disease. A church that “does not add insult to injury” has a better chance of restoring an addict’s self-image and helping them recover.

Mächt says that in New Hampshire, if an obituary of a person 50 or younger doesn’t list a cause of death, he assumes it was opioids. “But it doesn’t take your whole life away because you died in this way,” he said. Removing the stigma around addiction is one step to facing the problem.

Mike Barwell, media relations manager for Dartmouth-Hitchcock, said that the Centers for Disease Control and Prevention has done a study of social despair and emptiness, which seems to be rising. “What is it about this time and despair?” he asked. “And what is the spiritual response?”
But a default attitude in hospitals, Mächt said, has been “the medical team can’t do anything, so let’s get the chaplain to talk about the next life. But there are spiritual questions about a meaningful life in the here and now.” And chaplains are in a position to help with those questions – and maybe even to build social community. Mächt mentioned chaplains embedded in a healthcare staff who hear about everyday problems. “There’s a lot of untapped potential.”

“Chaplaincy is not about religion, it’s about the human spirit,” independent of theology, he said. And in a culture where doctrine is losing ground, recognizing the spirit might be the first step toward an idea of spiritual health that preempts resorting to drugs.
Dual diagnosis of addiction, mental illness presents extra problems

By Dan Waters

Dual diagnosis is a term used to describe the experience of a mental illness simultaneously with a substance abuse disorder. Either can develop first. The person with a mental illness can self-medicate with opioids — although in fact, opioid abuse worsens the conditions of a mental illness. According to the National Alliance on Mental Illness website, more than 7.9 million people in the United States experience both substance abuse and mental illness simultaneously. Many mental health clinics are using drug screening tools to identify patients who are at risk for substance abuse.

The outdated philosophy that one cannot treat mental illness when someone is still “using” has no place in current treatment plans. An integrated treatment plan is most effective. Both issues must be addressed, and an inpatient setting has many advantages including, a structured setting, 24/7 medical and mental care and supportive group work. Detoxification is the first step, and inpatient is more effective than outpatient for the same reasons.

Chaplains have the skills to be an integral part of supportive group work. The skills to walk with individuals through feelings such as “I feel alone in the world,” “Why is God punishing me?” or “I feel useless” are regular tools of a chaplain. A trained chaplain can accompany a person as they peel back the layers to identify grief, loss, or pain.

The patient in the story below was admitted with clinical depression, suicidal ideation, and heroin abuse. The Rev. Sally Martin, our chaplain assigned to the Behavioral Health Institute, relates this experience.

“In a worship service on the unit a young man came in late but was taking in everything that was said. At the end of the service, he began to share his opioid addiction story and what it has done to him. He had served in prison for a while. He found Christ in prison and successfully continued his walk of faith when he got out.

“Then he had surgery and was given pain medication and relapsed. He said that when he was using drugs, his family would lock up all medications, purses, and anything of value because he would steal to support his habit. Then he came up with something very profound. He said it was arduous work being an addict. He was forced to find or steal the money and then hide the fact that he was using drugs yet again from others. He was tired of it.

“The other patients sat there and were taking everything in like sponges. He was crying as he told his story. I tried to convey to the group that with God’s help this or other addictions can be beaten. I encouraged the young man that this was just a temporary setback. He shared that he had even made a noose to hang himself in the bathroom when his fiancée walked in. God’s providential hand was on this man’s life. My heart goes out to those that are searching for something. My prayer is that they will connect to their spirituality and be strengthened beyond words.”

The Rev. Sally Martin is an assistant chaplain working in the BHI units at Mercy Health St. Charles Hospital in the Toledo, OH, area; Dan Waters is the manager of mission and spiritual care at the same hospital.
Research on opioid addiction and spiritual care yields mixed results

By Austine Duru

The complex problem of opioid addiction and abuse in the United States has become a crisis more troubling than previously imagined. In 2011, the Centers for Disease Control and Prevention reported the use of illegal drugs such as heroin and recreational use of prescription painkillers such as oxycodone have risen to epidemic proportions and are worsening. The Substance Abuse and Mental Health Services Administration estimates that there are 4.3 million non-medical opioid users in the U.S. This has drawn the attention of elected officials, celebrities, and community activists.

Healthcare organizations are also grappling with this problem, which they have inadvertently helped create due to increased dispensing of powerful and highly addictive opioid painkillers. For most people, spirituality and religious coping are ways to begin to grapple with opioid addiction. Professional chaplains are considered critical in helping address the challenges. Unfortunately, little research exists on the specific ways that chaplains and spiritual care providers help address the problem. Also, research conclusions about the role of spirituality, faith, and religious coping in recovery from opioid addiction are mixed. However, there are a few substantive research articles on this topic.

A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction.¹ In this work, Karen Dugosh and her colleagues systematically reviewed 30 prior and recent publications based on empirical research on the best psychosocial interventions to use, along with approved medications, to combat opioid addiction. This is based on the widely studied “contingency management” and “cognitive behavioral therapy” models that have been used in conjunction with methadone treatment for opioid addiction. The findings from articles published between 2008 and 2014 suggest that psychosocial interventions such as counseling, spirituality, 12-step programs, cognitive behavioral therapy, etc., can be significant parts of comprehensive, recovery-oriented treatment. Fourteen of the 27 studies reviewed were related to methadone treatment, and eight of these 14 showed that participants benefitted significantly from psychosocial interventions, specifically resulting in less illicit drug use and increased program attendance. This is one of the strongest predictors of long-term success in addiction recovery. The literature review also points to significant gaps in the research regarding psychosocial interventions in conjunction with medications. More research is needed to help drive best practices.

A focus-group study on spirituality and substance-abuse treatment.² In this 2010 study, Adrienne J. Heinz, Elizabeth R. Disney, David H. Epstein, Louise A. Glezen, Pamela Clark, and Kenzie L. Preston explored the role of spirituality in recovery to determine the appropriateness of spiritual intervention in an inner-city drug treatment program. The authors used both quantitative and qualitative tools to determine whether spirituality could be incorporated into formal treatment while acknowledging unique differences and needs. The authors conducted focus groups with 25 methadone-maintained outpatients to examine beliefs about the role of
spirituality in recovery and its appropriateness in formal treatment. The groups also discussed the relationship between spirituality and behavior during active addiction. The analyses suggest that spirituality and religious practices can help recovery from active addiction. Many participants supported integrating a voluntary spiritual program into substance-abuse treatment. One limitation of the study was that all participants identified as strongly spiritual. Of note, “participants conveyed the need for a spiritual resource that would serve as an addition or an alternative to traditional church services and 12-step meetings. This resource would incorporate elements from both, while introducing new aspects specifically tailored to individuals faced with the arduous challenges associated with substance abuse recovery” (Heinz, Disney, Epstein, Glezen, Clark and Preston, 2010). This study has implications for outpatient chaplaincy services. It also points to the need for further research to determine the structure and nature of a spirituality group that would be both practical and beneficial in an outpatient substance-abuse clinic.

The Role of Spirituality in Treating Substance Use Disorders.³ James DiReda and Jude Gonsalvez investigated the interconnections of mind, body, and spirit in recovery from substance dependence, given that pain and suffering are often the root causes of addictive behaviors, and the resulting effects include isolation, alienation, shame, rejection, and emotional trauma. They were particularly curious about the role of spirituality in addressing the pain and suffering associated with substance abuse. The authors surveyed 50 women and men diagnosed with substance use disorders who participated in a 30-day residential treatment program. The results led to several important conclusions: 1.) Study participants defined and attributed meaning to spirituality in four categories 2.) Ninety percent of those surveyed believe in the value for spirituality and its meaning for them, and 81% were able to articulate how their spirituality has helped them in their recovery process. 3.) Ninety-four percent expressed the desire for a spiritual focus in their treatment program.

In a recent study titled Changes in Religious Coping and Relapse to Drug Use Among Opioid-Dependent Patients Following Inpatient Detoxification,⁴ Eve S. Puffer, Linda M. Skalski, and Christina S. Meade examined the relationship among religious coping, opioid use, and participation in the 12-step program. They believed that it is important to identify psychosocial factors associated with poor outcomes and high relapse rates among people struggling to overcome opioid dependence. The authors surveyed 45 participants receiving inpatient opioid detoxification at baseline and follow-up. Positive religious coping might be protective, while negative religious coping might be a barrier to treatment. “Positive religious coping at baseline was associated with history of 12-step participation after controlling for years of substance use (OR = 2.33, p=.01). That is, individuals with higher religious coping were more likely to have ever been to meetings. Furthermore, increased positive religious coping was associated with frequency of 12-step participation at follow-up (β= .42, p=.03). Negative religious coping was unrelated to 12-step participation” (Puffer, Skalski and Meade, 2013). The study concludes that positive religious coping could help in opioid recovery, while negative religious coping could be a barrier to recovery.

Substance Abuse Counselors' Recovery Status and Self-Schemas: Preliminary Implications for Empirically Supported Treatment Implementation⁵
by Elizabeth M. Nielson is an attempt to “better understand the relationship between substance abuse counselors' personal recovery status, self-schemas, and willingness to use empirically supported treatments for substance use disorders” (Nielson, 2016). In the study, 12 practicing substance abuse counselors address the enduring misperceptions that addiction counselors with personal history of addiction tend to be more competent than their non-recovering counterparts. The findings suggest that within the study sample, “recovering counselors tended to see those who suffer from addiction as qualitatively different from those who do not, and hence themselves as similar to their patients, while non-recovering counselors tended to see patients as experiencing a specific variety of the same basic human struggles everyone experiences, and hence also felt able to relate to their patients’ struggles” (Nielson, 2016). This finding suggests that counselors’ recovery status and corresponding self-schemas might be related to counselor willingness to learn and practice specific treatments. This research has implications for chaplains working in healthcare, substance abuse, or addiction recovery centers.

_Austine Duru, BCC, is the regional director of mission, ethics, and pastoral care at SSM Health in Madison, WI._

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**Notes**


⁵[https://dx.doi.org/10.4303%2Fjdar%2F235982](https://dx.doi.org/10.4303%2Fjdar%2F235982)
Acknowledge ‘dumb God talk,’ and get past it

By Connie May

Yearting for a new way will not produce it. Only ending the old way can do that. You cannot hold onto the old, all the while declaring that you want something new. The old will defy the new; The old will deny the new; The old will decry the new. There is only one way to bring in the new. You must make room for it. — Neale Donald Walsch

These words flung me back to my time as a hospice chaplain. With more and more people having no affiliation with a faith community at that most important time in their lives, I began to see something happening. People were saying in so many words, “If that is what God is like, I don’t need that.” In a strange sort of way, they were making room for the new. The old way wasn’t big enough for the new reality they were facing. One lady said she didn’t want any “dumb God talk,” but she had been asking the nurses questions that seemed more the chaplain’s territory. The nurse asked whether I could come once.

So one hot summer day, I stood outside her closed screen door and introduced myself as Connie May the chaplain, and I heard she didn’t like dumb God talk.

“What is that?” I asked.

She told me that a pastor once told her that she was going to hell because she wore fingernail polish and played cards.

“I hope you told him where he could go with that,” I said, and she opened her door.

This began a ministry to a woman who had raised several kids on her own and was a shop steward at work. Eventually I put her quote on my business cards, and it got me in doors and hearts that were closed before. Many people, especially the young, are done with dumb God talk — talk that makes God smaller, meaner, and less loving than they are. A test for such talk would be to introduce someone with the same language they use to describe God. Would they be insulted? Many of my families were living the kind of Gospel lives that Jesus taught in the ways they lived into their mystery of death and dying. They just needed someone to point out that being spiritual (which they always accepted) wasn’t the same as being “religious.”

I still remember having lunch with a man after his wife died. He had shared what taking care of her in her dying month involved. I challenged his not being “religious” by pointing out how he had been living the Gospel. All he needed was a translator. Love, especially in the face of loss, can bring out the truth that it is stronger than death. Isn’t that the truth of the resurrection?

My mission now is to identify and challenge myself and others when facing dumb God talk. It seems as if Jesus had that same problem with the religious authorities of his time. He kept saying, “You have heard it said, but I tell you . . .” Isn’t it funny that the ones who crowded around him were the ones rejected by the religious? Are we seeing this same thing today? When people are touched by a couple of women in pop-up tents offering to pray with someone, could they be the way God is bringing the new (Sneaky) Spirit into our world? I wonder. We can continue to defy, deny, decry all we want, but that same Sneaky Spirit has never yet been effectively contained yet. I trust this is just the newest angle God is using to make room at our inns. Then we can truly move from being like the God-fearers of Jesus’ day to the God-bearers of our own time.

Connie May, BCC, is a chaplain emeritus in Marion, IA.
Joint conference with APC will offer education, growth, and fun

By Mary Lou O’Gorman

It has been an extraordinary experience to participate in the planning and observe the development of NACC’s first joint conference with APC since 2005. Since that gathering in Albuquerque, NM, NACC and APC have become strong and effective collaborators in addressing our joint commitment to spiritual care by competent, board-certified chaplains and to supporting our members as well. This dynamic partnership has created an exceptional educational conference program, which will include quality keynote presentations, intensives, and workshops. The joint worship events will highlight and celebrate the diversity of the participants.

This conference will take place in Anaheim, CA, on July 12-15. Our theme is *Partners in Shaping the Future*. Pre-conference intensives, plenaries, workshops, and prayer/worship will address the following four goals:

1) Leading with professionalism and integrity  
2) Collaborating with other professions to serve those in our care  
3) Empowering the profession through research  
4) Supporting diversity and inclusiveness

The subcommittees have been led by Beth Lenegan, NACC, plenary chair; Brian Hurley, APC, workshops and education chair; Richard Bartoszek, NACC, spiritual needs chair; and Lance Tyler, APC, local arrangements chair. NACC planning committee members include Peg McGonigle and Jennifer Paquette (plenary); Lori Kaufmann, Michele Le Doux Sakurai, and Karen Pugliese (workshops and education); Linda Arnold and Robert Doering (spiritual needs); Kelly Bigler and Roger Vandervest (local events). These gifted leaders, along with NACC staff member Jeanine Annunziato and APC colleagues, have generously given their time and skill to plan and shape meaningful opportunities for conference attendees.

The members of this year’s plenary and education committees have spent untold hours attempting to ensure the quality and relevancy of the plenaries, intensives, and workshops. The attention to detail by these committee members has been impressive. We hope that these sessions will provide resources and learning experiences that will enable participants to facilitate ministry that is both collaborative and innovative.

The Spiritual Needs Committee has openly and reverently engaged in developing joint worship events and prayers that incorporate the heritage and traditions of the men and women who will assemble at this conference. The prayers before the keynote sessions, the opening and interfaith services, and the closing reflection exemplify the work of this committee and reflect the commitment to honor the beliefs and values of the diverse community who will gather at the conference. The committee is also planning NACC liturgical events, including Friday morning’s celebration of the Eucharist and Missioning Ceremony, Friday evening’s Prayer Service of Light and Sacrament of the Sick, and Sunday morning’s celebration of the Eucharist.
In addition to the conference itself, consider attending the pre- or post-conference intensives, the day of reflection led by Susan Morgan on Wednesday, July 11, and/or one of the excursions to Queen Mary or the Aquarium of the Pacific in the Anaheim area on Thursday, July 12.

I have had the privilege of attending joint conferences in 1988 (Minneapolis), 1994 (Milwaukee), 2000 (Charlotte), 2003 (Toronto), 2005 (Albuquerque), and 2009 (Orlando). I have found each of these to be a profoundly moving experience. Gathering with brothers and sisters from these cognate groups and with my NACC colleagues has enlarged my understanding of spiritual care ministry, has provided an invaluable opportunity to network and share insights as well as challenges, and has provided creative worship experiences that have nurtured and fed me. It is hard to put into words the impact and meaning of these events for me. If you have not had the privilege of attending a joint conference before, take advantage of this unique opportunity. It is the hope of all of those who helped plan this gathering that it will be informative, expansive, and energizing for you. We hope to see you in Anaheim.

Mary Lou O’Gorman, BCC, is co-chair of the Joint Conference Planning Committee.
Plenary speaker lineup addresses conference’s four themes

By Beth Lenegan

“Alone we can do so little, together we can do so much.” —Helen Keller

In July, chaplains from across the country will gather in Anaheim, CA, with the realization that we cannot do our ministry alone. Two associations will come together to look toward the future as professionals, who value the diversity of our members and our patients, and who continue to discover new research and resources. This gathering happens in the framework of prayer, hospitality, and fun.

This year’s conference planning committee identified the main theme as Partners in Shaping the Future, with four underlying topics that will be explored by our plenary speakers: collaboration, supporting diversity, research, and professionalism. The plenary subcommittee has invited four dynamic and versatile speakers to present on these topics.

On Thursday, July 12, Dawn Gross will begin our conference speaking on the art of collaboration. Working together, we can truly be present for those individuals entrusted in our care. We are chaplains in community, not in isolation. Gross holds a combined MD and PhD from Tufts University School of Medicine and the Sackler School of Biomedical Sciences. She is currently a hospice and palliative care physician in California, host of a call-in radio program, “Dying to Talk” on KALW 91.7, and a sought-after speaker, writer, and educator. Dr. Gross will begin our time together reminding us of the importance of joining together in partnership for the welfare of many.

On Friday, July 13, we will be reminded of supporting diversity and inclusiveness with our second plenary speaker, Dr. James Mason. We are called to accept and appreciate people of all races, creeds, cultures, and lifestyles, and we will be challenged to examine how open we are with colleagues and those we meet in ministry. Mason is the chief diversity officer for Providence Health & Services in Oregon. He is the former director of the Office of Multicultural Health for the State of Oregon and a co-founder of the National Association of State Offices of Minority Health. Mason will lead us to think beyond the traditional meaning of diversity.

The Rev. Dr. Steve Nolan will be the third plenary speaker Saturday, July 14, exploring current research in chaplaincy, spirituality, and healthcare. Nolan is a chaplain at Princess Alice Hospice and a visiting research fellow at the University of Winchester, England. He has published research on the concept of hope and has been described as an “appealing presenter, integrating lived experience of chaplaincy with solid research in such a way that participants at all levels of skill and competency could understand and relate.”

As we prepare to go home, we are sent forth in recognition that we are professionals with integrity. On Sunday, July 15, Adrienne Boissy, MD, MA, will speak to our current and future role as professionals. Boissy serves as Cleveland Clinic’s chief experience officer and led the development of the Center for Excellence in Healthcare Communication. Boissy is a staff physician at the Cleveland Clinic Mellen Center for Multiple Sclerosis and has a secondary appointment in bioethics. She attended Boston University and worked in neurobiological research at Brigham and Women’s Hospital, Boston. She completed her medical training at Pennsylvania State University College of Medicine and finished her neurology residency and neuroimmunology fellowship at Cleveland Clinic.

Each of these plenary speakers will unite the community of chaplains gathered in Anaheim and in their unique way challenge us to remain partners as we move into the future.

Beth Lenegan, BCC, is director of pastoral care at Roswell Park Cancer Institute in Buffalo, NY.