NAZARENE THEOLOGICAL SEMINARY

IMAGINING OTHER CARE:
INTEGRATING SPIRITUAL CARE PRACTITIONERS IN ADDICTION TREATMENT ENVIRONMENTS

A DISSERTATION SUBMITTED TO THE FACULTY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

DOCTOR OF MINISTRY
SPIRITUAL FORMATION & DISCIPLESHIP

by
SHANE A. ASH

KANSAS CITY, MISSOURI
2022

Shane Ash
Nazarene Theological Seminary
1700 E. Meyer Blvd.
Kansas City, MO 64131
www.nts.edu

Nazarene Theological Seminary is a graduate school of theology in the Wesleyan-Holiness tradition, which exists to prepare women and men to be faithful and effective ministers of the Gospel of Jesus Christ, offering itself as a theological resource in service to the Church of the Nazarene, its sponsoring denomination, and the wider Christian Church. NTS is a missional seminary serving a missional church.

All italics in quotations of Scripture have been added by the author.

NAZARENE THEOLOGICAL SEMINARY

Doctor of Ministry Dissertation Approval

Student Name: Shane Ash

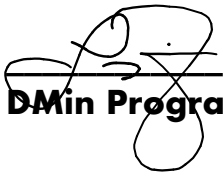
Dissertation Title: Imagining Other Care: Integrating Spiritual Care Practitioners in Addiction Treatment Environments

Date of Defense: March 14, 2022

We, the undersigned, determined that this dissertation has met the academic requirements and standards of Nazarene Theological Seminary for the Doctor of Ministry program.

Faculty Advisor, Susan Carole

Second Reader, Sonia Waters



DMin Program Director, Levi Jones

ACKNOWLEDGEMENTS

To all who have journeyed through St. Joseph's Addiction Treatment and Recovery Centers, your stories of searching and healing have inspired and empowered this project.

To the administration of St. Joseph's, your generous allowance of time and investment in this project is yet another demonstration of your commitment to the spiritual nature, inherent dignity, and worth of every person.

To Eric, whose story lives on. And Matthew, who has transformed.

To the community of Nazarene Theological Seminary, you are faithful and effective. And to my beloved cohort companions, you will always be remembered as the gifts of abundance amid the years of scarcity.

Verifiably, this project would not have reached completion without Susan Carole's wisdom and grace, Walter's gift of courage, and Erin's resilient friendship. Each of you have held my angst as an act of compassionate presence, and through you I have experienced the power of a caring-other.

Preeminently, Ashley, it is our faithful alliance and your expert coaching to "receive it all as gift" that willed me across the finish line. Your faith became my own. And definitively—Samuel, Addison, and Anah Mae—you are loved.

TABLE OF CONTENTS

ABSTRACT

Shane A. Ash

Imagining Other Care:
Integrating Spiritual Care Practitioners
in Addiction Treatment Environments

As the addiction treatment field developed in the United States, it did not integrate a professional discipline of spiritual care. Consequently, disparities in both the definition and availability of spiritual care persist, inhibiting fidelity to person-centered treatment. In response, this project argues for the integration of spiritual care practitioners by defining how spiritual care is vital within person-centered treatment and why embodied care of spiritual care practitioners is necessary within transformative environments. This work utilizes philosophical and theological anthropology, trauma therapy, the practice of spiritual direction, and the efficacy of professional chaplaincy to define the role of a spiritual care practitioner. The goal of this project is to impel the integration of professional spiritual care practitioners in addiction treatment environments.

DISCUSSION OF TERMS

Addiction Treatment – The wordage *addiction treatment* is used throughout this dissertation with the American Society of Addiction Medicine's (ASAM) definition of "treatment of addiction" in mind. ASAM defines the treatment of addiction as "the use of any planned, intentional intervention in the health, behavior, personal, and/or family life of an individual suffering from alcohol use disorder or from another drug addiction, and which is designed to facilitate the affected individual to achieve and maintain sobriety, physical, spiritual, and mental health, and a maximum functional ability."[1]

Environment – The wordage *treatment environment* refers to the general program or environment in which addiction treatment services are delivered. Environments for addiction treatment typically include detoxification services, individualized counseling services, short- and long-term inpatient residential programs, outpatient services, and community services centers.

Modality – The description of spiritual care as a modality of treatment or the wordage of a *modality of spiritual direction* is used in this dissertation in line with ASAM's definition of "modality." ASAM defines modality as "a specific type of treatment (technique, method, or procedure) that is used to relieve symptoms and promote recovery."[2]

Person-Centered – The wordage of *person-centered* is used throughout this dissertation with ASAM's definition of "patient-centered" in mind. ASAM defines patient-centered as an "assessment that is collaborative and treatment that is tailored to the needs of the individual and guided by an individualized treatment plan. This plan is developed in consultation with the patient and is respectful of informed consent and the preferences of the patient. Patient-centered care establishes a therapeutic alliance with the individual and therefore contributes significantly to treatment outcomes."[3]

Spirituality – Principally the word *spirituality* is used in this dissertation in effort to align with ASAM's definition, "A personal experience of existence or consciousness that provides context, meaning, and purpose in an individual's life, and guides attitude, thinking, and behavior. It is characterized by an individual's connection with self, with others, and with the transcendent (referred to as 'God' by many, the 'Higher Power' by 12-step groups, or 'higher consciousness' by others). It may take many forms and include nature, meditation, prayer, religious observance, music, art, or a community, which may be religious or secular."[4]

---

[1] David Mee-Lee and American Society of Addiction Medicine, eds., *The ASAM Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions*, Third edition. (Chevy Chase, Maryland: American Society of Addiction Medicine, 2013), 432.

[2] Ibid., 423.

[3] Ibid., 425.

[4] Ibid., 429.

CHAPTER ONE: WALKING TREES

Introduction

The story of a blind man who was brought to a healer for treatment serves as a literary transition in Mark 8 from the primary use of parables revealing the biopsychosocial powers at work within and upon persons, to a more forthright tone regarding not settling for mere "fuzzy sight" or understanding.[5] The story reveals the healer first provided a traditional medical approach, an ointment of spittle and mud smeared on the eyes.[6] The healer then asks the man, "Do you see anything?" And the man replies, "I see people; but they look like walking trees."[7]

The healer compassionately reaches out a second time, but this time Mark provides an important and sudden shift in his telling of the story. Rather than the focus remaining solely on the action of the healer, Mark transitions the attention to the action and lived experience of the one seeking healing. Mark emphasizes, "he looked intently, and his sight was restored, and he saw everything clearly."[8]

This project seeks to expand the vision and attention of addiction treatment providers by focusing on the spiritually related realities and lived faith experiences of those participating in addiction treatment environments. For, despite ongoing education efforts to integrate spirituality into treatment, an ambivalence to the matters of spirituality and faith among therapeutic practitioners remains an active hindrance to the efficacy of care. And, despite the faith frame and the theological imagination being a determinative phenomenon within personhood, little effort has been made within the addiction treatment field to assess and appropriately respond to persons

[5] Ched Myers, *Binding the Strong Man: A Political Reading of Mark's Story of Jesus* (Maryknoll, NY: Orbis Books, 1988), 240.

[6] Wendy Cotter, *Miracles in Greco-Roman Antiquity: A Sourcebook* (New York, NY: Routledge, 2012), 187-89, 214, 218.

[7] Mark 8:22-26.

[8] Ibid.

experiencing a faith crisis, or for those who are spiritually searching or soothing, or for those experiencing theological incongruence or resolve, or for those seeking to participate in faith-related practices amid a treatment episode.

In the healing efforts of addiction treatment, settling for merely a partial inclusion of what comprises and forms a person is not effectual. There is another way. This project imagines and advocates for the integration of spiritual care practitioners within addiction treatment environments—an *other*-focused care modality that goes beyond the limitations of both traditional psychotherapy and traditional pastoral care approaches.

PART ONE

Three Blinding Conditions

Research widely reports persons recovering from addiction frequently cite spirituality as a crucial and important pathway of recovery[9] and acknowledges that the large majority of persons seeking addiction treatment express interest in receiving spiritually focused treatment.[10] Similarly, evidenced within the contextual addiction treatment environment of this writer, 77% of persons report upon program admission a desire to "work on their spirituality" while in treatment.[11]

The matters of spirituality, faith, and religion are undeniably thick within the addiction treatment field; and the influence and determinative realities—positively or negatively—surrounding such matters are inescapable and self-evident within any addiction treatment environment. And the desire for greater emphasis on spirituality in addiction treatment is not limited to those receiving care. Hodge found 84% of addiction treatment professionals believe spirituality should be emphasized more in addiction treatment.[12]

Interestingly, the recently published research of Brian Grim and Melissa Grim in *The Journal of Religion and Health* reports 73% of addiction treatment programs in the United States

[9] Adrienne J. Heinz et al., "A Focus-Group Study on Spirituality and Substance-User Treatment," *Substance Use & Misuse* 45, no. 1-2 (January 2010): 134-153.

[10] Ruth M. Arnold, S. Kelly Avants, Arthur Margolin, and David Marcotte, "Patient Attitudes Concerning the Inclusion of Spirituality into Addiction Treatment," *Journal of Substance Abuse Treatment* 23, no. 4 (2002): 319-326, https://www.sciencedirect.com/science/article/abs/pii/S0740547202002829.

[11] St. Joseph's Addiction Treatment & Recovery Centers, Inc., *Assessment/Test - STJ BPS Test 1*, September 18, 2021. Statistic from agency published report covering data inputs from March 1, 2020 through March 1, 2021. Question of "Is spirituality an area you would like to work on during treatment?" is included in the standard interview questions asked of every resident upon admission. Of 425 respondents, 326 responded "yes", and 21 responded "no."

[12] D. R. Hodge, "Alcohol Treatment and Cognitive-Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion," *Social Work* 56, no. 1 (January 1, 2011): 21.

include a "spirituality-based element" within their scope of care.[13] Grim and Grim also report that "more than 84% of scientific studies show that faith is a positive factor in addiction prevention or recovery."[14] The evidence revealed by their study led them to claim that "the contributions of faith-orientated approaches is indisputable."[15] They also conclude,

> Lifesaving medicines and psychological interventions are important parts of rescue and recovery; however, they are not enough. Religion and religious participation can address the many issues that lead people to alcohol and/or drug dependency that medical interventions alone can fail to address. The evidence we have reviewed and presented… shows that religious beliefs, practices, and belonging as well as spiritual programs inspired by faith in a Higher Being significantly contribute to the prevention of and recovery from substance abuse.[16]

Given the explicitly known desire for receiving spiritually focused treatment among those receiving treatment, the strong agreement among most addiction treatment professionals that spirituality should have greater emphasis in addiction treatment, the reported presence of spirituality-based elements in addiction treatment environments, and the evidenced contribution of faith as a positive factor upon recovery, one could reasonably expect to find at least a semblance of organized professional discipline of spiritual care within the field. Yet, there is not a professional modality of spiritual care that spans the addiction treatment field nor is it commonplace to find integrated spiritual care practitioners within addiction treatment environments.

Unlike healthcare environments where certified chaplains and/or professional spiritual/pastoral care practitioners are recommended and often required by accrediting and certifying bodies within interdisciplinary systems of care, addiction treatment environments

[13] Brian Grim and Melissa Grim, "Belief, Behavior, and Belonging: How Faith Is Indispensable in Preventing and Recovering from Substance Abuse," *Journal of Religion and Health* 58, no. 5 (July 2019): 1713-1750.

[14] Ibid., 1736.

[15] Ibid.

[16] Ibid.

often rely on institutional traditions, personal interest and willingness of therapists or clinical staff, or the referral of clients to external or post-treatment sources. Bluntly, the lack of attention given to the professional practice of spiritual care within the addiction treatment field does not adhere to the field's own proclaimed person-centered approach, and ethically, spiritual care surrendered circumstantially to untrained and underqualified personnel creates great risk of harm to those within their care. By omitting professional spiritual care practitioners in addiction treatment environments, the addiction treatment field has created its own ethical, and spiritual, crisis.

However, this omitting does not seem to be the result of the addiction field being solely unhospitable with the profession of spiritual care; rather, it seems the field does not know how to move past its own stigmatizing of spirituality, faith, and religion to begin integrating a professional spiritual care practitioner role outside of its own historical definitions, expectations, and experiences. The often-referenced fears of moralizing and proselytizing are rightly highlighted and recognized, yet rather than leading to an exclusion of spiritual care practitioners, this awareness ought to help shape and require a standard of care and the integration of a professional approach.

To understand how and why we have arrived at the current reality and this moment of urgent avocation for the integration of spiritual care, a closer examination of three contributing conditions that have historically hindered the integration of a discipline of spiritual care in the addiction treatment field is necessary.

A History of Double Vision

The word *addiction* derives from its Latin root meaning "bound to."[17] This binding is traditionally understood as something impeding the agency and wellbeing of a person, and thus, something in need of freeing or healing. The study of addiction—as a binding thing—has created a multitude of theories regarding what it is, how it works, and how one might manage, heal, or be free from its deadly effects.

It has been proposed that alcoholism treatment in the United States began when someone asked their physician to treat the cause of their drinking rather than continually pointing out the symptoms of their drinking.[18] Identifying the cause and providing treatment for the cause has been the primary approach throughout the history of addiction treatment. As Sonia Waters summarizes, "Simply put, definition drives care. How we frame a condition changes how we view the problem and imagine its resolution."[19]

From 1774, when the earliest American essay on alcoholism was published,[20] to present-day research bolstered by brain imaging technology, the shifting theories regarding the cause of addiction and the subsequent treatment approaches are revealed within the research literature. Nearly every publication regarding addiction begins with a brief summarization of the history of addiction theories. Although the theory names change occasionally based on the author, two

[17] Maia Szalavitz, *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*, 1st ed. (New York, NY: St. Martin's Press, 2016), 23.

[18] William White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, 2nd ed. (Chicago, IL: Chestnut Health Systems, 2014), 517.

[19] Sonia Waters, *Addiction and Pastoral Care* (Grand Rapids, MI: Eerdmans Publishing, 2019), 18.

[20] "Significant Events in the History of Addiction Treatment and Recovery in America," *William White Papers*, Accessed October 25, 2021, http://www.williamwhitepapers.com/pr/AddictionTreatment&RecoveryInAmerica.pdf.

primary categories have emerged as the historical summarization of addiction theory and practice: the *moral choice model* and the *medical disease model*.[21]

This double vision of addiction is often presented as a dualistic either/or within the literature and seems a primary influence regarding the lagging presence of a professional discipline of spiritual care within the addiction treatment field. For, even though both views of addiction have been present since the beginning of addiction theory and practice, addiction treatment was significantly influenced in its inception years by spiritual caregivers and faith-based approaches. William White, who has written extensively on the history of addiction treatment notes; "The influence of religiously oriented 'rescue work' within the American temperance movement and the revivalist crusades is evidenced by the inclusion of chapters on religious conversion in early addiction-medicine texts."[22]

Of course, no history of addiction treatment can be told without referencing the well documented and notorious meetings begun by "Bill W. and Dr. Bob." Their response to the "spiritual malady" of addiction continues in the still presently active and highly influential groups of Alcoholics Anonymous and Narcotics Anonymous. These groups hold fast to their spiritual and religious language and practices.[23]

Yet, as addiction research progressed, it shifted its definitions and language toward the medical disease model as an effort to move *beyond* spiritual and religious toned language - in that spirituality, faith, and religious language and practices were seen firmly attached within the moral choice model, and thus were regarded as out of date, ethically problematic, and/or a limitation to the development of new theory and treatments.

[21] Waters, *Addiction and Pastoral Care*, 18.

[22] William White and David Whiters, "Faith-Based Recovery: It's Historical Roots," *Counselor* 6, no. 5 (2005): 58-62.

[23] "Historical Data: The Birth of A.A. and Its Growth in the U.S./Canada," accessed October 14, 2021, https://www.aa.org/pages/en_us/historical-data-the-birth-of-aa-and-its-growth-in-the-uscanada.

It is important to note here that some historical faith-based treatment approaches operating within a strict moral choice approach of addiction treatment have inexcusably stooped to forms of religionist moralism exploiting shame/guilt as a motivation for creating "right" behavior. Criticism of such practice is necessary, yet it does not dismiss the vital need of providing spiritual care—instead, as this project is impelling, it underlines the need for a professional discipline of spiritual care that adheres to an ethic and standard of care akin to other professional therapeutic and medical disciplines. For, as this project will demonstrate, spirituality and faith remain determinative influences in persons engaged in treatment environments and there is an ample body of evidence within the research literature emphasizing the importance of integrating spirituality in treatment. To dismiss a discipline of spiritual care due to mere potential abuse lacks in professional imagination, an efficacy to person-centered care, and adherence to an evidence-based approach.

The dualistic categories of moral *or* medical have resulted in a continued defensive and territorial attitude among addiction treatment providers and practitioners. However, within the past twenty years there have been a few attempts to introduce a different perspective into this dualistic divide and increase an awareness of spirituality with the therapeutic care professions.

Of note is the work of Kenneth Pargament, *Spiritually Integrated Psychotherapy, Understanding and Addressing the Sacred*; and the efforts of Ellor, Netting, and Thibault, *Understanding Religious and Spiritual Aspects of Human Service Practice.*[24] Also recognizing the growing problem of this either/or divide, the American Psychological Association published in 1999 a significant work edited by William Miller titled, *Integrating Spirituality into Treatment: Resources for Practitioners*. The title of this dissertation is an overt nod to Miller's

[24] James Ellor, Ellen Netting, and Jane Thibault, *Understanding Religious and Spiritual Aspects of Human Service Practice* (Columbia, SC: University of South Carolina, 1999).

important work, and another attempt to focus the vision of addiction treatment upon the importance of spiritual care. For, just as Miller named in his work, spirituality remains the "important and too often overlooked dimension of health."[25]

Following up on the initial work of Miller and others in the field, in 2014 Gedge and Querney investigated the outcome of the efforts to integrate spirituality into addiction treatment. Their research on the matter gives insight into the ongoing omission of spirituality within addiction treatment by naming an evidenced "ambivalence"[26] that continues to appear in the research literature regarding the attitudes and behavior of clinicians toward spirituality. Using Miller's original label of spirituality as "the overlooked dimension"[27] within addiction treatment, Gedge and Querney name three reasons why spirituality continues to be neglected within addiction treatment. They claim, "it is overlooked in evidence-based approaches to treatment, it requires knowledge and training secular-based clinicians lack, and it appears to risk violating the religious neutrality embraced both by secular theoretical and liberal political orientations."[28]

This project remains mindful of the research of Gedge and Querney by looking closely at evidence regarding spirituality and spiritual care, by highlighting the uniquely professional knowledge, skills, and experiences necessary for spiritual care, and by reimagining the reductionistic dismissal of the determinative dimension of faith and the lived experiences of spirituality within and upon persons. And while the work of Gedge and Querney importantly identifies the ongoing ambivalence toward spirituality in addiction treatment and provides helpful clarity regarding the reasons why, they also highlight potential responses. However,

[25] William Miller, ed., *Integrating Spirituality into Treatment: Resources for Practitioners*, 1st ed. (Washington, DC: American Psychological Association, 1999), 13.

[26] Elisabeth Gedge and Deirdre Querney, "The Silent Dimension: Speaking of Spirituality in Addictions Treatment," *Journal of Social Work Values and Ethics* 11, no 2 (Fall 2014).

[27] Miller, *Integrating Spirituality into Treatment*, 13.

[28] Gedge and Querney, "The Silent Dimension," 42.

within their evaluation and suggestions they fail to fully consider a response to integrating spirituality into treatment beyond increased training and supervision for already engaged clinician and therapist type roles. As this project will demonstrate, their rightly identified concerns are better answered with the integration of a professional discipline of spiritual care practitioners into addiction treatment environments.

In addition to the identification of the hindering ambivalence toward spirituality within the field is also a growing body of research literature highlighting and calling for new ways to define and respond to addiction beyond its traditionally dualistic definitions.

Marc Lewis, a neuroscientist, and author of *The Biology of Desire: Why Addiction is Not a Disease,* highlights the contributions of the traditional models of addiction treatment while also calling for a more comprehensive model that would include and more precisely value the core issues and concerns regarding the formation of addicted and recovering persons. Lewis describes the traditional models of treatment as partly beneficial and states that each model makes sense in some degree,

> yet none of them, either alone or in combination, has yielded definitive explanations as to how addiction works or how it can be effectively treated. Research on the cause and treatment of addiction absorbs billions of dollars each year, without a great deal of success. We need to understand addiction a lot better if we want those dollars to count. We need to address the central questions that anyone touched by addiction wants answered: What is it? How does it work? Why is it hard to stop? To answer these questions, we need to blow past the war of definitions and arrive at a coherent, comprehensive model.[29]

Lewis is correct to point addiction treatment past its dualistic "war of definitions" and toward a more comprehensive and person-centered approach that observes the formative aspects and responds to the lived experiences of those touched by addiction. And Lewis is not alone in this recognition and call. William White, regarded widely as the historian of addiction treatment

[29] Marc Lewis, *The Biology of Desire: Why Addiction Is Not a Disease*, 1st ed. (New York, NY: PublicAffairs, 2015), 3-4.

in the United States, sees the last fifty years of addiction theory and treatment unfolding through five overlapping models. White writes:

> Five increasingly overlapping models of addiction treatment emerged over the course of the past fifty years: 1) the medical model emphasizing the genetic and neurobiological roots of addiction and medical treatments delivered by and under the supervision of a physician, 2) a psychiatric model viewing addictive behavior as self-medication of emotional distress or psychiatric illness that required treatment by a mental health professional, 3) a psychological model viewing substance-related problems as a consequence of maladaptive learning requiring treatment focused on the acquisition of new coping and social skills, 4) a sociocultural model viewing substance-related problems as a consequence of family dysfunction or peer socialization requiring family reconstruction and reconstruction of personal identity and interpersonal relationships, and 5) a spiritual model that viewed alcohol and other drug problems as the outcome of a failed search for meaning and purpose. At present, the boundaries between these models are weakening as programs become increasingly eclectic in their clinical philosophies and practices.[30]

Recognizing this movement, as White describes, toward an "increasing eclectic" approach to addiction treatment is crucial for addiction treatment programs, for it will require an intentional integration of supplementary professional disciplines to aptly complement the presently heavily weighted medical and psychiatric disciplines. Specifically, it will require a remembering and integration of a spiritual care model.

Often the more comprehensive or eclectic approaches to addiction treatment are described as "biopsychosocial" models as they seek to integrate the biological, psychological, and sociological explanations and realities at work within and upon persons. However, while the biopsychosocial movement is a helpful step, even such biopsychosocial models are often narrowly focused.

Carlo DiClemente, who developed the transtheoretical model of intentional behavior change and is author of several influential studies and books on addiction recovery, specifically

[30] White, *Slaying the Dragon*, 465-66.

cautions against settling for a biopsychosocial model. DiClemente clarifies in his book, *Addiction and Change: How Addictions Develop and Addicted People Change*, that

> "integrative perspectives such as the biopsychosocial model are beginning to dominate clinical and research discussions of addiction. Unlike current iterations of the biopsychosocial model, however, a truly integrated framework should provide the glue to join the various research-supported explanatory models. Moreover, such a perspective should lead to a comprehensive view of addiction that could orchestrate the integration of the multiple determinants.[31]

This project agrees that a comprehensive view of addiction treatment must integrate multiple approaches and disciplines of care. And while the biopsychosocial model begins to move addiction treatment toward the necessary depth and complexity to match the lived experiences of those affected by addiction, "additional integrating elements are needed to make this tripartite collection of factors truly functional for explaining how individuals become addicted and how the process of recovery from addiction occurs."[32] One such additional and crucial element is the determinative dimension and lived experiences of spirituality and faith.

In a final effort to demonstrate the present dualistic conditions hindering the presence of a professional discipline of spiritual care within the addiction treatment field, it is important to acknowledge the conflicting response to the movements described within the research literature and the on-the-ground realities within the field.

The continued efforts and movement within the medical model of addiction treatment to omit or dismiss the dimension of spirituality from addiction theory and practice is easily demonstrated. This contrast is evidenced within the recent changes in the definition of addiction by the American Society of Addiction Medicine (ASAM).

[31] Carlo DiClemente, *Addiction and Change: How Addictions Develop and Addicted People Recover* (New York, NY: Guilford Press, 2003), 20.

[32] Ibid., 20.

In 2011, the ASAM Board of Directors adopted a short and long definition of addiction. The short definition read:

> Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
>
> Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[33]

Additional wordage in the long definition included "other factors that can contribute to the appearance of addiction, leading to its characteristic bio-psycho-socio-spiritual manifestations."[34] And among the other factors named, the following language was used: "disruption of healthy social supports,"[35] "distortion in meaning, purpose and values that guide attitudes, thinking and behavior,"[36] and "distortions in a person's connection with self, with others and with the transcendent (referred to as God by many, the Higher Power by 12-step groups, or higher consciousness by others)."[37]

In comparison, in September of 2019, ASAM adopted a new definition of addiction. The current definition of addiction by ASAM states:

> Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often

[33] "American Society of Addiction Medicine Releases New Definition of Addiction to Advance Greater Understanding of the Complex, Chronic Disease," *American Society of Addiction Medicine*, October 22, 2019, https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512_4.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Ibid.

> continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.[38]

The shift of language and focus of the new definition removes much of the attention given in the 2011 definition to the important spiritually and faith themed determinates within addiction and recovery. This narrow focus within ASAM's definition surely serves their important medical contributions within the field, yet it is an unfortunate movement away from the research literature that is calling for new ways to imagine, understand, expand, and engage the many phenomenological influences and responses to addiction and recovery.

Although the specific references to "biological, psychological, social and spiritual manifestations" have been removed from ASAM's definition, this project will demonstrate ASAM's new definition of "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences" still invites and demands an integration of a discipline of spiritual care.

In summary, the history of the dualistic vision of the moral model or a medical model within addiction theory and practice continues to influence an ongoing ambivalence and active territorial defensiveness regarding the definition of addiction and subsequent treatment practices. This ongoing condition is hindering the integration of a professional discipline of spiritual care within addiction treatment and has outright neglected the known desire of addiction treatment participants for spiritually focused treatment, thus inhibiting fidelity to a true response of person-centered care. The ongoing ambivalence and narrowing of definition and practice to medical and psychological causes and interventions does not reflect the growing interest, evidence, and efforts to include the determinative dimensions of spirituality and faith.

[38] "Public Policy Statement: Definition of Addiction," *American Society of Addiction Medicine*, Accessed October 25, 2021, https://www.asam.org/docs/default-source/quality-science/asam's-2019-definition-of-addiction-(1).pdf?sfvrsn=b8b64fc2_2.

There is a second condition also hindering the integration of spiritual care within addiction treatment environments; that is, the lack of clarity regarding the definition of spirituality.

The Astigmatism of Spirituality Definitions

Spirituality is an increasingly discussed and researched topic across the social science fields - demonstrated by more than thirty thousand articles published on the topic over the past twenty years.[39] However, a clear understanding of what is meant by the term "spirituality" in the research literature is often confused by indeterminate and compounded definitions. The disparity of definitions throughout the literature weakens its use within the expectations of the medical model's proclaimed reliance on evidence-based treatments, and in return, often limits institutional support for a discipline of spiritual care within the addiction treatment field.

Due to the lack of a standard definition of spirituality, research on the subject has not generated an authoritative catalog of evidence, but rather, has amassed many independent research projects based on the unique definition of spirituality variously embraced by the persons or institutions overseeing the research. This is not to dismiss, as mentioned before, the ample existing evidence regarding the contributions of spirituality and faith to treatment and recovery or to say the existing research is not empirically founded. However, it is a recognition that the disparity of definition contributes to the ongoing ambivalence to integrating a discipline of spiritual care due to its perceived lack of evidence-based research and practices.

This condition is evident in the literature review led by Christopher Cook that studied the intersection of research in the areas of addiction and spirituality. Cook's research included a review of 265 journal articles and books on the topic of spirituality. Cook summarizes:

[39] Giancarlo Lucchetti and Alessandra Lamas Granero Lucchetti, "Spirituality, Religion, and Health: Over the Last 15 Years of Field Research (1999–2013)," *The International Journal of Psychiatry in Medicine* 48, no. 3 (October 2014): 199-215.

> In only 12% of papers (n = 30) was the term 'spirituality' found to be explicitly defined. In a further 32% of papers (n - 84) a description of the concept of spirituality was offered and in 11% (n = 30) a related concept was defined. [Related concepts were: the 'spiritually healthy person' (n = 1), the human or divine 'spirit' (n = 4), the 'spiritual' (used unqualified: n = 6) and various nouns [2] qualified by the adjective 'spiritual'.] However, in 42% of papers (n = 110) spirituality was left undefined, and in only nine of these papers was it stated explicitly that spirituality was either too difficult to define or would be left deliberately undefined. In seven empirical studies, subjects were left to employ their own understanding of the term, and in five of these it was possible to analyse the subjects' reported understanding of conceptual content.[40]

This discovery serves as a witness that the opacity of spirituality, as indeterminately and variously defined within addiction research, is part of the fuzzy perspectives hindering the inclusion of spirituality and spiritual care in addiction treatment. Cook concludes that further clarity is needed and identifies thirteen core conceptions of spirituality in the literature to build upon toward a consensus. Cook's findings and suggestion to develop a standard definition of spirituality for research purposes is important regarding aligning and cataloguing the research, for surely if the research was clearly recognized in a definitive form, an evidenced-based rationale for integrating spirituality into addiction treatment would more readily received.

While it does seem a standardized definition of spirituality would be helpful to guide the increasing research interest in the topic, another perspective is offered by Philip Sheldrake.

Sheldrake sees the various definitions of spirituality within the literature reflective of another social condition at work. Sheldrake recognizes that the increasing use of the term spirituality and its diverse expressions within disciplines such as philosophy, psychology, and the social sciences has resulted in spirituality becoming a kind of "chameleon" term.[41] Like Cook, Sheldrake points out that there are common characteristics among the diverse uses of the term

[40] Christopher Cook, "Addiction and Spirituality," *Addiction* 99, no. 5 (May 2004): 543.
[41] Philip Sheldrake, "Constructing Spirituality," *Religion & Theology* 23, no. 1-2 (2016): 23.

within literature, but also importantly identifies that the term "spirituality" is primarily used socially to distinguish itself from "religion." As Sheldrake clarifies,

> 'Spirituality' is regularly distinguished from, and contrasted with, 'religion'. People who no longer identify with institutional religion or theistic belief wish to describe themselves as 'spiritual' and express this in the values they espouse and the practices they undertake to frame their pursuit of a meaningful life. Indeed, the French philosopher André Comte-Sponville has written a fascinating little book on atheist spirituality. However, this distinction frequently depends on a reductionist view of religion. For example, a recent American commentator on the contemporary spirituality phenomenon notes that, in the popular mind, 'religion' is associated with dogma, moralism, authoritarian hierarchies, the constraints of social expectations, and a predominant concern with buildings and money.[42]

Recognizing how the term spirituality is used to sometimes express a particular faith frame and define the experience of a person's sacred searching is important to this project in three primary ways. First, when used in the broadest sense, spirituality includes the continuum of faith frames and the varied personal experiences of sacred searching as described within this project. In this manner, the broadness of the term "spirituality" becomes a helpful and collective term that emphasizes the particular person-centered experiences of the dimensions of the faith frame and sacred searching. Second, just as Sheldrake asserts, it is important to recognize that the common definition in the "popular mind" regarding religion and matters of faith frequently relies on a reductionist view. Sheldrake points to this reduction of faith and religion, and the association with moralism, dogma, and the like, as a particularly strong influence upon the use of "spirituality" in the research literature. This project addresses concerns with this common reductionism of religion and faith within the field while, thirdly, acknowledging that some experiences with faith and religion can be traumatically causative within an addiction and thus vitally important to address within addiction treatment.

[42] Ibid.

These identified issues and conversations surrounding the popular phrase "spiritual but not religious" within the United States are well documented, and this continuing phenomenon is undoubtedly influential in part of what Sheldrake calls ongoing "politics" at work within the construction of the definition of spirituality. Sheldrake states,

> How we define 'spirituality' and also distinguish and describe different traditions of spirituality is not a simple matter of objective observation. All definitions and descriptions are in matter of interpretation which, in turn, involves preferences, assumptions and choices. In that sense, our approaches to spirituality may often be effectively 'political' in that they express values and commitments. Sometimes our historical narratives also reflect the interest of dominant groups - whether in a religious, institutional, theological or social-cultural sense. This process may sometimes be conscious but is more often unconscious and uncritical.[43]

Sheldrake is correct to point toward the biases and influences often involved in the process of identifying the definition of spirituality within the research. However, it is also important to note that the politics Sheldrake references are also directly influential in clinical practice. For example, a clinician engaged in a conversation about spirituality in the addiction/recovery field might personally lean toward defining spirituality as a personal coping skill or a practice of resilience in recovery and thus dismiss the benefits of a client's desire for communal participation within a mosque, temple, or church community. A mental-health practitioner might personally define spirituality as self-actualization and dismiss the opportunity during treatment for spiritual formation practices such as prayer or meditation.

The personal and often-unconscious bias of definition is not just at work within those who are providing care, but also at work within those participating in addiction treatment environments. The definition, and the personal and social influences upon the definition of spirituality, faith, and religion, makes for a complexity of perspectives not only in the research literature, but with the action and lived experience of every person. Working within this complex

[43] Ibid., 15.

field of influences and definitions requires a particularly trained and professionally engaged practitioner.

In summary, the lack of a standard of definition of spirituality within the research hinders the use of the literature as a sole claim for the discipline of spiritual care being an accepted evidence-based practice. The disparity of definition seems to perpetuate the ongoing ambivalence toward spirituality within the medical model dominated field and is fostered by a bias influenced by a reductionist societal perception of faith and religion. This condition is part of what allows the continued omission of a discipline of spiritual care within the addiction treatment field and can lead to an omission of the lived experience of spirituality, faith, and religion in persons participating in addiction treatment environments. For, not only is the definition of spirituality indeterminate and compounded within the research literature, but it is also equally indeterminate and compounded within persons participating within addiction treatment environments—in both those receiving and providing care.

This project does not seek to define a standardized definition of spirituality but does affirm the research field needs to establish a consensus for the purpose of concise and ongoing research. Rather, this project focuses on recognizing and responding to the complicated and complex phenomenon of the spirituality and faith realities at work within and upon persons. The goal of this project is to define *how* faith and spirituality are at work and how spiritual care can subsequently be provided. For as Sheldrake helps identify, the term spirituality is often only applied to the development of other predetermined constructs rather than approaching the subject of spirituality through observation. Or as Cook highlights, spirituality in the research is often treated as merely an adjective attached to a variety of nouns.[44] And as the introductory story of

[44] Cook, “Addiction and Spirituality,” 543.

the blind man illustrates, for transformative healing to happen, the lived experience of the person seeking treatment must be recognized and included as primary in the healing story.

The Tunnel Vision of Individualism

A third condition hindering the integration of spiritual care and spiritual care practitioners within the addiction treatment field - and one that helps make sense of the fuzzy perspective on spirituality and faith referenced above - is the dominant American ideology of *individualism* that has significantly influenced the development and modality of spiritual care.

In her book, *Moving Beyond Individualism in Pastoral Care and Counseling,* Barbara J. McClure identifies the implications and challenges presented by the ideology of individualism upon and within the pastoral care field. Particularly, McClure is advocating for pastoral counselors to recognize the social determinants of faith and religion at work upon persons rather than continuing to strictly approach persons with psychoanalytic theory and practices. Although McClure is writing to a now professionalized pastoral counseling field that now exists apart from the role of pastor within a congregation, her findings and suggestions help this project add clarity to why spiritual care has not been readily integrated into addiction treatment. Additionally, McClure provides important insights regarding how to navigate spiritual care forward as a professional discipline among the therapeutic disciplines while maintaining its important distinction about faith/spirituality.

McClure describes individualism as an ideology that "assumes the self is an independent entity, responsible for its own chances in life and the final arbiter of authority and judgement."[45] McClure also recognizes the complexity of unweaving and identifying the hindering intricacies of individualism while also working within its possibilities. McClure writes,

[45] Barbara McClure, *Moving beyond Individualism in Pastoral Care and Counseling: Reflections on Theory, Theology, and Practice* (Eugene, OR: Cascade Books, 2010), 3.

> It has long been observed that individualism is the operative ideology in American society. Fed by religious, political, economic, and cultural sources, individualism has come to shape the way Americans think about themselves and their relationships to one another and to their social institutions. But individualism is a complex ideology, containing with it seeds of both possibility and constraint, leading philosopher Charles Taylor to suggest that individualism both represents one of the finest contributions of modern civilization and serves as the source of much of the social, psychic, and spiritual malaise of modern people.[46]

While citing three of the most well-known written histories of pastoral care and counseling, McClure outlines how the pastoral counseling field transitioned in its development from being primarily led by theology to being primarily influenced by the language and theory of psychology.

McClure recognizes two core outcomes of the influence of individualism within the historical development of the professional pastoral counseling field. First, McClure claims that pastoral counselors have largely adopted the language and understanding of personhood as defined within Freudian constructs and have neglected to include the social and theological aspects of personhood.[47] Consequently, this adoption has led to what McClure identifies as the second outcome; that as pastoral counselors have adopted the same therapeutic diagnostic assumptions as psychotherapists and counselors, a significant gap remains within the care of persons. McClure writes,

> If our healing practices flow from the diagnostic assumptions that are implied in our operative understanding of key concepts, then our definition of these concepts, our diagnosis, and the resulting practices are limited and finally inadequate for the most effective care of all persons who would benefit from our attention. The most commonly drawn upon theories and practices are important as far as they go, but do not go far enough in helping us overcome a deep-seated individualism that my empirical research suggests still pervades the field. I am convinced that we must analyze dominant theories, theologies, and practices, as well as the structures that support them to understand better why this is the case. Simply put, I believe that our overly narrow conceptions of selfhood

[46] Ibid., 2.
[47] Ibid., 93-94.

> and sufferings obscure real sources of distress and make it difficult to effectively care for all those who seek our support….[48]

McClure is right to challenge and invite pastoral counselors to broaden their focus from solely psychological diagnosis and practices, and to a focus on the determinants of faith and spirituality and the formative social and theological dimensions at work upon and within a person. And not only is this a valid criticism for the pastoral counseling field, but it is also equally valid for spiritual care practitioners seeking integration into addiction treatment. For, as the aforementioned research has demonstrated, present therapeutic roles within addiction treatment lack theological education and experience and continue to demonstrate an ongoing ambivalence toward the determinants of spirituality and faith. And when pastoral counselors also exclusively rely on an individualistic understanding of personhood (as *self*-constructed and as the *self*-arbiters of their lives), they are prone to abandon and ignore the significant and determinative social and spiritual experiences of the faith dimension at work within and upon a person. In other words, as the history of pastoral counseling aligned itself with psychological language and insight, it ignored the significance of the *theological* imagination within personhood and evidence of the social and personal formational practices of faith. To underline this reality even further, McClure states, "This has meant that our work very often does not orient itself differently from that of practitioners who are not theologically informed, leading some to wonder what pastoral about is professionalized pastoral care and counseling."[49]

McClure's insights help this project point to a broader view of personhood and identify additional pathways for advocating for the importance of spiritual care with those participating in addiction treatment environments. For, while McClure certainly sees value within the insights of psychology and other social sciences, McClure invites pastoral counselors to be engaged with

[48] Ibid., 5.
[49] Ibid., 93-94.

each individual as social and theological listeners while also being psychologically aware. McClure clarifies that

> In order to pay attention to the particular without falling into individualism, then, pastoral practitioners will need to listen with two interpretive frames. First, we will continue to listen in the way we are now so good at: to the areas of pain, resistance, denial, confusion, and defensiveness. But practitioners must also listen with the understanding that goals, feelings, experiences, values, and desires - as they are embodied, experienced, and expressed by individual persons - are constructed (given form and content), within a particular cultural and social mileu. When pastoral counselors hear the chronicle of personal experience, they are hearing attestations to the effects of the way our lives are configured within the current social system. When we witness the experiences of the individual we are seeing society from a different angle; the effects of the larger socio-institutional structures that are always manifested locally and specifically, experienced in the day-to-day processes of an individual life.[50]

A modality of care with the focus on the particular social and theological influences and experiences within every individual would be a unique an important contribution of care for the addiction field. And McClure's insights regarding how this particularity has been neglected, by both pastoral counselors and within the general therapeutic field, are important to see as one of core conditions historically hindering the integration of spiritual care practitioners in the addiction treatment field. For within the failure to maintain a professional distinctiveness that sees a theological frame within the development and care of personhood, spirituality has morphed into another subject to cover in the education of therapists or a just another "element" to include in programming activities. Again, there is a significant reductionism of faith and spirituality at work in this neglect, but this time due to efforts of pastoral practitioners seeking to legitimize their work and make space to fit in within the therapeutic field. However, rather than accomplishing and establishing an integrated role within the addiction treatment, the pastoral counseling profession lost its artful distinction to the language and characteristics of the medical model and has thus limited its own potential within the field. As McClure articulates,

[50] Ibid., 253.

> …the importance of establishing ourselves as a credible profession alongside other developing professions has led us along the path of the medical model in practice and role; We tend to focus on the difficulties, even pathologies, of those who seek our support, and, in using language such as 'therapist' and 'client,' signal the expectation of the particular practices we limit ourselves to and the functions we are willing to perform.[51]

In summary, McClure provides an important critique of the pastoral counseling field and identifies how "individualism has become institutionalized within the very practice and organization of pastoral care itself."[52] McClure's advocating for pastoral counseling to move beyond the tunnel vision of individualism parallels the effort of this project to imagine and advocate for the integration of spiritual care practitioners in addiction treatment environments. For, as spiritual care practitioners provide particular attention to the lived experiences of spirituality and faith and offer careful attention to the determinative dimension of the theological imagination, a distinct and necessary professional discipline emerges. As a result, the value of spiritual care as a distinct discipline can be clearly seen and clarified from a blurred approach too often oriented solely within the replicated language, diagnosis, and practices of psychology-based therapists and clinicians.

In addition, this project gleans from McClure a broader perspective of personhood than the tunnel vision of an independent and self-arbitering entity while also recognizing and responding to the individualism at work and influential as the "spiritual malaise of modern people."[53] And while seeking to provide an alternative view of the distinctive and valuable contribution of spiritual care practitioners with addiction treatment environments, this project recognizes even its own use of terms such as "professional discipline of spiritual care" or "spiritual care practitioner" is reflective of the therapeutic professionalization prevalent within

[51] Ibid., 93-94.
[52] Ibid., 5.
[53] Ibid., 2.

spiritual/pastoral counseling. It is a goal of this project to both utilize the language necessary to communicate with the predominantly therapeutic dialect of the addiction treatment field and maintain a distinctiveness regarding the differences between spiritual care and psychoanalysis.

Summary of the Walking Trees

In summary, as the addiction treatment field developed in the United States, it has not integrated a professional discipline of spiritual care despite ample evidence regarding the contribution of faith as a positive factor of recovery and the explicitly known desire for greater focus on spirituality by persons participating within addiction treatment environments.

To understand how spiritual care has arrived at the point of needing urgent clarity and advocation within the addiction treatment field, an examination of the conditions causing the blurry perspective is necessary. Three contributing conditions have created a blurred view of spirituality and spiritual care within the addiction treatment field; they include: (1) The historical and often dualistic debate between the moral and medical models has stigmatized and limited the development and presence of a discipline of spiritual care within the addiction treatment field. This dualistic history has and continues to show up in the omitting of spiritual language within the medical-model theory and practice, despite significant evidence of the effectiveness of integrative models of care. (2) The lack of a standard of definition of spirituality within the research has hindered the use of the literature as a claim for spiritual care being an evidence-based practice. The disparity of definition is perpetuating the ongoing ambivalence toward spirituality within the medical model dominated field and is fostered by personal biases influenced by a reductionist societal perception of faith and religion. This condition is part of what allows the continued omission of a discipline of spiritual care within the addiction treatment field, and crucially, is resulting in the dismissal of the lived experience of spirituality,

faith, and religion in persons participating in addiction treatment environments. For, not only is the definition of spirituality indeterminate and compounded within the research literature, but it is also equally indeterminate and compounded within persons participating within addiction treatment environments—in both those receiving and providing care. The ongoing ambivalence and narrowing of definition and practice to medical and psychological causes and interventions does not reflect the growing interest, evidence, and efforts to include the determinative dimensions of spirituality and faith. (3) The ideology of individualism has significantly influenced the development of the pastoral counseling field and is prevalent within its practices and organization as a professional practice. As a result, the value of pastoral care as a distinct discipline within the addiction treatment field has been blurred by an approach of pastoral care too often oriented solely within the replicated language, diagnosis, and practices of psychology-based therapists and clinicians. Neglecting faith and religion as social determinants has allowed spirituality to be relegated to just another topic for psychoanalysis. Pastoral care, as identified by Barbara McClure, must broaden its understanding of personhood to include the determinative social and theological influences within and upon persons.

While there have been efforts made and emphasis provided over the past twenty years regarding the importance of integrating spirituality into addiction treatment, the efforts have been limited to attempts to add additional education, training, and supervision into existing therapeutic roles such as addiction counselors, social workers, or psychologists. Unlike other health-care environments where certified spiritual care practitioners are recommended and often required by accrediting and certifying bodies within interdisciplinary systems of care, addiction treatment environments often rely on institutional traditions, personal interest and willingness of therapists, adjunct staff, or the referral of clients to external or post-treatment sources.

Meanwhile, research continues to increase its findings and awareness regarding the importance of including spirituality in addiction treatment, yet the attempts to integrate spirituality into the traditional roles and environments has not changed the ongoing ambivalence regarding spirituality or the efforts to omit spirituality themed language from both addiction theory and practice. Another approach is needed to address an ethical provision of spiritual care within the addiction field and ensuring fidelity to a true biopsychosocial and theological provision of care.

Gerald May, a pastoral psychologist whose research and writing was highly influential in the pastoral care movement, also came to recognize this paradox and need. May wrote,

> Many of those who were addicted to drugs remained addicted, even though it appeared that their 'psychological' problems were getting resolved. Those who did go on to a drug-free life, a life filled with meaning, were candid enough to let me know that their transformation had little or nothing to do with my therapy. They explained that what had made the difference for them was some kind of deep spiritual, existential experience. An experience which went far beyond their bodies and minds and somehow got them more interested in being and less interested in *how* to be. I recognized the spiritual basis of these kinds of transformations, so I asked my clergy colleagues for help in understanding it.
>
> But by then my clergy colleagues were immersed in psychotherapy and their answers came straight from Freud. 'Well, maybe it's a change in cathexis, a primary narcissistic experience, or perhaps some displacement of Oedipal feelings,' they say. Then it began to dawn. Here I was, a psychotherapist suddenly wanting to become a priest, in the midst of priests who wanted to become psychotherapists. There's a lesson here, and it goes deeper than that the grass is always greener. The lesson is that an accurate perception of reality lies beyond *both* traditional psychotherapy *and* traditional religion.[54]

May is correct; spiritual care overly intertwined with psychoanalysis within the addiction treatment field has not yielded a clear vision of the potentials of spiritual care, and this invites a second look at imagining spiritual care and the work of spiritual care practitioners. For, as

[54] Gerald May, *Simply Sane: The Spirituality of Mental Health*, rev. ed. (New York, NY: Crossroad, 1993), 64.

McClure also concludes; "… now it is time for pastoral caregivers to be more theoretically complex, theologically open, more creative and flexible *in practice*."[55]

PART TWO

The Transformative Proposal

How can the lived experiences of spirituality and faith and the dimension of the theological imagination of persons participating in addiction treatment be included into the treatment process? What can the practice of spiritual care look like beyond the reductionism of spirituality, faith, and religion and the influencing ideology of individualism? How does the addiction treatment field begin to immediately respond to the urgent need of integrating spiritual care practitioners into addiction treatment environments as a response to person centered care? Those three questions will mark the path ahead for this transformative proposal regarding a new approach of including direct care for the spirituality and faith of persons participating in addiction treatment environments. For, despite an increasing awareness within the research

[55] McClure, *Moving Beyond Individualism*, 250.

regarding the importance of integrating spirituality into treatment, an ambivalence remains. And, despite the faith frame and the theological imagination being a determinative phenomenon of personhood, little effort has made to advocate for, include, assess, and appropriately respond alongside persons experiencing a faith crisis, spiritual seeking and soothing, or experiencing theological incongruence or resolve amid a treatment episode.

Two analyses were discovered in the research of this project that will help lead the response regarding the question of how to move spiritual care forward within the addiction treatment field. The first is from Barbara McClure, who claims the future of spiritual care will depend upon spiritual caregivers who learn to do their work in "the intersections of multiple disciplines including (but not limited to) psychology, ethics, medicine, ministry, business, sociology, and anthropology."[56] McClure continues,

> As a profession 'in between,' ideally pastoral practitioners will hold competing values in tension and negotiate them, using opposing views to gain perspective on and perhaps critique other perspectives rather than allowing an oversimplification of theories, theologies, or practices. Standing in such an intersection can be both dangerous and challenging. However, if pastoral practitioners can find ways to use their unique location, and learn from it, it can be a highly creative, fruitful, an important place to be. Indeed, the possibilities for imagining ways to resist what is oppressive are found in the fissures that exist in the order of things, and from the critical leverage one can gain when differences in ideologies, values or life experiences are compared and discussed."[57]

This broadening of the scope of practice of spiritual care is critical, and its breadth will be demonstrated within the literature review of Chapter Three that introduces and provides new language, connecting theories, and creative pathways regarding the discipline of spiritual care within addiction treatment. And throughout the literature review, particular attention will be given to the determinative dimension of the *theological imagination.* For, as McClure states, "Although psychological language makes most clear the interpersonal dynamics that create

[56] Ibid., 225-226.
[57] Ibid.

distress or pathology, it is often theological imagination that provides the basis for optimism about the human capacity for change."[58] The identification of the "theological imagination" as a determinative dimension for transformation will shape much of the proposal of this project.

Second, a brief paper titled *Faith-Based Recovery: Its Historical Roots* written by William White and David Whiters in 2005, outlines eight propositions for the needed dialogue between spiritual care and addiction treatment. Although now fifteen years later, the conversation is still needed and even more urgent. White and Whiters offer the following:

> Criticisms of faith-based approaches to addiction recovery continue today, leaving open the question of how such frameworks will compete with, be linked to, or be integrated with the mainstream system of addiction treatment. We believe that dialogue among those representing religious, spiritual, and secular frameworks of addiction recovery is needed and that such dialogue can be built on eight propositions.
>
> 1) There are many viable pathways and styles of addiction recovery.
>
> 2) Religious experience can serve as a powerful catalyst of recovery initiation for some people.
>
> 3) Religious beliefs, religious rituals, and supportive relationships within a faith community can serve as a framework of recovery maintenance.
>
> 4) Patterns of recovery pathways (religious, spiritual, secular) vary across developmental age and gender and between and within various ethnic communities.
>
> 5) The recovery and regeneration of people formally addicted to alcohol and drugs is cause for celebration, regardless of the medium of such recovery.
>
> 6) Recovery from addiction is a complex process, often involving physical, psychological, social, cultural, and ontological (the meaning of existence) dimensions.
>
> 7) Addiction recovery often requires the involvement of multiple disciplines and service practitioners, each of which is ethically mandated to practice within, and only within, the boundaries of their education, training, and experience.
>
> 8) Addiction treatment is best conducted out of respect for, and within, the cultural and religious heritage and the personal belief system that each client brings to the service environment.[59]

This project agrees that a dialogue is still urgently needed between the frameworks of spiritual care and addiction treatment and seeks to move the conversation forward within the outline of proposals provided by White and Whiters. Close attention will be given within this project to proposals seven and eight. These two proposals distinctly identify that addiction

[58] Ibid., 45.

[59] White and Whiters, "Faith-Based Recovery," 58-62.

recovery often requires multiple disciplines and service practitioners and that addiction treatment is at its best when the spiritual particularity that each person brings into a treatment environment is honored.

Ultimately, this transformative proposal recognizes the determinative and lived experiences of spirituality and faith within persons participating in addiction treatment environments and concludes that the integration of spiritual care through a modality of qualified spiritual care practitioners is essential. This integration of spiritual care practitioners must happen within addiction treatment environments before any claim to an efficacy of a person-centered approach can be made within the field.

The Process

The process of this project is to inform, imagine, construct, and advocate. The discovery and research for this project over the past two years has helped inform this writer and will hopefully serve as a means of informing others who are also interested in advocating for the spiritual and faith dimensions of persons participating in addiction treatment environments. The task of advocating for the unique other is central to this project, serving as the core motivation for the integration of spiritual practitioners into addiction treatment environments. In this regard, this project is an expression of practical and contextual theology.

This project is also akin to a case study, meaning it is a theoretical approach that imagines new ways and means to define the sacred domain, the faith dimension, and the possibilities of spiritual care within environments traditionally stuck in a false division of sacred and secular. As a result of the information presented, advocating for persons within addiction treatment environments, and the imagining of ministry possibilities - this project results in the

construction of a mode of care, practical framework, and a pathway toward integrating spiritual care practitioners in addiction treatment environments.

Summary and the Path Ahead

This chapter has included two parts: Part One was an overview of the three core conditions hindering the presence of a professional modality of spiritual care within the addiction treatment field. Part Two provided an overview of the transformative proposal and the process of this project. Simply put, the proposal argues for the integration of spiritual care practitioners within addiction treatment environments through the process of defining how spiritual care is vital within person-centered treatment and why embodied care of spiritual care practitioners is necessary in addiction treatment environments.

Chapter Two will explore perspectives, language, and theories within the research literature across a spectrum of fields of study. These contributions and insights help clarify phenomenologically how the sacred search, the faith frame, and the theological imagination is at work within and upon a person and recognizes the faith frame/theological imagination as a determinative dimension/experience of personhood. This work includes contributions from philosophical, medical, and theological anthropology, psychotherapy, trauma therapy, and contextual theology.

Chapter Three defines and examines the modes of practice of a spiritual care practitioner and provides a practical framework for the role of a spiritual care practitioner including: the necessary professional skills, education, certifications, job description language, standards of care, and an overview regarding how the art of spiritual direction is particularly formative as a effectual mode of spiritual care in addiction treatment environments.

Chapter Four provides a roadmap toward the integration of spiritual care practitioners in addiction treatment environments, insights from interviews with medical practitioners and administrative roles within addiction treatment provider agencies, and a summary of potential roadblocks and blind spots regarding the goal of this project to impel the integration of spiritual care practitioners into addiction treatment environments.

CHAPTER TWO: INTENTLY LOOKING

Introduction

As identified in the previous chapter, the history of the addiction treatment field omitting a professional discipline of spiritual care is partially due to fuzzy definition—leading to a dismissal of the evidenced benefits and a reductionism regarding the thick realities of faith and spirituality and their determinative influences upon and within personhood. This history also includes presently-active social, personal, and/or institutional biases— revealed not only in the research, but also within the ongoing ambivalence to matters of spirituality, faith, and religion within medical and therapeutic practice.

In response, this chapter seeks to shift the attention within the unfolding story of addiction treatment away from the provision of treatment to examine the lived experience of spirituality and faith active in persons participating in addiction treatment. For, recognizing and including the spiritual phenomena and faith dimensions of persons as both potentially a harmful influence upon persons and a helpful influence within the efforts of addiction treatment is ethically essential and critical to any claim of a treatment efficacy to whole person or person-centered care.

While the literature review within this chapter is only a sampling of the recent revival of interest in spirituality and faith across the fields of study, it intends to highlight perspectives, language, and theories from non-religious fields of study to help clarify phenomenologically how spirituality and faith is at work within and upon a person, and thus, identify the faith frame and theological imagination as a determinative dimension and experiences of personhood.

In addition, this chapter is following McClure's suggestion regarding broadening the scope of practice, awareness, and language of spiritual care practitioners. This project agrees

with McClure that spiritual care must learn to do its work in "the intersections of multiple disciplines."[60] And a clear image of a discipline of spiritual care in the addiction field is not bound to the provision of personal religious rituals or trapped within the psychological language and ideology of the individualistic self; rather, spiritual care must intently look and observe the whole person and all the makings of the person.

Therefore, this literature review begins to propose, highlight, and examine new language and approaches for the possibilities of spiritual care and spiritual care practitioners within the addiction treatment field. For, as McClure has again suggested, spiritual care must become more "theoretically complex, theologically open, more creative and flexible *in practice*."[61]

Part One of this chapter shifts the attention away from the provision of care and examines how the lived experience of spirituality and faith is active in persons participating in addiction treatment. The recognition and awareness of a determinative and lived experience of spirituality and faith actively influencing upon and within those in addiction treatment environments will underline the essential need of professional care for this determinative dimension of personhood.

Part Two will examine perspectives and language regarding the needed characteristics of a spiritual care practitioner role within addiction treatment. Using recent literature and research from trauma theory, the transformative power of therapeutic companionship will shape the needed characteristics of a spiritual care practitioner within addiction treatment environments.

PART ONE

[60] McClure, *Moving Beyond Individualism*, 225-226.
[61] Ibid., 250.

A Search for the Sacred

Kenneth Pargament, an internationally known and respected researcher, has written extensively about the intersection of psychology and religious beliefs. In his landmark work, *Spirituality Integrated Psychotherapy: Understanding and Addressing the Sacred*, he claims "the founding figures of psychology saw no reason to separate spirituality from psychological study and practice."[62] And he identifies it literally by pointing out that the root meaning of the word psychology is derived from *psyche* (soul) and *logy* (study of). Yet, as Pargament claims, early in the 20th century

> this picture began to change as the attitude of those in the field regarding religion shifted from interest and openness to suspicion and hostility. Under the influence of the positivistic philosophy of the time, psychology moved quickly to ally itself with the natural sciences and thereby distinguish itself from its embarrassingly close disciplinary kin, philosophy and theology. Within the developing field, religion came to be seen as an impediment to scientific search for enlightenment and a roadblock to rationally based efforts to improve the human condition.[63]

It is because of this ongoing movement and its reductionistic attitude toward theology and philosophy that Pargament correctly concludes that "modern practitioners of psychotherapy have become in some important respects quite different from those they serve and in some ways unprepared to help them."[64] This project also acknowledges this reality and points toward the needed integration of a discipline of spiritual care into the addiction treatment field.

Pargament, in his unique approach, appeals to the psychotherapy field to rethink its posture toward and awareness of spirituality and faith at work within and upon persons within their care. While Pargament is writing toward the broader field of psychotherapy, his critique directly parallels and helps translate the aforementioned evidence of the active ambivalence of

[62] Kenneth Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (New York, NY: Guilford Press, 2007), 7.

[63] Ibid., 8.

[64] Ibid., 9.

therapists toward spirituality specifically within the addiction treatment field. For, while perhaps within the past twenty years there has been some movement and response to spirituality and faith within the broader field of psychotherapy, the movement encouraged by Kenneth Pargament, William Miller, and others has not significantly impacted the therapeutic approach and practices within the addiction treatment field. Contrarily, despite research evidence and invitation within the literature, the field continues to move away from the inclusion of spirituality while under the influence of the medical disease model and primarily finds its attention focused on "brain circuits, genetics, the environment, and an individual's life experiences."[65]

However, while the shortsighted and reductionist approach continues its influence, even ASAM's current definition of addiction and its use of the language of "the environment" and "life experiences" ought to require attention to the sociocultural influences of the sacred domain and lived experiences of faith, spirituality, God, the divine, socially formed or personally formed theology, and/or faith/religious experiences. Pargament's warning is fitting for the present-day quandary,

> We can try to ignore the elephant, but that doesn't make it go away. Instead, it may lead to problems. 'Ignorance of spiritual constructs and experience,' Bergin and Payne (1991) write, 'predispose a therapist to misjudge, misinterpret, misunderstand, mismanage, or neglect important segments of a client's life which may impact significantly on adjustment or growth.' (p. 201) Spirituality is part of the psychotherapy process; our choice is either to look the other way and proceed with limited vision or to address spirituality more directly and knowingly.[66]

Pargament's insistence that "spirituality is part of the psychotherapy process" is particularly important when addressing the omission of spirituality and spiritual care within the addiction treatment field. His call for change and his reframing of a spiritually integrated psychotherapy also provides a new approach, language, and perspectives for the presence of

[65] "Public Policy Statement: Definition of Addiction."
[66] Pargament, *Spiritually Integrated Psychotherapy*, 15.

spirituality and attention to spiritual care within the addiction treatment field. Such an integrated approach would surely begin to respond to the stated desire of persons participating in addiction treatment for a greater emphasis on spirituality while participating in addiction treatment.

As pointed out in the previous chapter, the definition of spirituality is often vague and varied. In view of developing a precise and comprehensive definition, this project is attentive to Pargament's contribution of a distinct definition of spirituality and his description regarding *how* spirituality is at work within persons. Pargament defines spirituality not as something static, but an ongoing process and experience of personhood.

Pargament succinctly defines spirituality as "a search for the sacred."[67] He unfolds his definition in two ways: a description of *the sacred domain*, and an exploration of what it means to *search*.

Pargament clarifies the sacred domain as:

> At the core of the sacred lie concepts of God, the divine, and transcendent reality. However, the sacred does not stop there; The domain of the sacred extends beyond to a ring that encircles the self, relationships, and place and time. In fact, virtually any aspect of existence can be seen through the sacred lens as a manifestation of God or as the container of sacred qualities. Even experiences of great pain and suffering, our darkest nights of the soul, can be perceived in terms of a deeper transcendent dimension.[68]

Pargament's framing of the sacred domain as inclusive of the concepts of God, the divine, transcendent reality, the self, relationships, place and time, and even suffering is particularly important in identifying how spirituality is at work within persons in addiction treatment. Recognizing the reality of the sacred domain, either in real reality or in phenomenologically experienced reality, and that such a domain exists as a determinative influence upon and within persons is vital. Seeing "virtually any aspect of existence" including "experiences of great pain and suffering" "through the sacred lens" expands spirituality far

[67] Ibid., 32.
[68] Ibid., 49.

beyond any traditionally narrow or reductionist definitions. Recognizing the breadth and influence of the sacred domain is an important first step to recognizing and including the lived experiences of persons within addiction treatment.

Demonstrating the expansiveness and lived experience of the sacred domain is important. It is equally important to recognize that Pargament defines the core of the sacred domain as revolving around the concepts of God, the divine, and the transcendent. These theological realities touch and influence all other aspects, encompassing and influencing every part of a person. This project will expand on this reality further within the upcoming review of Tonya Luhrmann's anthropological research.

Secondly, Pargament defines spirituality as *a search for* the sacred. Pargament summarizes the lived experience of the search for the sacred with the following:

> Every search for the sacred is dynamic rather than static, evolving rather than fixed. The search begins with the individual's discovery of something sacred. Once he or she finds the sacred, the individual takes a spiritual path to sustain and foster his or her relationship with the sacred. Changes from within or outside of the individual's world, however, can violate, threaten, harm, or point to the limits of the sacred. The individual must then cope to preserve and protect the sacred as best he or she can. At times, though, in spite of the person's best efforts to sustain the sacred in the coping process, internal or external pressures can throw the individual's spiritual world into turmoil. Spiritual struggles can be short lived experiences, followed by a return to established spiritual pathways. However, struggles can also represent a fork in the road that leads to permanent disengagement from the search for the sacred, temporary disengagement from the search followed by rediscovery of the sacred, or fundamental transformations in the character of the sacred. Following a transformation, the individual shifts again to conservation and the effort to hold onto the sacred. The search for the sacred is not time-limited; it continues over the lifespan, unfolding in a larger field of situational, social, cultural, and psychological forces that both shapes and is shaped by the nature of the search. Within this ongoing pursuit, we can identify three important processes: discovery, conservation, and transformation.[69]

Most of the literary landscape of Pargament's research demonstrates how the sacred search is at work within and upon persons; particularly Pargament details three processes within

[69] Ibid., 61.

the search for the sacred: the processes of discovery, conservation, and transformation. These change processes are crucial both in understanding and including the potential of and realities of spirituality at work within persons participating in addiction treatment. After all, addressing and resolving spiritual struggle or stuck-ness is often the desire and topic of interest of those participating in and seeking addiction treatment.

Pargament further explores the process of transformation by identifying three common methods of spiritual transformations: (1) *Sacred transitions*—everyday life experiences and rituals such as birth and death, funerals and celebrations, and other rites of passage. Such transitions often change and significantly transform a person. (2) *Revisioning the Sacred*—a shift or pivot in *theological* understanding regarding God, the divine, and transcendent. Pargament rightly recognizes that theological revisioning is often necessary within spiritual methods of coping. (3) and *Centering the Sacred*. Regarding the centering of the sacred, Pargament writes:

> New visions of the sacred represent more than cognitive changes. They are often accompanied by other spiritual transformations in which the sacred is realigned within the individual's hierarchy of significant values and strivings. The shift may be from self-centered pursuits to a desire to make the world a better place. It may involve a change from a focus on anger, bitterness, and injustice to a focus on forgiveness and peace of mind. It may entail a process of detachment from intensely pleasurable but ultimately destructive pursuits, such as drugs or alcohol. Or it may involve a spiritual conversion from a life devoid of divinity to one in which God becomes the focal point of existence. In any case, the sacred moves from the marginal position to the very center of the individual's life and definition of him- or herself. There are three important steps in the process of centering the sacred. First, the individual recognizes the limitations of current strivings. Second, he or she decides it is time to let go of old values. Third, the individual replaces old sources of significance with the sacred.[70]

The sacred search, as defined by Pargament, reveals how the process of the search for the sacred unfolds and how the method of centering acts as a means of coping while emphasizing the process and methods are a means of change. As Pargament describes, spirituality, as a search for the sacred, is an ongoing process of change. As Pargament concludes,

[70] Ibid., 122-123.

> In response to spiritual struggles, many people engage in transformations. But spiritual transformation is not easy. For instance, to center the sacred, people have to confront the limits of a way of life. They must then undergo the painful process of letting go of old sources of significance. And then they face the task of rebuilding their lives and reorientating themselves around the new core values. Hard as this kind of changes is, it is not possible. Research on spiritual transformation is just getting underway, yet empirical studies from different domains (e.g., 12-step programs, conversion, forgiveness) suggest that many people are, in fact, able to make profound spiritual transformations.[71]

Understanding the sacred search as an instrumental process of change is part of the reason spirituality and spiritual care must be integrated into addiction treatment. For those who desire (and we know it to be a majority of the persons participating in addiction treatment environments) to walk this spiritual path of recovery, every effort must be made to provide the necessary and professional support.

In summary, this project recognizes five vital contributions of Pargament that support the proposal of this project: (1) Every person experiences a search for the sacred, even if the sacred may be variously defined. (2) The sacred domain and the inherent human striving and search for significance are inextricably connected. (3) The core elements within the sacred domain are theological and encompass the concepts of God, the divine, and the transcendent.. (4) The personal and dynamic process of transformation unfolds in the larger field of "situation, social, cultural, and psychological" influences that "both shapes and is shaped by the nature of the search." (5) Spirituality is a process of change, and the difficult but possible spiritual transformation directly affects the realities of identity, meaning, and behavior of persons.

In addition, Pargament also provides a practical bridge between the discipline of spiritual care and the evidence-based practices of psychotherapy. Akin to Carlo DiClemente's "process of intentional human behavior change,"[72] Pargament demonstrates how spirituality is a process of

[71] Ibid., 126.

[72] Carlo DiClemente, *Addiction and Change: How Addictions Develop and Addicted People Recover* (New York, NY: Guilford Press, 2003), 21.

change and how the sacred domain is included in every life experience. Pargament is a vital resource that the addiction treatment field must "intently look" toward as it seeks to address the gap between its current practices and the stated desire for greater emphasis on spirituality by those participating in addiction treatment environments.

However, one area that Pargament mentions, but does not fully explore, needs further attention. As Pargament rightly identifies, the core elements of the sacred domain are theological and encompassing the concepts of God, the divine, and the transcendent.. The following research and perspectives from Tonya Luhrmann will help shape a language and framework in this regard. For, again, as McClure clarified, "Although psychological language makes most clear the interpersonal dynamics that create distress or pathology, it is often theological imagination that provides the basis for optimism about the human capacity for change."[73]

The Faith Frame

Tonya Luhrmann, a medical and psychological anthropologist,[74] offers another helpful perspective in identifying how spirituality and faith are determinative influences upon and within persons participating in addiction treatment environments. In *How God Becomes Real*, Luhrmann details her anthropological research across various people groups regarding how gods and spirits phenomenologically become and remain real and how the experience of gods and spirits shapes both personal behavior and society.

The term *phenomenology* is used within anthropological and philosophical circles to describe how an object directly experiences upon and within a person.[75] Anthropology and even the paleoanthropology fields have long studied human behavior and the tendency to mark real

[73] McClure, *Moving Beyond Individualism*, 45.

[74] "Tanya Luhrmann, "About the Author: An Anthropologist Studying the Mind," *Tanya Luhrmann*, Accessed October 24, 2021, https://www.tanyaluhrmann.com/about.

[75] Paul Ricœur and Kathleen Blamey, *Oneself as Another* (Chicago, IL: University of Chicago Press, 2008).

things with symbolically real things. For example, while detailing the experienced realities expressed within Paleolithic images, J. Wentzel van Huyssteen writes in *Alone in the World?*, "What does seem to be universal to all of us as humans is that we mark durable objects with symbols, a behavior strongly associated with anatomically modern humans and a modern human way of life that is embedded in, and expressed through, culture. We make sense of our worlds by producing symbolic ones that include real and imaginary creatures, myths, and beliefs."[76] In other words, the dimension of the theological imagination is an inherently human reality.

Likewise, Luhrmann's particular interest is in the phenomenological experience of gods and spirits - even if such gods and spirits are self-narrated or imaginatively defined objects. Without insistent interest or focus on the ontological existence of gods and spirits, Luhrmann's work focuses on how the phenomenological experience itself becomes a very real lived experience within a person.

Like Pargament's *sacred domain*, Luhrmann identifies a *faith frame* active within and upon persons serving as a determinative story and lens through which a person interprets both their inner world and the world about them. This faith frame is part of the everyday lived experience of a person's reality. Luhrmann defines the faith frame as a "special way of thinking, expecting, and remembering."[77] Luhrmann also claims the faith frame as one of the ordinary ways a person self-narrates, and thus is determinative in the formation of identity and behavior for persons.

Furthermore, according to Luhrmann, the faith frame is so determinative and convincing that it can contradict and override other common narrative frames and experiences of reality. The

[76] J. Wentzel Van Huyssteen, *Alone in the World?: Human Uniqueness in Science and Theology* (Grand Rapids, MI: William B. Eerdmans, 2006), 175.

[77] T. M. Luhrmann, *How God Becomes Real: Kindling the Presence of Invisible Others* (Princeton, New Jersey: Princeton University Press, 2020), xii.

special faith frame, in Luhrmann's research, is named not as an optional frame for a special few who have chosen deep religious commitments or have unique spiritual experiences, but rather, often works as the primary influence upon and within persons in a particularly determinately manner. Luhrmann states, "[The] faith frame coexists alongside the ordinary ways people make sense of the world, and sometimes contradicts them."[78] Throughout her research, Luhrmann identifies how the faith frame serves for many as the guiding narrative, providing meaning and purpose, and defining both the social and personal lived experiences of a person. The faith frame can be the predominant experience through which a person lives their life.

As Luhrmann describes; "…to think with the faith frame is a decision to enter into another mode of thinking about reality that calls on the resources of the imagination to reorganize what is fundamentally real and that exists in tension with the ordinary expectation of everyday reality."[79] Luhrmann's description of how the faith frame is sustained and enabled by the human dimension of the imagination is of particular importance, for the imagination is both an activity and inherent dimension within every person. Certainly not everyone is primarily experiencing reality through a recognized or fully formed faith frame, but every person is experiencing the narrating influences of the faith frame through the imagination.

Luhrmann describes the imagination as an inherent part of personhood that does the work of meaning-making, interpretation of memories, and the shaping of expectations. As Luhrmann repeatedly points out in her research in contrast against traditional understandings within the anthropological field, the faith frame is not simply cognitive beliefs of the mind, it is an active narration and experience happening in and through the imagination in which a person makes real in every part of their being and embodied acting. Within Luhrmann's anthropological view, the

[78] Ibid., xiii.
[79] Ibid., 23.

faith frame is a primary and determinative influence within personhood and is both working within and upon persons though the imagination.

Luhrmann's emphasis on the imagination as an inherent dimension and experience of a person and that the imagination is both the actor and the writer of the narration of life experience is aligned with the philosophical anthropology work of Paul Ricoeur. Ricoeur, who explores the connections of memory, identity, and imagination, also highlights the imagination as the central influence in the development of experience, identity, and behavior.

Ricoeur presents the imagination as both the problem and solution to the struggles of persons, that is, the struggle, or stuck-ness, of persons is often found in their own narration dialogue between real history and imagined fiction. Ricoeur claims the stories that we tell ourselves about ourselves/others/experiences are most often rooted in actual historical events yet assigned a reality-forming meaning within the imagination. While Ricoeur recognizes there is a difference between real history and narrative versions of history, he, like Luhrmann, argues that both become historical, and thus real, within persons and play a decisive and determinative role in our experience of life, personal identity, and behavior.[80] In other words, we are more than morally formed people or biologically determined persons, we are narrative determined and imaginatively formed persons. Our biopsychosocial experiences—or ASAM's "environment" and "life-experiences"—are fully experienced in two realities—the events themselves and our imagination's transformation of the event. Both are real experiences, and the everyday task of the imagination is the constant re-narrating of experience, identity, and meaning within one's present experiences.[81] As Ricoeur would argue, the imagination is an inherent dimension of personhood, and furthermore, as this project identifies—and Pargament and Luhrmann also both identify—

[80] Paul Ricœur and Mark Wallace, *Figuring the Sacred: Religion, Narrative, and Imagination* (Minneapolis: Fortress Press, 1995).

[81] Ibid.

there is a particularity and specialty about the theological imagination acting as a determinative influence within and upon personhood.

In anticipation of a common critique that "well, not everyone believes in God or gods" and thus not everyone is determinatively influenced by the theological imagination, Pargament offers:

> Clients do not enter psychotherapy as isolated beings. They are accompanied by a way of looking at the world that is, in part, the product of a larger context, made up of many ingredients: gender, ethnicity, age, family, friends, congregation, community, and culture. This point is especially important to stress in the spiritual realm. Modern day definitions emphasize the private, interior, subjective character of spirituality. Readers are reminded repeatedly that they can be spiritual without being religious. While it is true that people can reject a traditional religious identification, they cannot disconnect their spirituality from a greater context. …the search for the sacred always unfolds within the field of larger forces, even if the client is unaware of these forces or reacts against them. The context that is rejected by the client continues to play as critical a role in spirituality as the context that is explicitly accepted.[82]

In other words, the sacred search or the faith frame includes even the realities and narratives of denial, rejection, indifference, or even completely unrecognized, as well as any recognized and active frames. And the psychological and anthropological understanding of the human person includes a sacred domain or a faith frame socially influencing upon and within a person "even if the client is unaware…or reacts against them."

Inescapably, as Luhrmann defines, the faith frame is a formative influence within the experiences and reality of persons participating in addiction treatment as it is an inherent part of personhood itself.

It is the faith frame through which a resolute religious person carries a hopeful anticipation of a miraculous cure, or the believer disappointed about the unanswered prayer for God to cure their addiction urges. It is equally a faith frame at work within the person who declares a defended and defensive pose of "I hate what God has done to me" or the person who

[82] Pargament, *Spiritually Integrated Psychotherapy*, 183.

declares “I am just not interested in God or other unreal and unhelpful topics.” And it is the faith frame at work in the one who declares, “nature is my Higher Power.” The examples are truly unending, as is the influence of the faith frame upon persons and the dimension of the human imagination.

The Theological Imagination

Beyond identifying the faith frame as an inherent dimension and determinative influence upon personhood, Luhrmann helpfully describes how the faith frame is formed by the imagination. Luhrmann describes a process of “real making” accomplished by *paracosms*—defined as “a personal imaginative world, private, precise, and intimate.”[83] She argues that a paracosm is a vivid and detailed story in which gods and spirits come to be real within a person. And it is within and through these detailed stories at work within and upon a person that the faith frame is both formed and experienced. This faith frame, experienced as a paracosm within the imagination, is a determinative experience, the lived experience for many people.

Luhrmann is correct in identifying the paracosm as determinative in shaping the faith frame and regarding how the faith frame is determinative in shaping human experience and behavior. And it should be noted here that detailed stories within the faith frame and the paracosm Luhrmann identifies are primarily and particularly theological in nature. And within the broad theological stories of gods, spirits—as Richard Kearney identifies—are also stories and vivid paracosms of strangers and monsters. These also are determinative because they become real as a lived experience within persons. Therefore, as more than a cognitive set of personal beliefs, theology as a detailed and experienced paracosm, is a lived and determinative reality within personhood.

[83] Luhrmann, *How God Becomes Real*, 32.

Another important perspective Luhrmann contributes is the anthropological recognition of gods as social relationships. Through and within the faith frame and made vivid in the paracosm, gods or spirits become real social relationships to and with persons. In that, when one experiences the phenomenological realness of a god or spirit, there is a socialness and relatability with the invisible other. The god becomes real and thus is relational in nature. And furthermore, because the relationship with an invisible other is experienced directly within the person, there is a particular personal and intimate closeness in the relationship. As Luhrmann says,

> The same is true of the gods. A relationship with a God or spirit is a parasocial relationship, like relationships with all invisible others. One cannot have an ordinary face to face relationship with invisible others; They have no faces. God is not of course thought to be a fictional character by persons of faith. Nonetheless, the relationship is parasocial because its content occurs largely inside the person's head, using his or her imagination, and what must be imagined about the God emerges from the rich stories in which the God is embedded: the myth like stories of a serene Hebrew God surveying his creation or in a more irritable mood throwing his miscreant humans out of Eden. It is because Christians know the story of Jesus so well that his passion brings tears again and again to their eyes.[84]

Luhrmann's framing and approach to religion and lived experiences of the theological imagination is helpful for the argument within this project. For, rather than categorizing faith and religion as merely personal choice regarding cognitive beliefs and thus seeking to separate the sacred dimension and the faith frame from personhood and erringly justifying the omission of spirituality and spiritual care from addiction treatment environments, an anthropological framework of spirituality, faith, and religion that respects and acknowledges the determinative and lived experiences of religion, faith, and spirituality at work within and upon persons is a vital and transformative perspective.

The addiction treatment field would benefit by following the lead of anthropology that understands the determinative and transformative realities of spirituality and faith as part and

[84] Ibid., 30.

parcel of the lived experience of personhood. As Luhrmann states, “Faith may be the socialization of inner experience, but the faithful each still have their own private, inner worlds. That is the paradox of the paracosm: the more richly detailed the shared imaginative landscape, the more vividly individuals can rework it as their own. A kindled God is both deeply communal and utterly individual.”[85]

A *Change* Relationship

Luhrmann’s argument is predicated on her proposal regarding “how people change when they make gods and spirits real and develop a relationship with an unseen presence that feels alive.”[86] The kindled aliveness of an invisible other becomes a real and often meaningful relationship within and for persons as a process and provocation of change. And, as a social reality and lived experience, the kindled and developed relationship becomes more than an happening in the mind—it can become a very real and responsive social reality. And, like any relationship, this relationship with the invisible other is not static; it requires kindling, participating, and learning. Faith practices kindle this aliveness. And “what happens when faith practices kindle a god or spirit into feeling real? The answer is that gods and spirits respond. That is, what it means for gods and spirits to feel real is that humans feel a responsiveness, an aliveness - and this places them into a relationship that changes the humans.”[87] Luhrmann continues,

> This sense of relationship doesn't happen to everyone, and in different religions it happens in different ways. Even if one begins from the faith perspective that gods and spirits are always communicating, it is clear that not all who are faithful hear, know, or

[85] Ibid., 32.
[86] Ibid., xv.
[87] Ibid., 157.

> feel what those gods and spirits mean to convey. They do not always feel that gods and spirits are interacting with *them*. This is why gods and spirits must be made real, and the reason it is so important to take seriously the difference between the realness of the everyday world and the realness of gods and spirits. Gods and spirits are invisible, immaterial, not accessible to the senses in ordinary ways. If humans are to feel the presence of these beings, they must know how to look, how to listen, and how to experience the event. They must learn how to know that spirits respond.[88]

This description regarding how the relationship with the invisible other can be kindled and practiced as a change element is important within this project's proposal. For, Luhrmann additionally connects how an actively kindled relationship with gods and spirits transforms and changes a person in more than the activity of the mind, but within the *body* and *behavior* as well. Luhrmann lists several epidemiological findings regarding how kindling faith activities directly link to positive health outcomes. As Luhrmann lengthily describes:

> The most obvious point about the way connection changes people is that social connection changes bodies. This is the striking epidemiological findings that weekly church attendance has positive health benefits. (Epidemiologists know most about associations with attendance because frequency of attendance is the easiest variable to add into a large survey.) Attending services seems to boost the immune system and decrease blood pressure (Woods et al. 1999; Koenig and Cohen 2002). It may add two to three years to one's life (D. Hall 2006). One study found a seven-year difference in life expectancy, at age twenty, between those who never attended church and those who attended more than once a week (Hummer et al. 1999). Part of this story is that those who attend services have healthier behaviors: they may be more hesitant to drink, take drugs, or engage in risky sex. But that is not the whole story. In the 2012 edition of the *Handbook of Religion and Health*, the authors surveyed all the studies they could find. Despite differences in definition, measurement, outcome, and quality, across close to three thousand original data-based quantitative studies, they found that
>
> > at least 2/3 of these studies report that R/S [religious/spiritual] people experience more positive emotions (well-being, happiness, life satisfaction), fewer emotional disorders (depression, anxiety, suicide, substance abuse), more social connections (social support, marital stability, social capital), and live happier lifestyles (more exercise, better diet, less risky sexual activity, less cigarette smoking, more disease screening, better compliance with treatment). This helps to explain why R/S people on average are physically healthier (less cardiovascular diseases, better immune and endocrine function, perhaps less cancer and better prognosis, and greater longevity). (Koenig, King and Carson 2012: 600-602)

[88] Ibid.

> Epidemiologists also find that social support matters to health, whether or not the social support has anything to do with religion. Social people are happy people. More socially isolated people are less healthy and more likely to die (Diener and Seligman 2002). Loneliness is as lethal as smoking (Cacioppo and Patrick 2008). Moreover, it is clear that there is a casual arrow that points from social support to health outcome, rather than the other way around (House, Landis, and Umberson 1988). To be sure, culture matters. The general effects appear to hold true of any other countries and other faiths, but what counts as well-being shifts—social harmony in Japan, self-esteem in the United States (Ryff et al. 2014). Still the greater the social support, the greater the well-being.[89]

The evidence Luhrmann highlights is in line with broader research regarding faith and spirituality, and it is the same research often dismissed and discounted within the addiction treatment field. In line with the interest of this project, Luhrmann's anthropological perspective on the lived experiences of religion and faith demonstrate that a kindled relationship and practiced connection with an invisible other can serve as a change agent, and often leads to positive health outcomes.

In summary, Tonya Luhrmann's anthropological perspective regarding the lived experiences of faith provides critical new language and a new insight into how spirituality, faith, and religion are at work upon and within persons. Luhrmann's shifting of attention from the traditional approach regarding the what of spirituality/faith beliefs to the how of faith is crucial in moving the attention of the addiction treatment field to fully include care for the lived experiences of spirituality, faith, and religion at work within persons participating in addiction treatment environments. As Luhrmann claims, it means that we must understand "that when gods and spirits feel real to people, they have become beings that humans can love, argue with, and wrestle against. The deep anthropological puzzle about the human involvement with gods and spirits is how people come to feel intensely that invisible beings matter to their lives—how the invisible world comes close to humans and looks back, alive."[90]

[89] Ibid., 163-164.
[90] Ibid., 184.

This *aliveness* is particularly important due to Luhrmann's claim regarding the faith frame—experienced as a paracosm within and through the imagination—as a determinative reality of personhood and a social and lived experience with gods and spirits. This realness forms meaningful relationship and a social connection, which in turn, can create change and healthy outcomes and well-being.

Transformative Faith Narratives

Another significant resource influencing this project is the research of Erin Dufault-Hunter, *The Transformative Power of Faith: A Narrative Approach to Conversion.* Dufault-Hunter's research was inspired with particular interest in how persons with highly self-destructive and violent backgrounds, including those with serious drug and alcohol addictions, have experienced personal transformation through faith.[91] The explicit evidence of transformation discovered in her interviews led her to study the process of change and offer a critique of the often reductionistic understandings of faith and religion within the sociological and psychological fields.

Dufault-Hunter invites attention to the dominant *narrative* that forms and comprises a person. She sees a growing interest by both religious ethicists and social scientists regarding how narrative - like Luhrmann's paracosms - transforms and defines a person. Although she notes some differences in approach by religious ethicists and social scientists, she recognizes that despite their differences, narrativists in the social sciences and in theology recognize how story "shapes human experience and holds the key for any epistemological strategy seeking to understand and explain it."[92]

[91] Erin Dufault-Hunter, *The Transformative Power of Faith: A Narrative Approach to Conversion* (Lanham, MD: Lexington Books, 2012), xi.

[92] Ibid., 69.

In creating her own narrative framework for understanding conversion, Dufault-Hunter first defines how religionists—those who see theology and associated practices as narrative formative—see the narrative unfolding as a type of alternative story that a person sees through and in return begins to shape and determine the self and the experience of others and the world. Akin to Luhrmann's faith frame, Dufault-Hunter writes,

> Stories build upon a plot, and as narrative theologians and ethicists note, they—specifically religious traditions—provide us with an alternative scheme for our lives. As we participate in its alternative worldview, these stories find coherence and consistency within a new framework. Just as a good novel is not utterly predictable (characters in the story, if it is a well told tale, can still surprise us), our lives within this new world do not follow a strict and predetermined pattern. Converts engage in an act of reflective imagination, by which they 'emplot' their lives according to an alternative narrative.[93]

And particularly, as Dufault-Hunter contends, because these alternative stories are built upon a plot of religion, some social scientists struggle to connect or merge the processes together. Dufault-Hunter clarifies, "Because of discomfort on this point, some social scientists lean heavily on reductionist theories. Unlike the hard sciences that can point to a clear *causal* relationship (though this, too, is under review within the scientific community), life stories weave their intricate plot in ways more like science's chaos theory—in a discernible but complicated pattern."[94] This complex holding and weaving together of life experiences—to include all aspects of the lived experiences, both hard external and the soft inner lived experiences of the faith frame and paracosms-type realities—is what Dufault-Hunter sees as vitally important to grasp within the religionists' approach and contribution to a narrative framework. Furthermore, Dufault-Hunter argues that the personalized or inner lived experiences of an individual can become real to *others* "as we gain in appreciation of the religious agent's actions and participation in the interpretation, editing, and sustaining of the narrative."[95]

[93] Ibid., 71.
[94] Ibid.
[95] Ibid.

Additionally, religion narrativists include and recognize that the transformation not only happens within the influence of the alternative narrative, but also that an effective alternative narrative must be sustained and formed within a social community of alike stories and practices. Dufault-Hunter writes, "In order to achieve this end, we need to participate in a social network that coaches us in rituals that reinforce this new identity. We become apprentices, so that we might, through repetition and habit, become masters of necessary skills or practices."[96] Like the patterned prayers throughout a day of Muslims or the Daily Office of monks, the shared practices taught and engaged within a larger participating community is part of how transformative faith narratives work.

Dufault-Hunter points to such embodied religious experiences and recognizes their connection to *change* is more than an activity within the mind (this is, of course, where narratives primarily live and breathe—just as Luhrmann clarified about the real-making imagination). But additionally, and important within addiction treatment, religious experiences are *also* connected to physiological changes of and within the body. Dufault-Hunter writes,

> Interestingly, this understanding of the interdependence of habit, emotion, and character find support in recent research on the neuroplasticity of the brain. Once thought to be relatively unchangeable after about twelve years of age, the brain displays an ability to repair itself or make new connections. One study considered the brain activity of Tibetan monks, looking at their baseline and at changes that occurred when they engaged in objectless meditation, which cultivate states of being such as "lovingkindness" (Lutz et al. 2004). Researchers discovered the long-term Buddhist practitioners' brains differ - particularly those areas of that deal with cognitive and affective functions. Even new practitioners showed alterations in their resting and in their meditative state after several months. As the researchers put it,
>
> > it is not unexpected that such differences would be detected during a resting baseline, because the goal of meditation practice is to transform the baseline state and to diminish the distinction between formal meditation practice and everyday life… These differences imply…that such alterations may affect task-related changes. (Lutz et al. 2004, 16373)

[96] Ibid., 74-75.

> This religious practice actually alters the physical realm, affects daily actions, and indicates an alteration in character. Strong religion, with its insistence on literal enactment of faith (e.g., the abstract value of 'lovingkindness' must be embodied, integrated through concentrated effort into one's being-in-the-world), instinctively mirrors this holistic, irreducible understanding of human nature.[97]

In summary, using a narrative framework to understand how spirituality and faith are at work as transformative influences within persons through the development of alternative narratives and the social practices is important for developing a new approach regarding the integration of spiritual care within addiction treatment environments. For, the ongoing omitting and ambivalence toward spirituality by the medical model—biasly deeming matters of faith/religion as physiologically unrelated to treatment of a person—is a serious overlooking of the activities and influences of faith within and upon not only the mind, but also the body. For, as Dufault-Hunter identifies within her examination of the religionists' approach and use of narrative, faith and its practices are evidenced to alter the mind and body, and subsequently also directly affecting behavior and the character (identity) of persons.

Permission to Transform

Additionally, while developing her narrative lens of faith conversion, Dufault-Hunter points out that the inherence of narrative within personhood leads scholars and practitioners to lean toward attending to stories as a means of transformation. As Dufault-Hunter states,

> In the social sciences, scholars turned to narrative because they sense its power to inform the pragmatic. Some of the most articulate arguments for utilizing narrative in the social sciences come from Donald Polkinghorne and Mark Freeman, who view it as both a method and a means (Polkinghorne 1988; and Freeman 1993). It is a method for understanding humankind, an assumption about how people make sense of the world. As a means, stories must be attended to as a way of helping people deal with the problems and challenges in their lives. Polkinghorne insists that such an approach merely recognizes what all of us do instinctively. Not only can academicians understand the concept of story; all of us practice storytelling in some form.[98]

[97] Ibid., 75.
[98] Ibid., 78.

Dufault-Hunter is correct in identifying how social science and psychology have recently leaned toward using a narrative approach as both a means and method of change. To this end, there is also an increasing use of narrative theory and research within the addiction treatment literature, including studies on personal identity and its direct impact on drug use,[99] and studies on flexible and transformable identity as a means of recovery.[100] Furthermore, there is also an increasing mention within the literature regarding the innate human ability to self-narrate, and the value of including the narrating resource of the imagination into person-centered addiction treatment approaches.[101]

Alongside the awareness of an innate self-narrating by the imagination and its influence upon addict-identity, there is growing research regarding the impact of "institutional storytelling" that proposes the addict-identity can be "transformed through interactive achievement" within substance-use treatment and recovery environments.[102] Also within the research is the emergence of models of treatment/recovery within the literature built upon transformation of the addict-identity. Some of those developing theories even go as far as directly defining a "biographical reconstruction" process in their approach to addiction/recovery treatment.[103] The *Social Identity Model of Recovery* is a treatment concept built upon the theory that "identity change in recovery is socially negotiated" and can be "transmitted in social networks through a

[99] James McKeganey and Neil McIntosh, "Identity and Recovery from Dependent Drug Use: The Addict's Perspective," *Drugs: Education, Prevention and Policy* 8, no. 1 (January 2001): 47-59.

[100] Silje Louise Dahl, "Remaining a User While Cutting down: The Relationship between Cannabis Use and Identity," *Drugs: Education, Prevention and Policy* 22, no. 3 (May 4, 2015): 175-184.

[101] Kim Etherington, "Understanding Drug Misuse and Changing Identities: A Life Story Approach," *Drugs: Education, Prevention and Policy* 13, no. 3 (January 2006): 233-245.

[102] Ditte Andersen, "Stories of Change in Drug Treatment: A Narrative Analysis of 'Whats' and 'Hows' in Institutional Storytelling," *Sociology of Health & Illness* 37, no. 5 (June 2015): 668-682.

[103] Gerda Reith and Fiona Dobbie, "Lost in the Game: Narratives of Addiction and Identity in Recovery from Problem Gambling," *Addiction Research & Theory* 20, no. 6 (December 2012): 511-521.

process of social influence."[104] The *Positive Identity Model of Change* centers its theory on identity transformation through a "self-verification" process.[105]

Such theories and models of treatment/recovery emphasizing identity conversion and processes of transformation and the power of storytelling and story hearing are important pathways and therapeutic permission for integrating a narrative approach to spiritual care in addiction treatment environments. For, already presently active within addiction treatment—and within the support of evidenced-based models—are explicit efforts to change narrative, to transform character, identity, and behavior. Of course, the discipline of spiritual care must be aware of the ethics of its approach, but the long-held critique and often-referenced dismissive rationale regarding concerns of "faith conversion" must be examined as potential bias rather than informed reason. The faith frame, theological imagination, sacred searching, the metanarrative, and communal identity of religion…these lived experiences are just as—if not more—influential upon and within persons and ought to be recognized and included within the care of persons participating in addiction treatment environments.

It is essential that the narrative lens of faith, religion, and spirituality be considered and included when providing care for persons in addiction treatment. And Dufault-Hunter's narrative framework of transformation allows for an ethical inclusion and recognition of the whole frame of personhood. While writing about narrative therapists who are influenced by the work of narrative theorists like Spence, Polkinghorne, White, and Epston, Dufault-Hunter claims,

> Another important contribution of this movement is its willingness to speak overtly about the morality of the act of re-storying, and it does this in two ways. First, narrative therapy

[104] David Best, et al., "Overcoming Alcohol and Other Drug Addiction as a Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR)," *Addiction Research & Theory* 24, no. 2 (March 3, 2016): 111-123.

[105] Ayna B Johansen, et al., "Practical Support Aids Addiction Recovery: The Positive Identity Model of Change," *BMC Psychiatry* 13, no. 1 (December 2013): 201.

> maintains that new stories must be embodied or performed in order to be transforming. Secondly, narrative therapists believe that this embodiment by the individual becomes a "counterpractice" to the dominant narrative in which the client finds himself or herself—a kind of revolutionary activity. The stories that people 'live through determine their interaction and organization, and…the evolution of lives and relationships occurs through the performance of such stories or narratives' (White and Epston 1990, 12). For these authors, the text analogy defines people not by their pathology or some other underlying structure but by their own choices, and recognizes that this performing (or one might say practicing) is itself constitutive of their self (or in narrative ethics, their character) (White and Epston 1990,12). This acknowledgement that narratives must be embodied to be transformative certainly coincides with the sensibility of narrative ethicists—who would want to emphasize the importance of the story *told* for the person *produced*.[106]

This insight is particularly important to this project's proposal in that directly within the social sciences' approach to narrative ethics there is an inherent recognition of choice, and the practicing of those choices is constitutive of a self. It is within this recognition, that a person, and all that constitutes a person—be it the real-making experiences of the theological imagination, the everyday choices and behaviors, or the metanarrative influences of a faith frame—must be considered and included when caring for a person. Full person-centered care must have a framework of care that includes the whole reality of personhood, and a narrative approach that integrates spirituality, faith, and religion will help addiction treatment see a whole person. And, as this project maintains, it will require intent looking at spirituality and faith in a different light. Rather than viewing matters of faith with ambivalence, reductionism, or dismissiveness, spirituality and faith must be seen as determinative frames of personhood in need of careful attention of their full complexities, conflicts, and potentials.

Yet another valuable assertion by Dufault-Hunter regards the process and practices of narrative transformation used by narrative therapists. Dufault-Hunter writes,

> These therapists' assumption regarding the oppressiveness of metanarratives, however, and their ability to display how this occurs for individuals, can be useful to anyone interested in profound personal transformation. They utilize a technique called 'externalizing the problem,' in which they have a client rearticulate the presenting

[106] Dufault-Hunter, *The Transformative Power of Faith*, 80.

> dilemma in a nonpersonalized way. Such externalization reveals oppressive metanarratives of race, sex, class, or faith tradition while simultaneously restoring agency and emphasizing personal responsibility. On the one hand, the practice affirms the convert's sense that there is something 'out there,' a powerful force such as racial prejudice or systemic poverty that works against them in their psychological well-being. Narrative ethicists can utilize the insights of sociologists and psychologists, who make it their job to interpret and articulate the presence of such forces. Yet sociologists and psychologists need to recognize that seeds of this practice lie within many religious traditions already, encouraging the faithful to name forces in order to resist them.[107]

Interestingly, the therapeutic process of externalizing depends on "a witness" or "witnesses"[108]—and this is exactly what religionists also know—that is, a witnessing community helps emplot the story. It is the same transformative process, just with different emphasis on who serves as the community/witness. Within the therapeutic exercise, it is the narrative therapist who takes on the role of supporting and sustaining the conversion process. Dufault-Hunter notes the therapists she reviewed in her research admitted that they helped people transform their narrative, as unobtrusively as possible, as a means of moving people from an oppressive story to a more liberating story.[109] As Dufault-Hunter clarifies,

> In acknowledging this, they offer narrative ethicists examples of how 'experts' can come alongside people in a nonhierarchical way, encouraging others in their new behavior or practices. Narrative therapists achieve this by asking a number of questions, so that the client herself 'weaves' her own story, while the therapist points out the 'unique outcomes' of this process of deconstruction, followed by reconstruction through embodiment.[110]

This permission to transform and awareness of how an expert can ethically come alongside in a nonhierarchical way is paramount in this project's proposal. For, just as narrative therapists join alongside and within the narrative conversion of persons, so also can spiritual care practitioners come alongside people in nonhierarchical ways and work within the narratives at work within persons participating in addiction treatment. The desire for greater emphasis on

[107] Ibid., 82-83.
[108] Ibid., 81.
[109] Ibid., 84.
[110] Ibid.

spirituality and faith by those entering addiction treatment is exactly that; a desire for transformation either within an oppressive or harmful construct or the desire for community and otherness as they seek to deeply emplot the faith they hold. Additionally, Dufault-Hunter points out that the reflective questions of therapists can be often limited by their own bias, personal reflection, and subjective worldview.[111] To counter this potential bias, Dufault-Hunter adds a uniqueness within the narrative approach that is engaged by spiritual care practitioners. She claims,

> Contrary to what narrative therapists might think, religious narratives encourage and often insist on a dual reflection: How does the story reflect on my life, informing me about how I need to live my life? And how does my personal, individual experience shape the story, how it is to be understood in light of my experience? In this paradigm, 'local knowledge' influences the way a metanarrative is told and embodied, while simultaneously the story is given authority by the individual to dramatically reorder his or her life and activity….[112]

This dual reflection suggested by religious narratives, empowers participatory action and is enacted directly within a person. This inner experience is part and parcel of the relationship developed in the real making with gods and spirits. This "local" knowledge is highly person-centered and grants permission to transform within oneself.

The Language of Transformation

A final insight, yet vitally important to clearly seeing the necessity of a professional discipline of spiritual care for persons in addiction treatment environments, is the particular language involved in both the telling and receiving of a faith narrative. Dufault-Hunter is crucially aware that individuals telling their stories and experiences of life through their faith frame, describing the longings of their sacred search, or processing their theological

[111] Ibid., 81.
[112] Ibid., 84-85.

puzzlements, will always utilize language in ways that most psychologists or therapists are not trained to comprehend.

Leaning into the work of James Day, Dufault-Hunter claims that effective narrative therapy must recognize the power of language within the faith stories we tell and the nuanced meanings that language makes possible.[113] The hearing and speaking of faith language is part of the transformative experience. As Dufault-Hunter writes, "Language then, actually *does* something. We are made by language even as we make it, and this has implications for understanding the person-in-community."[114]

Dufault-Hunter continues, "If religious language acts as Day proposes, then the role of those who specialize in this language—ministers, theologians, and ordinary believers—becomes more important for understanding religious faith. Converts borrow from a vast linguistic reservoir to tell their story—and also change its meaning by such use."[115] And as Dufault-Hunter warns, "This shift from language-as-referential to language-as-performative means that religious terminology cannot be abstracted from its context without serious distortion."[116] Therefore, "Given the nature of language, sociologists must be content that they cannot completely explain or describe religious experience."[117] This results in Dufault-Hunter concluding, "then it is only by developing a holistic approach to conversion that attends to its narrative nature that we can begin to truly understand it."[118]

Dufault-Hunter is correct in pointing to the need to recognize the importance of religious and faith language—steeped with inferred meanings, quotes from sacred literature, parables, and

[113] Ibid., 85.
[114] Ibid.
[115] Ibid., 86.
[116] Ibid.
[117] Ibid., 87.
[118] Ibid.

traditional narratives. The inclusion of such a specific dialect is crucial when listening and reflecting with narrative formed persons participating in addiction treatment. To include the peculiar uniqueness of faith vernacular expressed by persons is to include the person themselves. This inclusion brings the actual and whole self—along with all its social influencing stories—into treatment and has specific consequences for how spirituality and spiritual care are integrated into addiction treatment. For, the historical attempts made thus far to introduce general education, training, and supervision for psychological practitioners cannot provide adequate awareness of the complex and often mysterious theological language needed to truly hear a telling of a faith story. By the very nature and reality of their role, psychologists largely speak and hear a different language than theologians and spiritual care givers. And to take seriously the spiritual and faith dimensions of persons participating in addiction treatment, faith stories must be heard from within the very language and frame they are told.

In summary, Erin Dufault-Hunter points us toward using a narrative lens to understand how persons, including those with serious drug and alcohol addictions, experience personal transformation through faith.[119] Dufault-Hunter's work stands as a witness to the importance of including alternative stories—particularly the alternative theological and religious stories—that determinatively shape both personhood and life experiences.

In this review, Dufault-Hunter has provided three crucial insights for this project's proposal: (1) a narrative approach is both the means and the method of change, (2) the nonhierarchical processes and practices of narrative therapy are ethically transformative, and (3) the complexity and nuanced language used by sacred seekers within the telling of faith/religion narratives requires common linguistic knowledge and experience to hear and receive without imposing a false or reductionist interpretation. These three perspectives help shape this project's

[119] Ibid. xi.

description of how spiritual care practitioners can provide spiritual care for persons—including the full complexities, conflicts, and potentials of spirituality, faith, and religion.

PART TWO

Introduction

Beyond McClure's encouraging of spiritual care toward becoming more "theoretically complex, theologically open, more creative and flexible *in practice*"[120] is also the overarching proposal of William White and David Whiters regarding the needed conversation between spiritual care and addiction treatment. In their eight proposed foundational agreements between

[120] McClure, *Moving Beyond Individualism*, 250.

spiritual care and addiction treatment, they name addiction recovery as a complex process that includes the ontological dimension. They also conclude that addiction treatment must be conducted with respect for and within the cultural and religious perspectives of each client. And William White and David Whiters clearly assert that addiction recovery often requires "the involvement of multiple disciplines and service practitioners."[121] Responding to their assertion that multiple professional disciplines and practitioners are needed, this project argues that a discipline of spiritual care in the form of a qualified spiritual care practitioner is specifically needed within the addiction treatment field. For, those charged with care and respect for the lived-realities and determinative influences upon persons participating within addiction treatment environments have evidenced an ambivalence, lack of expertise, and an effort to dismiss the directly related biopsychosocial realities associated within the spiritual and faith related phenomena.

It seems the trajectory of the proposals of White and Whiters are also being recognized by others. Marc Galanter—who has researched the intersection of spirituality, addiction, and recovery—claims that "the paradigms on which contemporary psychiatry is based do not readily lend themselves to the consideration of spirituality as an empirically validated component of mental function, and this suggests why this construct has been slighted by members of the psychiatric research community."[122] And as a result, Galanter cautions the psychiatric field that because of the presently growing interest, "spiritually grounded approaches may come to be an accepted domain for the rehabilitation of addiction…,"[123] and, although it "will pose a challenge

[121] White and Whiters, "Faith-Based Recovery," 58-62.

[122] Marc Galanter, "Spirituality and Addiction: A Research and Clinical Perspective," *American Journal on Addictions* 15, no. 4 (January 2006): 287.

[123] Ibid., 291.

to the progressive practice of addiction psychiatry…it may be defined by evidence-based techniques."[124]

The recognition of a needed spiritual care role within treatment environments is also revealed within a recent bestselling memoir of Dr. Kalanithi, a neurosurgeon, who was diagnosed with brain cancer. His experience as a patient led him to seeing both treatment and personhood beyond merely a *medical* diagnosis of cancer. As he observed his own treatment experience from the perspective of a patient, and as he interacted with other patients, Dr. Kalanithi recognized the necessity and value of a different kind of treatment role. Andrew Root, in telling Kalanithi's story, writes,

> Kalanithi recognized that the only way to truly heal someone is to create the space for them to share their story, to give your person to them, accompanying them in their journey of sickness that too often leads to death. Kalanithi's job now, as surgeon-patient, was to be a pastor who creates space for the ministry that shares deeply in personhood, inviting the sharing of stories as much as the articulation of diagnoses and procedures.[125]

Dr. Kalanithi's story is a lived example of the growing recognition that health care treatment, in all its various forms, must recognize and include spiritual care. Just as Dr. Kalanithi recognized, and then became for others within his treatment ward, the embodied work of creating space for receiving stories and companioning others in the process of narrative reconstruction is vital within healing care. As Galanter demonstrated to the addiction psychiatry field and Kalanithi discovered within his medical field—White and Whiters are correct in their claim that addiction recovery will also require multiple disciplines and service practitioners.

The following sections will review literature regarding the transformative power and potential of integrating such a therapeutic relationship specifically into addiction treatment environments. First, the issue of power as both a harmful and helpful source will be discussed,

[124] Ibid.

[125] Andrew Root, *The Pastor in a Secular Age: Ministry to People Who No Longer Need a God* (Grand Rapids, MI: Baker Publishing Group, 2019), xvii.

highlighting the importance for spiritual caregivers to recognize the particularity of others. Second, a review of the transformative power at work in and through the therapeutic alliance will be reviewed, recognizing the companioning relationship as a core agent of change. Following, a comparison of the practice of spiritual direction with the essential healing elements revealed within trauma theory literature will highlight the power and characteristics at work within the role of the spiritual care practitioner. The research literature within these reviews will support and inform the transformative proposal offered in Chapter Three regarding the necessary and valuable integration of spiritual care practitioners into addiction treatment environments.

The Potential of Power

One of the common critiques regarding the exclusion of a discipline of spiritual care in addiction treatment environments regards the fear of proselytization[126] and subsequent fear surrounding the potential abuse of power. The abuse of power in any therapeutic treatment environment is of legitimate concern, and particularly important to be aware of with persons who are participating in addiction treatment environments due to the many power dynamics at work in such environments.[127] Power and its potential for both good and for misuse is an unavoidable reality within any therapeutic modality or caregiving relationship. And rather than dismissing a discipline of spiritual care due to the same ethically related concerns inherently at work within all professional disciplines, it must be acknowledged, considered, and ethically approached.

The root of the critique against spirituality, faith, and religion is perpetuated within psychotherapy by the traditional belief that faith frames and sacred searching are merely

[126] Christopher Meissner, "Prayer or Prison: The Unconstitutionality of Mandatory Faith-Based Substance Abuse Treatment," *Cleveland State Law Review* 54 (no. 4): 671.

[127] Louise Wilson, "The Impact of Power Dynamics When Counselling Clients with Problematic Substance Use," *Psychotherapy and Politics International* 19, no. 2 (June 2021): 2, https://onlinelibrary.wiley.com/doi/10.1002/ppi.1572.

pathological hindrances and oppressive stories. The spirit within the psychiatric profession, mentioned by Galanter and others, was seemingly implanted by the influence of Freud who believed religion to be a form of psychopathology. However, not all early psychotherapists agreed. Alfred Adler, Carl Jung, and Viktor Frankl all spoke often about the transcendent nature of personhood as a positive effect.[128] The reduction of the matters of spirituality and faith to *only* oppressive influences are not just misinformed, but grossly negligent in the face of the evidence regarding increased and sustained wellbeing in the lived experience of those engaged in healthy spiritualities. This bias should not continue to lead to the omission of spirituality and spiritual care within addiction treatment. And at the same time, the potential of religious abuse and theological-related psychological trauma that often influence negatively upon substance use and hinder recovery should lead to an urgency for an ethical and caring response. Addiction treatment environments need a professional approach to spiritual care and a clarified understanding of the transformative power of spiritual care.

The ongoing issues surrounding power within therapeutic contexts has been extensively studied, and it is often noted how, historically, power was mistakenly categorized as only a *negative* force.[129] However, the concept of power is now readily recognized as unavoidable and must be openly acknowledged and engaged within therapeutic contexts. In her recently published article, *The Impact of Power Dynamics when Counselling Clients with Problematic Substance Use*, Louise Wilson states that "it is essential for the therapist to be aware of their power and to avoid abuse and to foster a more equalized relationship, requiring collaboration rather than unidirectional authoritarian power."[130] And Wilson continues by claiming that "power itself is

[128] Ellor, Netting, and Thibault, *Understanding Religious and Spiritual Aspects*, 4.
[129] Wilson, "The Impact of Power Dynamics," 3.
[130] Ibid.

not a moral concept; it is the way power is used that has moral implications."[131] This project leans into Wilson's advice and awareness that "the therapist has role (and personal) power in their responses and the client has agency. The therapeutic relationship is dialogical, and power is exerted by both parties in different ways. Furthermore, as each relationship is unique the power dynamic varies accordingly."[132] In other words, the reality of power being at work in any therapeutic work is unavoidable. The issue is not power itself, but rather, how power is engaged and expressed. Wilson concisely summarizes this point by referencing the research of Mearns and Throne who state that in our "desire to not *abuse* our power, we have somehow lost the ability to *exercise* our power."[133]

Power Dynamics and Caregiving

Keith Dow serves as a helpful resource and provides an example of how to navigate the dynamics of power and identify the important motivations and postures for a spiritual care practitioner. Dow carefully illustrates in his book, *Formed Together; Mystery, Narrative, and Virtue in Christian Caregiving*, the needed activity of "pastoral deconstruction."[134] Similar to McClure's appeal to the pastoral care field regarding its lack of theological openness and its reliance on psychoanalysis while seeking to resolve the distresses of an attempted autonomous self, Dow sees the need for caregivers to recognize a deeper complexity of personhood and the need for caregivers to identify and work within a theological anthropology.

Writing with respect for those with intellectual disabilities that he has cared for throughout his lifetime, Dow provides an important critique regarding the motivations and

[131] Ibid.
[132] Ibid., 5.
[133] D. Mearns and B. Thorne, *Person-Centered Approach to Therapeutic Change* (London: Sage Publications, 2000), 217.
[134] Keith Dow, *Formed Together: Mystery, Narrative, and Virtue in Christian Caregiving* (Waco, TX: Baylor University, 2021), 7.

practices of caregiving and points to the need of recognizing that there is more at work in those receiving care than what often initially meets the eye.

Dow first confronts the common hubris in the interactions between the care receiver and the caregiver. Dow identifies that often a caregiver presumes a client can be known in the same way of knowing one's own self.[135] Dow writes, "Then, we presume to know ourselves or be able to 'give an account' of our own lives from an ethical standpoint."[136] And, referencing recent theories of consciousness, Dow identifies that often "our knowledge of others involves more projection than it does *observation*. In other words, our already established predictions of *who* and *what* people are or are not outweigh our openness and ability to listen to and learn from others."[137] Dow is correct to confront the hubris of therapeutic interactions that often assume a person can be properly understood or heard in a momentary encounter or analysis. Likewise, it is a powerful hubris at work in the medical model of addiction treatment that assumes the thick complexities and influences upon addiction and personhood can be fully named in its reductionistic diagnosis. Awareness and alertness to such matters helps avoid imposing this hubris power upon persons, and such alertness must also be included in the practices and ethics of a spiritual care practitioner. A spiritual care practitioner must be able to hold the complexity of personhood and make room for the deep interweaving of faith narratives without projecting upon them their own fears, expectations, or meanings.

In a similar way, Dow secondly points to what he calls "the myth of the transparent God."[138] Dow's point here is concise: to claim a fully knowable God is theological hubris. While surely much more time could be spent in consideration of this point, it suffices to say for the

[135] Ibid., 76.
[136] Ibid.
[137] Ibid., 82.
[138] Ibid., 113.

purpose of this project that Dow clearly recognizes the motivation and posture of a spiritual care practitioner must allow room for mystery and engage a theological openness that does not lead to the power dynamic of projection or assumption of right or wrong knowledge.

Dow concludes with his proposed five virtues for caregiving. For Dow, the specific ethic of Christian caregivers must be rooted in the commitment and practice of these five virtues: courageous humility, loving mercy, confession and forgiveness, lament and mourning, and quiet attentiveness. And, as Dow clarifies, "these virtues are not intended to replace competencies as dedicated by professional caregiving environments."[139] Dow summarizes those five virtues as an act of *compassionate presence*.[140] And as Dow says, they serve "for the moments when we believe that we cannot *do* much of anything. People are not problems that can be solved, and so the virtues that we need are for moments of misunderstanding, of revelation, of grief, of joy—moments when the overflowing of the being of another overwhelms us—when we can no longer fit our neighbor into a neat mental compartment."[141]

While much of Dow's unique and important work is not universally applicable within this proposal, it is, however, a valuable resource for those seeking to identify a theologically informed approach to caregiving with the Christian tradition. This section is not intended as an appeal for developing a universal theology of caregiving but seeks to clarify that the conversation surrounding power dynamics in spiritual care and caregiving with persons in addiction treatment environments must articulate its own theological and anthropological motivations. This allows the spiritual care practitioner to see more clearly and allows care receivers to be seen more fully. For, as Dow summarizes, "when we respond to the transcendent

[139] Ibid., 165.
[140] Ibid.
[141] Ibid.

call to care, we respond to particular *others*."[142] Intently seeing the unique particularity and complexity of the other without the encumbered burden of projected and limited knowingness is vital to sharing and navigating power. As Dow states,

> It is our sense of givenness and limitation that helps us to remain objective to ourselves and subjective to others, humbly willing to question our own accounts and to be open to the stories of others. This same posture recognizes that we will not be able to respond to everyone equally. When we answer the call to serve another, we are turning down the call to serve *another* other, or *every other* other. Whereas pride seeks to meet the needs of everyone on its own, humility accepts the limits of embodiment. The experience of human limitation makes the gifts we give that much more significant. The call to love others brings us to the realization that everyone is equally worthy of love, yet we will never be able to love everyone equally or unconditionally. In giving to others, we also recognize that there are *other others* giving as well, and that we are not alone in meeting the needs of the world.[143]

Dow's example of a humble holding of power is revealed in his compassionate approach. And his awareness of the other others also participating in the care of persons is important. For, it is that kind of awareness, posture, and practice for which this project is advocating. Just as William White and David Whiters identified, addiction recovery often requires "the involvement of multiple disciplines and service practitioners."[144] And this project claims that a discipline of spiritual care in the form of a qualified spiritual care practitioner is specifically needed and urgent within the addiction treatment field as a means of *other* care.

The Therapeutic Relationship

With an eye on Wilson's perspective regarding the needed attentiveness to the potentials of transformative power at work within therapeutic relationships and Dow's respect for the realities of the other others, a further look at the literature surrounding the characteristics of the therapeutic relationship is needed.

[142] Ibid., 173.
[143] Ibid., 141-142.
[144] White and Whiters, "Faith-Based Recovery," 58-62.

Donald Meichenbaum, in his chapter in *Trauma and the Therapeutic Relationship*, clarifies that "the therapeutic alliance has come to be defined as the extent to which the patient and the psychotherapist jointly agree on the goals of treatment and the means or task by which to achieve those goals ('pathways thinking') and the quality of the affective bond that develops between them."[145] Meichenbaum also observes that trust is an essential characteristic within a therapeutic relationship[146] and that "the patient must feel secure and confident that the therapist is genuine, empathetic and warm, and, moreover, that the therapist can cope with bearing witness to the patient's reported trauma and understanding its significance."[147] Within Meichenbaum's research he discovered the therapeutic relationship is commonly named "the primary vehicle, prerequisite, process,"[148] and "glue" for transformative trauma treatment.[149] Meichenbaum also claims the therapeutic relationship as central to behavioral change for clients, and highlights evidence that the therapeutic relationship accounts for approximately one-third of treatment outcomes. Meichenbaum calls the therapeutic alliance the "cornerstone" and declares the core task of therapy is to "build a relationship together that will become the agent of change."[150]

With similar language to Luhrmann and Dufault-Hunter, Meichenbaum stresses the importance of storytelling and story forming within trauma therapy. Meichenbaum says that "one central goal of trauma therapy, no matter what form it may take, is to help patients develop and live a 'healing story.'"[151] Meichenbaum also claims that patients "need to develop 'redemptive'

[145] David Murphy and Stephen Joseph, eds., *Trauma and the Therapeutic Relationship: Approaches to Process and Practice* (Basingstoke, Hampshire: Palgrave Macmillan, 2013), 16.
[146] Ibid.
[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Ibid., 14.
[151] Ibid., 18.

stories that bolster hope, strengthen self-confidence and indicate that their efforts will bear fruit. Changes in story telling provide access to new solutions."[152]

Meichenbaum's description of the power and potential of the therapeutic relationship supports the transformative proposal of this project regarding the role of a spiritual care practitioner as a transformative treatment within addiction treatment environments. For, as this project claims, the transformative power of the spiritual care practitioner relationship serves as a therapeutic relationship for those in addiction treatment environments. This relationship must also establish trust and hear stories in ways a client senses they are being heard and understood. This relationship is also grounded in compassion and warmth and working alongside the client as a companion in a narrative building process is part of the practice of a spiritual care practitioner.

Richard G. Tedeschi and Lawrence G. Calhoun similarly suggest an "companion" model as the best approach to facilitate posttraumatic growth.[153] They write, "…we emphasize companionship rather than expertise, even though we are trying to describe a way for clinicians to be more expert in their attempts to help trauma survivors."[154] They suggest the companion relationship is centered in listening and also insist that "although the emphasis at the start is learning about the survivor's experience, it becomes even more crucial to understand what the trauma has done to the survivor's core beliefs or assumptive world."[155] They also recognize that the "expert companion needs to be comfortable working within the framework of the clients' beliefs, and it is not unusual, at least in some cultural and geographical contexts, for these beliefs to include religious elements…."[156] For Tedeschi and Calhoun "being a companion means staying close to the client's belief system, and respecting it. Being an expert means understanding

[152] Ibid.
[153] Ibid., 96-97.
[154] Ibid.
[155] Ibid., 98.
[156] Ibid., 107.

how the beliefs work, seeing where people are inconsistent, where they may be violating their own assumptions, or where these beliefs do not support relief from the distress of trauma and they need revision."[157]

In addition, Tedeschi and Calhoun conclude that within their model's perspective, "the clinician is a companion on what can be a long journey. The clinician is also a person who has expertise that should be used, when appropriate, to help the person manage psychological distress and symptoms, and perhaps also to become a different and better person in the process of struggling to survive."[158]

Tedeschi and Calhoun's recognition regarding the power of an expert companion and how the expertise of the companion ought to be used, as appropriate, to help the client in both narrative and personal transformation aligns with the work of spiritual care. Their description of the therapeutic relationship in such ways and its explicit awareness of the transformative power of companionship directly affirms this project's transformative proposal regarding a spiritual care practitioner role within addiction treatment environments.

The Trauma Lens

To fully explore the characteristics and potential of the therapeutic relationship, a closer look at some of the primary and influential literature within the field of trauma therapy is necessary. Trauma and its interweaved realities in addiction and substance use are readily recognized as inextricably linked together[159] in the research literature. Trauma-informed care is widely assumed as vital in the addiction treatment process.[160] To speak of the realities of

[157] Ibid.

[158] Ibid., 108.

[159] "Traumatic Stress and Substance Abuse Problems," *International Society for Traumatic Stress*, Accessed October 31, 2021. https://istss.org/ISTSS_Main/media/Documents/ISTSS_TraumaStressand SubstanceAbuseProb_English_FNL.pdf.

[160] Bruce Carruth, "Psychological Trauma and Addiction Treatment," *Journal of Chemical Dependency Treatment* 8, no. 2 (September 1, 2006): 1-14.

addiction is to speak of the realities of trauma. The treatment and care responses to trauma are important to this proposal, as it informs the practices and posture of a spiritual care practitioner.

The following section is an intent look at the influential works in trauma therapy of Bessel Van Der Kolk, Judith Herman, and Ronnie Janoff-Bulman. While each arrives at the core cause of psychological trauma in a different way, the following section will summarize common healing approaches recognized by each of the aforementioned primary sources.

Near its inception, psychotherapy leaned into the discovery of the "talking cure."[161] Yet, as the field of psychotherapy developed, the early evidence demonstrated that a person stuck in a trauma state (then commonly referred to as hysteria) could be healed through a therapeutic exchange of speaking and hearing of the traumatic event(s). Herman claims that by the mid 1890's it was known that "hysterical symptoms could be alleviated when the traumatic memories, as well as the intense feelings that accompanied them, were recovered and put into words." [162]

Psychotherapy continued to rely on this basic practice of a "talking cure" and further refined the practice with therapeutic techniques of analysis and abreaction such as Cognitive Based Therapy or Dialectical Behavior Therapy, all built upon the basic premise of the "talking cure."[163] Trauma therapy still utilizes this basic psychotherapy practice yet recognizes the complexity of the trauma imprint into the emotions, body, and mind of a trauma survivor and concludes that additional practices must be included in therapeutic care for a trauma survivor. Within this section's three primary trauma therapy resources, the suggested therapeutic practices

[161] Christopher Marx, Cord Benecke, and Antje Gumz, "Talking Cure Models: A Framework of Analysis," *Frontiers in Psychology* 8 (September 13, 2017): 1589.

[162] Judith Herman, *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror* (New York, NY: BasicBooks, 2015), 12.

[163] Marx, Benecke, and Gumz, "Talking Cure Models," 1589.

of trauma treatment can be summarized as: a compassionately present relationship, a calm and safe environment, and a (re-)connection to healthy others.

Ronnie Janoff-Bulman maintains there is more at work in the "talking cure" than just an exchange of words. She insists that the therapeutic relationship must be a "caring other" and a "sort of teacher." There is a compassionate relationality at work in Janoff-Bulman's approach that goes beyond a therapeutic event of listening and hearing. Janoff-Bulman states,

> The therapeutic effects of good clinical interventions for survivors derive from two types of learning and processing that occurs simultaneously in therapy. In the first, the therapist serves as a caring other who provides the client with the experience of acceptance and caring in the face of open acknowledgement of the survivor's experience. In the other, the therapist functions as a sort of teacher who provides the client with ways of minimizing the trauma's affective overload and maximizing the reworking and reappraisal of the experience.[164]

Janoff-Bulman also distinguishes the importance of the "caring other" to act as "a container for the survivor's painful, overwhelming affects"[165] and acknowledges the therapist's compassionate posture reflects "a more positive, benevolent world" for the trauma survivor. Janoff-Bulman further raises the importance of the healing companionship beyond that of just a therapeutic listener or a mirror by stating:

> Perhaps more important, it provides the survivor with the actual experience of being valued, of being understood and cared for in the aftermath of the traumatic event. The Kohutian notion of 'positive mirroring' is a useful metaphor to describe the value of the therapist's empathy, respect, and responsiveness; through a mirroring process, clients learn directly about themselves. Interestingly, the therapist's smoothing, empathetic stance serves as a mirror not only reflecting the self but also reflecting, from the other side of the mirror, a more positive, benevolent world than the one powerfully experienced through victimization.[166]

Notably, as Janoff-Bulman asserts, the needed therapeutic role goes beyond a "talking cure" and into a modeling for the client a healthy and whole self. She insists a trauma victim

[164] Ronnie Janoff-Bulman, *Shattered Assumptions: Towards a New Psychology of Trauma* (New York, NY: Maxwell Macmillan International, 1992), 161.

[165] Ibid., 162.

[166] Ibid.

needs something more than therapeutic processing, but rather a reimagining of their human-interactions by experiencing what it means to interact with a compassionate (benevolent) person.

Janoff-Bulman also recognizes the role of community ("caring *others*") and the "safe, protected environment" in the healing treatment of victims of psychological trauma. She states,

> The support of close, caring others is also of crucial significance during the survivor's recovery. It provides direct evidence that the world is not necessarily malevolent and meaningless, and that the survivor is worthy of support. Other people can acknowledge and validate the enormity of the victim's coping task. They can also provide a safe, protected environment within which to openly explore the traumatic experience. Talking, discussing, venting, and sharing trauma-related thoughts and feelings provide rich opportunities for survivors to approach, reappraise, and work through their experience.[167]

Janoff-Bulman's naming of the "caring other," a "safe environment," and the role of "caring others" directly aligns with the literature of Bessel Van Der Kolk and Judith Herman.

Judith Herman, widely known as a pioneer within trauma research, also explores the same three approaches for the care for psychological trauma. Herman says succinctly that "recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life."[168] Her first and third stage clearly fit into the summarized elements defined within this section, and her second stage of "remembering and mourning" imply the presence of a "witness" or a compassionate "hearing" relationship.

Throughout her writing, Herman points to the power of this therapeutic relationship and additional new relational connections with others for the trauma survivor as the primary focus of the therapeutic experience. Herman says,

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people,

[167] Ibid., 173.
[168] Herman, *Trauma and Recovery*, 156.

> the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, identity, and intimacy. Just as these capacities are originally formed in relationships with other people, they must be reformed in such relationships.[169]

Also present within the compassionately present relationship must be the capacity to identify harmful constructions within the trauma story and a provision of careful guidance toward helpful reconstruction. For Herman, "it is understandable for both patient and therapist to wish for a magic transformation, a purging of the evil of the trauma. Psychotherapy, however, does not get rid of the trauma. The goal of recounting the trauma story is integration, not exorcism."[170] Yet, Herman claims that "in the process of reconstruction, the trauma story does undergo a transformation, but only in the sense of becoming more present and more real. The fundamental premise of the psychotherapeutic work is a belief in the restorative power of truth-telling.[171] A primary task of the compassionately present relationship is to act as a witness and holder of pained truth.

Herman also details how trauma disempowers a person, leaving them without a sense of safety. This lack of safety is why the establishment of empowerment in a safe environment is a primary task for therapeutic work. More strongly than Bulman or Van Der Kolk, Herman warns that "no therapeutic work should even be attempted until a reasonable degree of safety has been achieved."[172] Herman states,

> Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirements of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitant engagement in

[169] Ibid., 133.
[170] Ibid., 181.
[171] Ibid.
[172] Ibid., 160-61.

> exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.[173]

Herman's awareness of the role of safety is important, for the safe environment will often require a witness or listener who can hear the unique nuances of the languages of faith and religion. For, to share with someone who cannot see or comprehend the deep meanings or personal realities does not create safety.

Bessel Van Der Kolk also identifies the three summarized practices in his research. Van Der Kolk reveals the compassionately present relationship by notably not consistently using the label "therapist" when he speaks of the role of the needed therapeutic relationship. Rather he focuses specifically on the intrinsic motivations and postures of the relationship. In a single paragraph he uses "someone," "accompany," "guide," "safeguard," "anchor," and "coaching" to define the compassionately present relationship:

> You have to find someone you can trust enough to accompany you, someone who can safely hold your feelings and help you listen to the painful messages from your emotional brain. You need a guide who is not afraid of your terror and who can contain your darkest rage, someone who can safeguard the wholeness of you while you explore the fragmented experiences that you had to keep secret from yourself for so long. Most traumatized individuals need an anchor and a great deal of coaching to do this work.[174]

While Van Der Kolk's trauma research is significantly influenced by the recent advances of neuroscience, he also continues to recognize the complexity of healing responses for a traumatized person requires more than biological treatment. Van Der Kolk advocates for a combination of three approaches to help trauma survivors heal. His "top down" avenue is represented in the summarized practices of a compassionately present relationship and a (re-) connection to healthy others. And his "bottom up" avenue aligns with embodied experiencing the third practice of safe environments. Van Der Kolk states that

[173] Ibid., 172.

[174] Bessel Van der Kolk, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* (New York, NY: Penguin Books, 2015), 213.

> There are fundamentally three avenues: 1) top down, by talking, (re-) connecting with others, and allowing ourselves to know and understand what is going on with us, while processing the memories of trauma; 2) by taking medicines that shut down inappropriate alarm reactions, or by utilizing other technologies that change the way the brain organizes information, and 3) bottom up: by allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, or collapse that result from trauma. Which one of these is best for a particular survivor is an empirical question. Most people I have worked with require a combination.[175]

When Van Ver Kolk describes those top-down and bottom-up approaches in his research, he readily acknowledges that the modern era is creating opportunities for the development of new healing treatments. He affirms that the "vast increase in our knowledge about the basic processes that underlie trauma has also opened up new possibilities to palliate or even reverse the damage. We can now develop methods and experiences that utilize the brain's own natural neuroplasticity to help survivors feel fully alive in the present and move on with their lives."[176]

In addition, Van Der Kolk provides an important awareness that person-centered evidence (the "empirical question") must lead the healing pathway for trauma survivors. Van Der Kolk claims that the empirical evidence that therapeutic relationships and healthy connection in community *are* healing mechanisms by adding, "Study after study shows that having a good support network constitutes the single most powerful protection against becoming traumatized."[177] He continues to expand the possible evidenced therapeutic treatments by adding:

> Traumatized human beings recover in the context of relationships with families, loved ones, AA meetings, veteran organizations, religious communities, or professional therapists. The role of those relationships is to provide physical and emotional safety, including safety from feeling shamed, admonished, or judged, to bolster the courage to tolerate, face and process the reality of what has happened.[178]

[175] Ibid., 3.
[176] Ibid.
[177] Ibid., 212.
[178] Ibid.

This literature review has summarized the research of Bessel Van Der Kolk, Judith Herman, and Ronnie Janoff-Bulman regarding how psychological trauma is best responded to and therapeutically treated. As evidenced above, the suggested therapeutic practices of trauma therapy within these sources can be summarized as: *A compassionately present relationship, a calm and safe environment, and a (re-) connection to healthy others*. These trauma-informed components are distinctly vital with this project's proposed mode of practice for spiritual care practitioners in addiction treatment environments for they are widely recognized as evidence-based practices of treatment in both trauma care and addiction treatment.

Summary of Intently Looking

In summary, this chapter has intently looked at research literature from a variety of fields of study including contributions from philosophical and theological anthropology, psychotherapy, trauma therapy, and contextual theology. This deeper look at how spirituality, faith, and religion are at work within persons is in response to Barbara McClure's analysis and prodding of the spiritual/pastoral field to become more "theoretically complex, theologically open, more creative and flexible *in practice.*"[179]

First, this chapter identified perspectives and insight from Kenneth Pargament whose work is important to address the omission of spirituality and spiritual care within the addiction treatment field. His call for change and his reframing of a spiritually integrated psychotherapy provides new approach, language, and perspectives for the presence of spirituality and attention to spiritual care within the addiction treatment field. Pargament succinctly defines spirituality as "a search for the sacred."[180] A definition he unfolds in two ways: a description of the sacred domain, and an exploration of what it means to search.

[179] McClure, *Moving Beyond Individualism*, 250.
[180] Pargament, *Spiritually Integrated Psychotherapy*, 32.

Pargament's framing of the sacred domain as inclusive of the concepts of God, the divine, transcendent reality, the self, relationships, place and time, and even suffering is particularly important in identifying how spirituality is at work within persons in addiction treatment. Recognizing such a sacred domain exists, either in real reality or in phenomenologically experienced reality, and that such a domain exists as a determinative influence upon and within persons is vital.

Important in Pargament's contribution is how the process of the search for the sacred unfolds and his emphasis on the spiritual process and methods as a means of change. Identifying spirituality as a process of change is of paramount importance in the advocation for spiritual care within addiction treatment environments.

Second, this chapter looked at the landmark work of Tonya Luhrmann. Luhrmann provides an anthropological evaluation of how gods and spirits become real to and with persons. Luhrmann also helps clarify phenomenologically how the theological imagination is a determinative dimension within and upon a person and recognizes the faith frame as a determinative experience of personhood.

Luhrmann is an important resource and provides critical new language and perspective regarding the understanding of what comprises a person. For, the shift of attention from the traditional approach regarding the why and what of spirituality, faith, and religion to the how is crucial in moving the attention of the addiction treatment field to the include the lived experience of spirituality, faith, and religion at work within personhood and persons participating in addiction treatment environments.

This chapter also noted that the detailed stories within the faith frame and Luhrmann's paracosms are primarily and particularly theological in nature. And within the broad theological

stories of gods, spirits—as also Richard Kearney identifies—are also stories and vivid paracosms of strangers and monsters. These too are determinative because they become real as a lived experience within persons. Therefore, as more than a cognitive set of personal beliefs, theology and the theological imagination is a lived and determinative reality within personhood. This perspective is also particularly important to this project due to Luhrmann's claim that within the faith frame—experienced as a paracosm within and through the imagination—lives a determinative reality of personhood and a lived experience of alive and meaningful relationship with gods and spirits. This realness forms a relationship and a social connection, which in turn, can form identity and behavior change, healthy outcomes, and well-being. It is equally true that theology shaped relationships with gods and spiritus can form unhealthy and harmful experiences. In simple words: theology matters.

Next, this chapter reviewed the research of Erin Dufault-Hunter regarding the importance of a narrative approach to transformation. Three crucial takeaways were discovered: (1) a narrative approach is both the means and the method of change, (2) the nonhierarchical processes and practices of narrative therapy are ethically transformative, and (3) the complexity and nuanced language used by sacred seekers within the telling of faith/religion narratives requires common linguistic knowledge and experience to hear and receive without imposing a false or reductionist interpretation. It was Dufault-Hunter that pointed and transitioned this chapter toward a recognition of the permission to transform the determinative narratives.

Part Two of this chapter provided an intent look across the literature regarding the power and transformative potential of therapeutic relationships. Leaning into the advice and words of Mearns and Throne who state that in our "desire to not *abuse* our power, we have somehow lost the ability to *exercise* our power,"[181] Part Two examined how power dynamics must be

[181] Mearns and Thorne, *Person-Centered Approach to Therapeutic Change*, 217.

acknowledged and shared within the therapeutic relationship. Several voices contributed to the insights, including Keith Dow's unique work, who recognized the compassionate presence required for caregivers to remain objective to themselves and subjective to others. Meichenbaum, Tedeschi, Calhoun and others also helped define how the therapeutic relationship and expert companion role are distinctly vital for transforming care.

And last, an intent look at the common elements of care discovered across three prominent trauma theorists helped form an awareness of the necessary therapeutic practices of trauma informed care. The discovered practices of a compassionately present relationship, a calm and safe environment, and a (re-) connection to healthy others are distinctly vital with this project's proposed mode of practice for spiritual care practitioners in addiction treatment environments.

Next, this project begins to define and examine a discipline of spiritual care in addiction treatment environments by providing a practical framework for the role of a spiritual care practitioner including: the necessary professional skills, education, certifications, job description language, standards of care, and an overview regarding how the art of spiritual direction is distinctly formative as a mode of spiritual care in addiction treatment environments.

CHAPTER THREE: IMAGINING OTHER CARE

Introduction

Having identified that the large majority of persons participating in addiction treatment desire spiritually-focused treatment, and having demonstrated sacred searching and the faith frame as determinative experiences of personhood, and having recognized that a person-centered

approach in addiction treatment necessitates the inclusion of a client's spirituality and care for the dimension of the theological imagination, this chapter now focuses on how a spiritual care practitioner provides spiritual care and treatment and how the addiction treatment field can begin to integrate spiritual care practitioners in treatment environments.

The omission of a professional discipline of spiritual care in the addiction treatment field is seemingly not due to the field being solely unhospitable with the profession of spiritual care. However, it is due to an ongoing ambivalence toward spirituality within the medical model and a lack of awareness regarding how to imagine and integrate a discipline of spiritual care beyond its historically reductionistic view. A new approach is necessary. Rather than the tried-and-failing additional education of medical practitioners to include spirituality within their scope and practice, or a reliance on spiritual-themed elements in treatment programs, this project advocates for the integration of a professional spiritual care practitioner that is responsible for providing effective spiritual care and spiritually focused treatment.

This new approach certainly involves a handful of challenges, yet it is motivated by the primary goal of shifting attention beyond diagnosis or judgment and to the consideration and inclusion of the complex otherness of every person participating in addiction treatment. Like Keith Dow asserts about the central motivation in caregiving, the primary task of integrated spiritual care practitioners is to attend to the particular other.[182] This distinct commitment of recognizing and caring for each individual other is the core motivation and ethic of a spiritual care practitioner.

So, how can spiritual care be imagined and formed in a way that provides clarity to the concerns, addresses the ambivalence, reveals the biases, and finally includes care and treatment

[182] Keith Dow, *Formed Together: Mystery, Narrative, and Virtue in Christian Caregiving* (Waco, TX: Baylor University, 2021), 175.

for the whole person participating in addiction treatment environments? The following three parts unfold a proposal for defining the role of an integrated spiritual care practitioner who provides spiritual care and treatment in addiction treatment environments.

Part One will review the growing field of spiritual direction, also commonly called spiritual *companionship*. Alongside a brief historical overview of this interspiritual modality, the alikeness of spiritual direction with the transformative therapeutic relationship reviewed in Chapter Two will be examined. As a transformative therapeutic relationship, spiritual companionship also aligns with the necessary "caring other" and the "compassionately present relationship" revealed in trauma research. This project claims spiritual direction is a transformative therapeutic modality that can be provided by spiritual care practitioners in addiction treatment environments.

Part Two will provide an overview of the important contributions of professional chaplaincy as a means of providing a professional framework for spiritual care practitioners. The professional discipline of healthcare chaplaincy holds unique value as a model of an already fully integrated discipline of spiritual care within a broader interdisciplinary framework. A combination of the efficacy, ethics, and outcome awareness of professional chaplaincy and the therapeutic companionship practices of spiritual direction makes the role of a spiritual care practitioner within the addiction treatment field a transformative discipline of treatment.

Part Three is written as a conversation starter for administrators and addiction treatment providers and provides a simple definition of the Spiritual Care Practitioner role that could be used within a job description, along with additional resources for the development of standards of practice, code of ethics, and standard qualification and competencies. These practical resources are intended to impel addiction treatment providers toward action regarding the

integration of spiritual care practitioners within their respective addiction treatment environments.

PART ONE

Spiritual Direction as a Therapeutic Relationship

Recalling Meichenbaum's research that was overviewed in Chapter Two regarding the therapeutic relationship and his assertion that the primary task of therapy is to "build a relationship together that will become the agent of change,"[183] and recalling Tedeschi and Calhoun's suggestion that an "expert companion"[184] approach to treatment best facilitates growth

[183] David Murphy and Stephen Joseph, eds., *Trauma and the Therapeutic Relationship: Approaches to Process and Practice* (Basingstoke, Hampshire: Palgrave Macmillan, 2013), 14.

[184] Ibid., 96-98.

and change while maintaining and respecting the agency of the other, and recalling Wilson's advice that the "therapeutic relationship is dialogical and power is exerted by both parties in different ways,"[185] this chapter proposes the modality of spiritual direction/companionship as a relational and dialogical pathway of change for persons in addiction treatment environments and a transformative mode of treatment provided by spiritual care practitioners.

Spiritual direction is a long-standing mode of spiritual care with historical roots in many of the faith traditions. In the Christian tradition, spiritual direction is notably present as early as the 3rd century when spiritual seekers traveled to the cloistered communities of the Desert Mothers and Fathers to seek out spiritual and trusted relationships known for their healing and wisdom. Many modern-day monastic communities, formed out of the tradition of the Desert communities, still provide spiritual direction as a service for spiritual seekers and education, training, and often even certification for spiritual directors.

By the 5th century, in the Celtic Christian tradition, the role of a spiritual director was an identifiable social construct and known by the Gaelic term, *anam cara* (soul friend).[186] John O'Donohue describes the healing work within the *anam cara* relationship:

> The Celtic tradition recognized that an *anam-cara* friendship was graced with affection. Friendship awakens affection. The heart learns a new art of feeling. Such friendship is neither cerebral nor abstract. In Celtic tradition, the *anam cara* was not merely a metaphor or ideal. It was a soul-bond that existed as a recognized and admired social construct. It altered the meaning of identity and perception. When your affection is kindled, the world of your intellect takes on a new tenderness and compassion. The *anam cara* brings epistemological integration and healing.[187]

Many of the faith traditions have similarly recognized spiritual direction roles within their respective traditions. Like an *anam cara*, the Buddhist name for the spiritual companion role is

[185] Wilson, "The Impact of Power Dynamics," 5.

[186] John O'Donohue, *Anam Ċara: A Book of Celtic Wisdom* (New York, NY: Harper Perennial, 2004), 16.

[187] Ibid.

kalyana-mitra – meaning, a noble friend.[188] Similarly, a *hashpa'ah* is the name of the relationship between a Jewish directee and director, and *mashpia* is the title for a Jewish spiritual director.[189] *Murshid* is the title of a Spiritual Director within the Sufi tradition.[190] Other traditions use titles such as spiritual companion, elder, guide, teacher, master, mentor sponsor, friend, or guru.[191]

Though rooted and formed within a diverse landscape of faith traditions, spiritual direction has uniquely maintained its efficacy and unique form as a transformative modality of care through an ongoing commitment to the directee as the primary focus of the relationship.

This unique other-centered form of spiritual care and transformation has captured the attention of many spiritual care practitioners in the present day, as it is a mode of spiritual care and formation unencumbered by the power dynamics identified in some ecclesial centered forms. The interest in the art and practices of spiritual direction, from both practitioners and spiritual seekers, is presently expanding due to its efficacy to a person-centered and transformation empowering approach.

Spiritual Directors International (SDI) is an online community (SDIcompanions.org) and rapidly growing organization that is widely recognized as the current leading voice of collaboration and resources for spiritual directors across the spiritual traditions.[192] SDI defines a *Portrait of a Spiritual Director* as:

[188] Ibid., 25.

[189] "Hashpa'ah: Training Programs for Jewish Spiritual Directors," *Aleph Ordination Program*, Accessed October 25, 2021, https://aleph.org/aop/hashpaah-training-program-for-jewish-spiritual-directors/.

[190] "Murshid," *Lexico*, Accessed October 26, 2021, https://www.lexico.com/en/definition/murshid.

[191] "Portrait of a Spiritual Director," *Presence: An International Journal of Spiritual Direction* 24, no. 4 (December 2018): 40-41.

[192] "SDI: The Home of Spiritual Direction and Spiritual Companionship," Accessed October 25, 2021, https://www.sdicompanions.org/.

> Spiritual directors or companions support the unique spiritual journey of every individual. They are welcoming and present with those they companion, listening and responding without being judgmental. They are contemplative and honor silence as a spiritual practice. They are intuitive spiritual friends—accountable and compassionate, hospitable and open, loving yet independent.[193]

Like many written definitions of a spiritual director, SDI's definition centers not merely on the tasks of the director but on the core characteristics and motivations of the spiritual direction relationship. This tendency within the field leads to varied wordage in the definition of a spiritual director, yet the universally agreed upon principles within the practice of spiritual direction are notably reflected within SDI's definition: spiritual directors provide a spiritual direction relationship that is "welcoming and present," "listening and responding without judgement," "compassionate," "loving yet independent."

Similarly, Dyckman and Carroll state in their description of the spiritual direction relationship that "what happens in spiritual direction depends on the relationship between two individuals. There is no specific undeviating blueprint. It touches deeply at the heart of what human relationships are and what it means to help another."[194] Likewise note how Christensen and Laird define Henri Nouwen's understanding of spiritual direction as "a relationship initiated by a spiritual seeker who finds a mature person of faith willing to pray and respond with wisdom and understanding to his or her questions about how to live spiritually in a world of ambiguity and distraction."[195] And as Janna Larson states, "spiritual direction is essentially companioning someone in his or her spiritual life. Other ways of describing spiritual direction include holy listening, spiritual friendship, sacred journeying."[196]

[193] "Portrait of a Spiritual Director," 40.

[194] Katherine Dyckman and L. Patrick Carroll, *Inviting the Mystic, Supporting the Prophet: An Introduction to Spiritual Direction* (New York, NY: Paulist Press, 1981), 22.

[195] Henri Nouwen, Michael Christensen, and Rebecca Laird, *Spiritual Direction: Wisdom for the Long Walk of Faith*, 1st ed. (San Francisco, CA: Harper San Francisco, 2006), vii.

[196] Anne Solomon, "Describing Spiritual Direction," *Spiritual-Life*, Last modified March 20, 2015, Accessed October 25, 2021, https://www.spiritual-life.co.uk/single-post/2017/04/18/describing-

Barry and Connolly's definition of spiritual direction is one of the most referenced definitions of spiritual direction within the literature on the subject. Barry and Connolly state that they

> define Christian spiritual direction, then, as help given by one believer to another that enables the latter to pay attention to God's personal communication to him or her, to respond to this personally communicating God, to grow an intimacy with this God, and to live out the consequences of the relationship. The *focus* of this type of spiritual direction is on experience, not ideas, and specifically on the religious dimension of experience, i.e., that dimension of any experience that evokes the presence of the mysterious Other whom we call God.[197]

While Barry and Connolly's book is written specifically to spiritual directors within the Christian tradition, their identification of the relationality of spiritual direction that extends beyond the director-directee relationship and includes the experience of a sacred relationship is shared across the spiritual direction approaches. While Barry and Connolly name "the mysterious Other" who they call God, SDI's description of a spiritual director states that

> spiritual directors may name the deepest of truths in diverse ways. They also honor the names that others revere. Here are some of those terms of reverence: Universe, God, Lord, Allah, YHWH, Great Spirit, Higher Power, Mystery, Sunyata, Brahman, Tao, Divine, Sacred, Holy, Almighty, Ultimate, the Beyond, Intimate, Abba, Nirvana, Wisdom, Source, Vishnu, Creator, Enlightenment, Interconnection, Holy One, All.[198]

The competency to approach and provide spiritual care in response to the particular spiritual experiences and the faith frames of persons is part of the uniqueness of the modality of spiritual direction and its value to spiritual care practitioners in addiction treatment environments. Spiritual direction is a form or mode of care that remains consistent regardless of the faith frame of the directee. Spiritual direction stands with readiness, inclusiveness, and an ethical commitment to focus particularly within and upon the phenomenological experience of

spiritual-direction.

[197] William Barry and William Connolly, *The Practice of Spiritual Direction*, rev. ed. (New York, NY: HarperOne, 2009), 8-9.

[198] "Portrait of a Spiritual Director," 40.

the directee. Even the seeking of spiritual direction is initiated by the directee. This is a mode of spiritual care that translates well into addiction treatment environments as it answers the call of those in treatment who readily state their desire for spiritually focused treatment yet often find the matters of spirituality and faith neglected due to the reductionisms, ambivalence, and biases that have already pointed out within this project. Instead, the formation of a "loving yet independent" therapeutic relationship with a spiritual director responds to both the desire of clients to "work on their spirituality" while in treatment and to the concerns within the addiction treatment field regarding the potential abuse of power through the practitioner's infusion of their own values or beliefs upon persons. The healing therapeutic relationship of the modality of spiritual direction provides a boundary for the spiritual care practitioner adhering to the modality and practices of spiritual direction.

In addition, the practice of spiritual direction also allows for persons to seek treatment from the "expert companion" as they engage in the process of change and discovery of meaning described by Kenneth Pargament's search for the sacred or while exploring their theological imagination and experiencing the realness of their paracosm as described by Luhrmann's faith frame. Perhaps this is best illustrated by Margaret Guenther's metaphorical comparison of spiritual directors who act as spiritual midwives. Guenther explains that "in her attentive presence, the midwife is not authoritarian, yet she has great authority. She has skill, knowledge, and perspective that the birthgiver cannot have, if only because she stands outside the process. She is capable of a loving detachment, but at the same time feels solidarity with the one giving birth."[199] Guenther continues in her comparison by stating that, "with the clearer perspective of the midwife who stands outside the process, the spiritual director is able to offer interpretations

[199] Margaret Guenther, *Holy Listening: The Art of Spiritual Direction* (Cambridge, MA: Cowley Publications, 1992), 97.

to the birthgiver. I say 'offer' rather than 'impose,' for the director-midwife can never see the whole picture…. In any event, it is important to leave the directee free to accept or reject our insights."[200] Guenther is correct, the modality of spiritual direction provides a way of developing the therapeutic relationship that includes the guiding expertise of the spiritual "midwife" or the "expert companion" approach while ensuring and maintaining the agency and freedom of the directee.

William A. Barry and William J. Connolly, in *The Practice of Spiritual Direction,* provide a further list of the core practices of spiritual direction. They claim that any authentic description of the practices of spiritual direction will include "empathetic listening, paying attention, affirming, assisting in clarification, raising questions when the directee wants them, and helping the directee to recognize the effective attitudes that influence his or her attitude to God. All of these activities—and others—are indispensable to the work of direction."[201]

Likewise, SDI names the skills and knowledge required for spiritual directors as one who "listens deeply: noticing, tracking, distinguishing, prioritizing, paraphrasing, waiting, probing, challenging, and disclosing – always ready to serve the directee and the spiritual direction relationship."[202] SDI's description also states that the spiritual director must understand "how and when to make appropriate referrals; acknowledging assumptions and personal bias, and recognizing when those get in the way of the spiritual direction; recognizes and avoids dual relationships"[203]and adheres and gives "careful attention to SDI's *Guidelines for Ethical*

[200] Ibid., 98.
[201] Barry and Connolly, *The Practice of Spiritual Direction*, 47.
[202] "Portrait of a Spiritual Director," 40.
[203] Ibid.

Conduct."[204] (SDI's guide can be found online[205] and is a valuable resource for training and supervising spiritual directors.)

Both the common practices and the common commitment to the ethics of spiritual direction are important for spiritual care practitioners in addiction treatment environments. Spiritual direction, understood as a transformative therapeutic relationship and its practices and commitments honored as a mode of treatment, holds great potential for spiritual care practitioners in addiction treatment environments. It is the intention of this project to point the addiction treatment field toward an identifiable and professional mode of spiritual care that answers the aforementioned concerns of the addiction treatment field regarding spiritual care. Spiritual direction, provided by qualified spiritual care practitioners, offers a different way of imagining spiritual care beyond the traditional pastoral care models.

Spiritual Direction as Trauma's *Caring Other*

Another noteworthy intersection with the modality of spiritual direction and addiction treatment is its alikeness to the necessary therapeutic relationship described in the review of trauma therapy in Chapter Two. It is not the intention of this project to define the practices of spiritual direction as solely therapeutic, but rather, to decisively connect the highly relational modality and practices of spiritual direction as potently beneficial when seen through the research of trauma therapy.

Psychological trauma is thickly connected with addiction, and the importance of treating trauma and addiction *concurrently* is well-documented.[206] The review in Chapter Two of Janoff-Bulman, Herman, and Van Der Kolk's research regarding psychological trauma and the

[204] Ibid.

[205] "Guidelines for Ethical Conduct," rev. ed., *Spiritual Directors International*, Accessed November 15, 2021, https://www.sdicompanions.org/docs/guidelines/Flip/guidelines_ethical_conduct.html.

[206] Carruth, "Psychological Trauma and Addiction Treatment," 1-14.

subsequent necessary healing treatments revealed that the suggested therapeutic practices of trauma therapy across their work can be summarized as: a compassionately present relationship, a calm and safe environment, and a connection to healthy others. In very similar tones, all three of the reviewed sources identify and name the healing power of the therapeutic relationship. Janoff-Bulman calls it the "caring other," Herman names it as the "healing relationship," and Van Der Kolk speaks of a necessary "coach," "accompany," or "guide." The trauma-informed healing relationship, safe environment, and a healthy connection to caring others can be readily found within the modality of spiritual direction.

SDI's description of the spiritual director nearly identically mirrors the trauma research language as it describes the role of a spiritual director who is "welcoming and present," "listening and responding without judgement," "compassionate," and "loving yet independent." Each of these commitments and practices of the spiritual director are reflective of the practices and motivations encouraged by trauma therapy as vital for the foundationally required compassionately present relationship. Arguably, Janoff-Bulman's "caring other" description of the compassionately present relationship directly parallels SDI's description of spiritual direction.

Margaret Guenther defines the spiritual director as "a safe place"[207] and further affirms how spiritual direction serves as the safe environment for trauma by specifically naming that in the safety of a spiritual direction session "the survivor of sexual abuse needs to know that no detail can shock or disgust us. The penitent needs to know that we hear but do not judge…".[208] Guenther continues, "The director who is convinced of God's love and mercy, even when the directee is not, is able to accept any disclosure with equanimity. Through her loving acceptance

[207] Guenther, *Holy Listening*, 19.
[208] Ibid., 20.

she is able to model and reflect the love of God so yearned for by the directee who despairs of his own worthiness."[209] In Guenther's specific example, the traumatized person is provided the compassionately present relationship, a safe place, and a healthy reconnection with a Caring Other. This kindling of compassionate presence also recalls Luhrmann's research, also reviewed in Chapter Two, revealing that as a paracosm of gods and spirits is kindled and becomes real, it can transform a person. Again, this is not just a belief process within the mind, but an embodied experience through the theological imagination and throughout the body and behavior as Luhrmann's list of epidemiological findings demonstrated. The connection to healthy others, for many, is about a connection to a healthy and loving *Other*.

Furthermore, often present within the experience of spiritual direction beyond a physically safe environment is a sacredly safe environment. As Pargament's research regarding the search for the sacred illustrated, meaningful connection is being both created and provided through awareness of the sacred presence of God, or the sacred connection with nature, or a sense of the transcendent. The discovery of a safe environment within sacred presence for a person can continue far beyond that of the spiritual direction session environment.

As summarized above, the modality of spiritual direction provides and reflects the necessary treatment responses of a *compassionately present relationship, a calm and safe environment, and a connection with healthy others* found within the trauma therapy literature; and these practices are more than a therapeutic practice. They are inherently part of the modality of spiritual direction.

This section has so far demonstrated the practices inherently present in the modality of spiritual direction directly and concurrently respond to matters of spirituality, trauma, and addiction. The connections between trauma therapy and spiritual direction revealed in this paper

[209] Ibid., 21.

have potential for further exploration and research and could very well be part of the "empirical question"[210] posed by Van Der Kolk regarding what modality potentially works best for an individual survivor of psychological trauma. However, this project principally desires to point to the modality of spiritual direction as a practice that equals the evidence-based practices of trauma therapy, and thus, is a potently helpful treatment response when concurrently responding to trauma and addiction.

It is important to note here that spiritual direction literature often seeks to define itself apart from psychotherapy. This is not resistance to psychotherapeutic or evidence-based practices, but an effort to resist the defining of spiritual direction as solely about treating the therapeutic self. Similar to trauma therapy, spiritual direction recognizes the whole of a person goes beyond the mind and body and includes much broader connections and relationships than that commonly focused on in the psychotherapy field.

As Richard Rohr writes, "Therapists largely deal with the psychological self, because the profession as such cannot address the ontological, metaphysical, theological self. That is a very different level of being."[211] And as Henri Nouwen acknowledges,

> Spiritual direction and therapy or psychological counseling often appeared to be one and the same thing. We are very familiar with words such as *conscious* and *unconscious*, *depression* and *regression*, *frustration* and *defense mechanisms*, *dysfunction*, *addiction* and *co-dependency*. Psychological terminology is used more frequently in our society than spiritual words such as *atonement*, *resurrection*, *sin*, *forgiveness*, and *grace*. However, if you simply remain in the psychological world, if you raise only psychological questions, you will get only psychological answers, when your heart needs spiritual wisdom.[212]

[210] As referenced in Chapter Two of this paper, Van Der Kolk provides three avenues of care for those who suffer with psychological trauma and then poses the question, "Which one of these is best for a particular survivor is an empirical question."

[211] Richard Rohr, *Immortal Diamond: The Search for Our True Self*, 1st ed. (San Francisco, CA: Jossey-Bass, 2013), 34.

[212] Nouwen, Christensen, and Laird, *Spiritual Direction*, 23.

It is exactly this broad awareness that underlines the effectiveness of spiritual direction with those who suffer from psychological trauma and addiction beyond that of mere therapeutic practices. The compassionately present relationship, safe environments, and the connection to healthy other(s) provided within the modality of spiritual direction extends beyond the work of a good therapist, for as noted throughout this project, even a very good psychotherapist is most often not prepared, appropriately trained, or willing to journey into the fray of the theological imagination or serve as a co-witness to the presence of gods and spirits. A spiritual director will journey with a person into the depths of faith and spirituality, providing a loving-yet-independent guide and presence along the way, and thus, allowing the directee to experience a new kind of caring other/Other relationship.

It is also within the expertise of the spiritual director to utilize other evidence-based therapeutic techniques alongside the common spiritual-formation practices of silence, presence, prayer, pain-holding, confession, and assurance. For example, a spiritual director may use Cognitive Behavior Therapy, Narrative Therapy, Active Listening, Motivational Interviewing, or Unconditional Positive Regard within their dialogical relationship. Together, these spiritual formational and psychotherapy practices comprise a modern understanding of the care and treatment within the modality of spiritual direction that can find its place as an option in the treatment of those who suffer from the often-co-occurring states of psychological trauma and addiction. Like neuroscience has helped observe the live happenings of the human brain and body, so spiritual direction allows a person to discover the deeper meaning and determinative influences of the theological imagination at work within them.

Research on Spiritual Direction and Addiction Treatment

While claiming spiritual direction as an effectual modality of treatment due to its person-centered posture and parallelism to the evidence-based practices of trauma therapy, it is also required to address the research on spiritual direction and addiction treatment. To date, there is only one methodologically controlled research study completed regarding the direct impact of spiritual direction on addiction treatment outcomes. The project was led by William R. Miller, Alyssa Forcehimes, Mary O'Leary, and Marnie D. LaNoue and the results were published in 2008 in the *Journal of Substance Abuse Treatment*.

Contrary to their expectations, their study found no significant outcome differences between traditional addiction treatment and treatment with spiritual direction. However, as will be discussed in this section, both the conclusions of their study and its methodology have been questioned. Certainly, additional research must be completed to fully explore the potential and possibilities of spiritual direction within addiction treatment before any universal conclusions can be made. The following section reviews and offers a rebuttal to their counterclaim regarding the potential of spiritual direction in addiction treatment.

In their published findings, they report on the outcomes of two controlled clinical trials regarding the application of spiritual direction within addiction treatment. The first trial was conducted with professional spiritual directors providing twelve sessions of guidance with clients (1-3 times during inpatient treatment episode and the remaining in an outpatient environment) and the second trial was conducted with "regular clinical staff"[213] who received 24 hours of training in a manual-guided version of spiritual direction.[214] While the study was predicated on their prediction that spiritual direction would prove to be a key component in recovery from

[213] William R. Miller, Alyssa Forcehimes, Mary O'Leary, and Marnie D. LaNoue, "Spiritual Direction in Addiction Treatment: Two Clinical Trials," *National Institutes of Health*, December 2008, 5, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600849/pdf/nihms77787.pdf.

[214] Ibid., 6.

addiction, the two case studies failed to detect any significant impact on substance use outcomes.[215]

As William White noted in his editorial response to this study, the inconclusive findings have potential of being used and misused to support the many biases within the often territorial and secular frameworks of addiction recovery. This awareness prompted White to specifically warn that

> some will mistakenly declare that 'the science is in' and that the alleged role of spirituality in addiction recovery is nothing more than a myth. In an era in which far more abstracts in popular press summaries are read than scientific reports, much of the subtle nuances of Miller et al.'s discussion of their findings risks being lost. This potential justifies multiple professional commentaries on these studies and an assertive response to any misrepresentation of study findings.[216]

White follows up his warning with a list of critiquing questions regarding the research methodology and its understanding of spiritual direction. White notices that the nuanced language within the concluding discussion of the report is particularly important. For, throughout the publication and in the concluding discussion, the authors reveal important admissions about the study. Three of the notable admissions and concerning issues of the study include: (1) "None of the three [professional spiritual directors] had previous experience working with substance dependent persons"[217] nor were their sessions conducted as an integrated interdisciplinary role within the treatment environment. Likewise, the 24 hours of training for "regular clinical staff"[218] to deliver a manualized version of spiritual direction is dismissive of the expected training and experience of a spiritual director. For comparison, many spiritual direction certification programs are two years in length and include hundreds of hours of supervised training. Experience with

[215] Ibid., 8.

[216] William L. White, "Spiritual Guidance, Addiction Treatment, and Long-Term Recovery," *Journal of Substance Abuse Treatment* 35, no. 4 (December 2008): 443.

[217] Miller, Forcehimes, O'Leary, and LaNoue, "Spiritual Direction in Addiction Treatment," 3.

[218] Ibid., 6.

working alongside persons with substance use disorder is important for spiritual directors working within addiction treatment environments, equally so is quantifiable experience with the modality of spiritual direction. (2) Although voluntary and with consent, the study was not completed with spiritual seekers. Notably, the researchers readily admit that "we experienced such difficulty in completing sessions with patients who had consented to the treatment."[219] A core component of effective spiritual direction is the seeking and leading of the spiritual experience by the directee. One might even properly say that there is no spiritual direction without the direction of the directee. It seems the study, as designed, failed to fully consider the nature of spiritual direction as a person-centered and other-focused relational experience. The lack of directee engagement, of course, would directly affect any kind of measurable outcomes. (3) The closing sentence of the study reveals the awareness of the author that they may have wrongly approached the application of spiritual direction as a mechanical fix for addiction rather than, as this project claims and is pointing toward, a therapeutic and transformative relationship. They conclude their publication by admitting that "in this regard, it may have been naive to expect enduring effects from such brief intervention, an error mirroring the broader model of curing a chronic condition with an acute treatment episode."[220]

Considering these identified issues and the admissions of the researchers, this project argues the potential of outcomes regarding the use of spiritual direction within addiction treatment has yet to be fully explored. However, the research of Miller et al. is a very important starting place for understanding how to potentially study spiritual direction as a transformative modality within addiction treatment environments. Notably, Miller et al. specifically name spiritual direction as a professional discipline "devoted to facilitating human spiritual

[219] Ibid., 8.
[220] Ibid., 9-10.

development, which could be integrated into treatment."[221] And they acknowledge that there is a "longstanding tradition of spiritual direction, for which there are professional training and certification programs. Spiritual directors are not necessarily religious clergy, and as with psychotherapy, a wide array of counseling styles is evident, varying in their directiveness and linkage to specific religious traditions."[222] As White summarized in his editorial response, the outcomes of these two case studies only "mark the beginning of a new era of research on [spiritual direction], not the final statement on spirituality and addiction recovery."[223]

In summary, there remains a gap and need for ongoing research on spiritual direction and addiction treatment and recovery. It should be affirmed in further studies that spiritual direction is not best approached as a merely a mechanical set of practices, rather, spiritual direction is best recognized as parallel and reflective of the therapeutic relationship illustrated in the research of Meichendbaum, Tedeschi and Calhoun, Janoff-Bulman, Herman, and Van Der Kolk. This trauma-informed and evidence-based approach to the provision of spiritual direction by spiritual care practitioners opens a new way to imagine other-focused care and still contains important possibilities as a modality of spiritual care for the spiritual care practitioner providing treatment with persons participating in addiction treatment environments.

[221] Ibid., 2.
[222] Ibid.
[223] White, "Spiritual Guidance, Addiction Treatment, and Long-Term Recovery," 443.

PART TWO

The Efficacy of Professional Chaplaincy

The field of professional chaplaincy needs no grand introduction. Chaplaincy is a proven and integrated clinical form of spiritual care predominantly operating within hospital environments. This section will examine the important contributions of professional chaplaincy in its development of a framework of professional spiritual care for addiction treatment environments.

The Joint Commission, the largest healthcare accrediting organization in the United States, requires within their accreditation standards that healthcare organizations administer spiritual assessment and provide spiritual care.[224] However, most addiction treatment programs pursue and utilize other accrediting bodies which do not require a provision of spiritual care. This recognition affirms the reason the appeal of this proposal is directed toward the addiction treatment providers and administrators who are directly responsible for ensuring the fidelity of person-centered treatment for those within their care.

Perhaps the reason chaplaincy has not been included by other accrediting bodies is the transformative treatment expectation of the addiction treatment field that is often thought to be lacking in a traditional chaplain approach. Chaplaincy, in its typical hospital setting, is thought to be an important contribution because it serves as a final act of care or a comforting presence amid a health treatment experience.[225] Inversely, addiction treatment environments are much more dialogical and focused on empowering a re-entry to life through transformative care and

[224] Hodge, "Alcohol Treatment and Cognitive-Behavioral Therapy," 21.
[225] This writer is aware there are active efforts within professional chaplaincy to reimagine chaplaincy as much more than this reductionistic description.

treatment. And it is true that a discipline of spiritual care in addiction treatment environments will need to be shaped around and recognized as a contribution within a transformative treatment approach, for, it must be remembered that it is exactly spiritually focused treatment or "working on spirituality" that persons participating in addiction treatment environments have stated they desire to receive. However, it would be a great disservice to the efficacy of professional chaplaincy to not carefully consider its contributions when advocating for and developing a spiritual care practitioner role in addiction treatment environments.

The proposal of this project is a combination of the aforementioned transformative therapeutic relationship formed through the modality of spiritual direction *and* the clinical standards of care within the framework of professional chaplaincy. This combination of practices and standards holds great potential to impel addiction treatment providers to imagine and integrate a new approach to spiritual care within their treatment environments.

The first contribution of professional chaplaincy is a recognition of how its evidence-based research has determined its integration in healthcare systems. Years of empirical research have connected the presence and activity of chaplains in healthcare settings to increased patient satisfaction scores, improved reputation and marketability, and higher hospital reimbursement from Medicare and Medicaid Services.[226] Chaplaincy is understood within the healthcare system as a contributing factor that goes beyond the provision of direct spiritual care. Chaplaincy has demonstrated that when examined, spiritual care directly affects the bottom line.

Second, the educational and training process of professional chaplaincy provides a rigorous clinical supervision experience and board certification process. Board-certified chaplains are required to have a minimum of a graduate-level theological degree and multiple

[226] "The Impact of Professional Spiritual Care," ACPE, et al., Accessed November 15, 2021, 7, https://www.professionalchaplains.org/Files/resources/The%20Impact%20of%20Professional%20Spiritual%20Care_PDF.pdf.

units of Clinical Pastoral Education.[227] While there are roughly six recognized chaplain certifying bodies in North America, the Association of Clinical Pastoral Education (ACPE) is the premier educational group and is recognized as the standard for spiritual care and education. ACPE claims its membership body includes "certified CPE educators, spiritually integrated psychotherapists, spiritual care professionals and practitioners, pastoral counselors, chaplains, faith communities and seminaries."[228]

Third, professional chaplaincy includes standards of practice and a code of ethics that was developed in 2015 by the Association of Professional Chaplains. These ethical standards provide a clear performance expectation for both practitioners and provider agencies regarding the behavior and professionalism of spiritual care practitioners. The standards of practice include three domains of care: standards 1-7 regard care for the care recipients, standards 8-10 regard care for the organization, and 11-15 regard standards for maintaining competent care. The *Standards of Practice for Professional Chaplains* are outlined by the Association of Professional Chaplains as follows:

> Standard 1, Assessment: The chaplain gathers and evaluates relevant information regarding the care recipient's spiritual, religious, emotional and relational needs and resources.
>
> Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote the well-being of the care recipient.
>
> Standard 3, Documentation of Care: The chaplain documents in the appropriate recording structure information relevant to the care recipient's well-being.
>
> Standard 4, Teamwork and Collaboration: The chaplain collaborates, within the chaplain's scope of practice, with other care providers to promote the well-being of the care recipient.

[227] Ibid.,10.

[228] "About ACPE," *ACPE: The Standard for Spiritual Care & Education*, Accessed November 14, 2021, https://acpe.edu/about-acpe.

Standard 5, Ethical Practice: The chaplain adheres to the APC Code of Ethics and other codes of ethics as required by the chaplain's professional setting to guide decision-making and professional behavior.

Standard 6, Confidentiality: The chaplain respects the confidentiality of information from all sources, including the care recipient, legal or organizational records, and other care providers in accordance with federal and state laws, regulations and rules.

Standard 7, Respect for Diversity: The chaplain models and collaborates with other care providers in respecting and providing sensitive care regardless of diverse abilities, beliefs, cultures or identities.

Standard 8, Care for Employees and Affiliates: The chaplain provides effective chaplaincy care to the organization's employees and affiliates via individual and group interactions.

Standard 9, Care for the Organization: The chaplain provides chaplaincy care to the organization in ways consistent with the organization's values and mission statement.

Standard 10, Chaplain as Leader: The chaplain provides leadership in the chaplain's professional setting and profession.

Standard 11, Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice as understood within the chaplain's professional setting.

Standard 12, Research: The chaplain remains informed of relevant developments in evidenced-based and best practices in chaplaincy care through reading and reflecting on the current research and professional practice; and, where practical, collaborates or provides leadership on research studies.

Standard 13, Knowledge and Continuing Education: The chaplain takes responsibility for continued professional development and demonstrates a working knowledge of current theory and practice as appropriate to the chaplain's professional setting.

Standard 14, Technology: The chaplain appropriately uses technology to enhance delivery of care and to advance the work of the profession.

Standard 15, Business Acumen: The chaplain values and utilizes business principles, practices and regulatory requirements appropriate to the chaplain's role in the organization.[229]

[229] "Standards of Practice for Professional Chaplains," *Association of Professional Chaplains*, October 22, 2015, 1-2, https://www.professionalchaplains.org/Files/professional_standards/standards_of_practice/Standards_of_Practice_for_Professional_Chaplains_102215.pdf.

This project recognizes the standards of practice outlined by professional chaplaincy as vital to include in the development of a framework for a discipline of spiritual care within addiction treatment environments. These standards directly address the ethical concerns of a discipline of spiritual care operating within the addiction treatment field. The professional expectations and standards of a board-certified chaplain ought to impel the addiction treatment field and its governing bodies and providers to trust that certified spiritual care practitioners are qualified professionals who operate and are accountable within a professional ethic and standard of practice. It is the proposal of this project that a spiritual care practitioner within the addiction treatment field be trained and certified as a professional chaplain alongside the competencies and skills of the modality of spiritual direction.

In summary, this project is advocating for the integration of spiritual care practitioners in addiction treatment environments. It is proposed that developing a spiritual care practitioner role around the aforementioned transformative therapeutic relationship of spiritual direction *and* recognizing the efficacy and framework of professional chaplaincy answers the concerns, addresses the ambivalence, confronts the biases, and provides great potential to help imagine and impel a new approach to the provision of spiritual care in addiction treatment environments. This proposal demonstrates that when addiction treatment providers integrate spiritual care practitioners, they will enable care for the whole person, including the ethnographic experiences of spirituality/faith/religion, the anthropic dimension of the theological imagination, and the spiritual phenomena determinatively at work within persons in their care.

PART THREE

Description of a Spiritual Care Practitioner

Part Three is written specifically with addiction treatment providers in mind and provides practical language and a description of the spiritual care practitioner role that can be used in the formation of a job description. The following section provides a summary of the spiritual care practitioner role and the essential responsibilities, activities, standard qualifications, and competencies. These practical descriptions are intended to assist addiction treatment providers in the action of pursuing the integration of spiritual care practitioners within their respective addiction treatment environments.

What is a Spiritual Care Practitioner?

A spiritual care practitioner is an individual qualified by education, training, certification, and experience who provides expert care and treatment within the scope and standards of practice of spiritual care. A spiritual care practitioner has training and experience with the modality of spiritual direction, is informed in the therapeutic practices of trauma therapy and addiction treatment, is clinically trained, or certified as a professional chaplain, and has a Master of Divinity or graduate level degree in religion, theology, or pastoral counseling.

A Position Summary for a Spiritual Care Practitioner in an Addiction Treatment Environment.

Under general supervision, and operating with interdisciplinary collaboration, the spiritual care practitioner provides spiritual assessment, delivery of care, documentation of care, and follow up ensuring the provision of individualized spiritual care for every resident.

The Essential Responsibilities and Activities of a Spiritual Care Practitioner.

The essential responsibilities and activities of a spiritual care practitioner include:

- Provides confidential and individualized spiritual care and guidance with respect for diverse abilities, beliefs, and identities.
- Adheres to (name the agency or professional association) Code of Ethics while exhibiting professional behavior and decision-making.
- Participates within and collaborates with the interdisciplinary team.
- Facilitates spirituality focused groups for residents.
- Documents care practices within (name records structure).
- Enhances education and development of their expertise within current theory and practice of their scope of care and standards of practice.

Standard Qualifications and Competencies of a Spiritual Care Practitioner

The standards qualification and competencies of a spiritual care practitioner include:

- Experience/training/certification in spiritual direction.
- A board-certified professional chaplain (or a minimum of two units of Clinical Pastoral Education).
- A minimum of a master's degree in theology, pastoral care/counseling, spiritual formation, or an equivalent human-service related field with spiritual care experience.

These brief role descriptions provide a basic framework through which an addiction treatment provider can define the role of an integrated spiritual care practitioner who provides spiritual care and treatment in their respective addiction treatment environment.

Summary of Chapter Three

In summary, Chapter Three has explored the modality of spiritual direction, also commonly called spiritual companionship. Alongside a brief historical overview of this interspiritual modality, the parallel practices of spiritual direction with the transformative therapeutic relationship were reviewed and were demonstrated to importantly align with the necessary "caring other" and "compassionately present relationship" revealed in trauma

literature. The alike practices within the modality of spiritual direction and the transformative therapeutic relationship found necessary in trauma therapy and addiction treatment provide significant potential for spiritual direction as a modality of care that can be provided by spiritual care practitioners in addiction treatment environments.

Second, the important contributions of professional chaplaincy were reviewed. Chaplaincy, as a proven and interdisciplinary form of spiritual care, can serve as a means of providing a professional and clinical framework for spiritual care practitioners in addiction treatment environments. The certification process and the standards of care of professional chaplaincy combined with the therapeutic companionship practices of spiritual direction creates the transformative role of a spiritual care practitioner within addiction treatment environments.

Third, practical language and a definition of the spiritual care practitioner role was provided that can be used by addiction treatment providers to begin the process of identifying and recruiting spiritual care practitioners. These practical resources are intended to inspire and impel addiction treatment providers toward action regarding the integration of spiritual care practitioners within their respective addiction treatment environments.

Next, Chapter Four will include three concluding discussions. First, a concluding summary of the transformative proposal of this project. Second, a summary of conversations with addiction treatment providers and administrators. These quotes and discussion are intended to identify potential conversation partners and begin to advance the needed conversation regarding the ongoing advocation for the integration of spiritual care practitioners in addiction treatment environments. And third, a concluding discussion regarding the necessary next steps and challenges ahead in the advocating process of integrating spiritual care practitioners in addiction treatment environments.

CHAPTER FOUR: CONCLUSIONS

As the addiction treatment field has developed in the United States, it has not yet integrated a professional discipline of spiritual care. This reality exists despite ample evidence regarding the influence of the lived experiences and social determinants of religion, faith, and spirituality; demonstrable research regarding faith practices as a positive factor of recovery; and the explicitly known desire for greater focus on spirituality by persons participating within addiction treatment environments.

While there have been efforts made and emphasis provided over the past twenty years regarding the importance of integrating spirituality into addiction treatment, these efforts have been mostly limited to attempts of adding additional education, training, and supervision into existing therapeutic roles such as addiction counselors, social workers, or psychologists. Unlike hospital environments where professional spiritual care practitioners are recommended and often required by accrediting and certifying bodies within interdisciplinary systems of care, addiction treatment environments often rely on institutional traditions, personal interest and willingness of therapists, adjunct staff, or even the referral of clients to external or post-treatment sources. This effort has fallen short of its intention as evidenced by the ongoing ambivalence toward the determinative matters of faith and spirituality within the field. A disparity remains in both the definition and availability of spiritual care within addiction treatment environments. Such ambivalence and disparity are inhibiting fidelity to the person-centered care model the field proclaims as its strength and commitment. It is urgent that the addiction treatment field recognize and give attention to the integration of a professional discipline of spiritual care within addiction treatment environments to address this growing gap in the pathways of care.

The strategy of this project was to provide an alternative perspective and understanding of spirituality and spiritual care by focusing first on the phenomenological experience happening with persons regarding the determinative dimension of faith and the lived experiences of spirituality, and in response, provide a model of spiritual care capable of providing effectual and transformative spiritual care. For as the introductory story of the blind man illustrated, for transformative treatment to happen, the action and the lived experiences of a person seeking treatment must be recognized as primary in the healing story. The addiction treatment field must recognize its current view of spiritual care and its lack of inclusion of the matters of spirituality and faith in treatment is not inclusive of the both the desire for greater focus on spiritually focused treatment and the lived experiences of spirituality and faith determinatively at work within and upon persons in their care.

This project has provided new sources, perspectives, and insights into how spirituality and spiritual care can be reimagined and responded to within the addiction treatment field by means of examining research literature from a variety of fields of study including contributions from philosophical and theological anthropology, psychotherapy, trauma therapy, and contextual theology.

Notably, this project has demonstrated that the theological imagination is a determinative dimension of personhood. This sacred domain, as defined by Pargament, or the faith frame, as defined by Luhrmann, is an active reality within persons forming a determinative story and lens through which a person experiences and interprets both their inner world and the world about them. The theological imagination is part of the everyday lived experience of a person's reality and one of the ordinary ways a person self-narrates, and thus is determinative in the formation of

identity and behavior for persons. This dimension of personhood must be included as part of person-centered treatment.

This project has also demonstrated that spirituality acts as a process of change. In other words, spirituality is a dynamic and transformative process directly affecting the realities of identity, meaning, and behavior of persons. The kindling aspects of faith practices and theology form real relationships and thus intimate lived experiences with meaningful social connection, and in turn, these social experiences transform identity and influence change of behavior, ease trauma enactments, create healthy outcomes, and maintain personal fulfillment.

The process of change happens within the sacred searching of an individual and is best navigated when guided/coached/companioned by a spiritual care practitioner. Like trauma therapy's awareness of the needed therapeutic alliance for affectual treatment, spiritual care is aware of the necessary embodied presence of the spiritual guide.

This project has demonstrated that the growing sole reliance in the addiction treatment field on a medical model of care is limiting the potential recovery and transformation of persons participating in addiction treatment environments. While addiction treatment proclaims itself as person-centered, it is demonstrating its own blindness to the experience of personhood through the omission of spirituality and the exclusion of a professional discipline of spiritual care. The medical modalities are firmly necessary within effectual addiction treatment as they serve as the primary mode of care for early intervention and ongoing life-saving treatment, however, the medical model does not have a response nor treatment plan for identity and narrative transformation, social connection, theological incongruence, or the kindling of connection with the transcendent or sacred. The inclusion of other treatment and recovery pathways, and particular attention to the determinative spiritual and faith experiences of a person within a

person-centered treatment model, will require treatment providers to engage direct spiritual care to fulfill the treatment goals of their clients. As this project has demonstrated, the integration of a spiritual care practitioner within addiction treatment environments is an embodied, evidence based, ethical, and professional approach and response to the requirement of person-centered care.

In effort to help addiction treatment providers (re)imagine how the care and treatment of a spiritual care practitioner happens within addiction treatment environments, this project described a combination of the modality of spiritual direction and the framework of professional chaplaincy. The modality of spiritual direction serves as a transformative therapeutic relationship that importantly aligns with evidence of the compassionately present relationship, a safe environment, and a healthy connection with others as described in the literature of trauma research and therapy. This project demonstrated that spiritual direction is an other-centered, theologically open, and an ethical modality of care that can be provided by spiritual care practitioners in addiction treatment environments. The modality of spiritual direction, also commonly called spiritual companionship, acts as a therapeutic relationship/alliance acting as a treatment form. Additionally, the framework of professional chaplaincy provides an already-proven discipline of spiritual care that can guide the ethical operation of spiritual care practitioners within professional and clinical environments. The rigorous education and certification processes, the adherence to the professional code of ethics, the standardized set of practices, and the attention to treatment outcomes make professional chaplaincy the right oversight framework for a spiritual care practitioner operating in addiction treatment environments. The combination of the efficacy, ethics, and outcome awareness of professional chaplaincy and the therapeutic companionship posture and practices of spiritual direction makes

the role of a spiritual care practitioner within the addiction treatment field a professional and transformative discipline of spiritual care.

In summary, this project advocates for the integration of spiritual care practitioners in addiction treatment environments who specialize in the provision of the transformative therapeutic relationship of spiritual direction and work within the standards of practice and ethical framework of professional chaplaincy. This proposal implores addiction treatment providers to begin integrating spiritual care practitioners who will enable care for the *whole* person, including the ethnographic experiences of spirituality/faith/religion, the anthropic dimension of the theological imagination, and the spiritual phenomena determinatively at work within persons in their care.

Perspectives from the Addiction Treatment Field

What are the next steps toward integrating spiritual care practitioners into addiction treatment environments? This project has thus far imagined and described how spirituality and faith are inherently at work within and upon persons and how spiritual care can be provided through the integration of spiritual care practitioners in addiction treatment environments. The remaining two sections of this chapter focus on the task of thinking about the pathway ahead regarding the process of advocating and initiating the process of ensuring every person participating in addiction treatment has access to professional spiritual care.

First, this section will provide direct feedback and discussion from addiction treatment providers and administrators, and second, this section will deliver a concluding discussion regarding the next steps and challenges ahead in the important task of integrating spiritual care practitioners in addiction treatment environments.

In effort to begin the conversation with providers and administrators, and as a means of identifying potential real time challenges, opportunities, and a future roadmap regarding the ongoing advocation for the integration of spiritual care practitioners in addiction treatment environments, three interview questions were emailed to a range of medical practitioners, administrators who work within addiction treatment provider agencies, addiction education specialists, and New York State addiction treatment governance administrators.

The premise statement included in the initial email communication and a selection of subsequent email responses are provided in this chapter. Each response is grouped and organized under the corresponding question. Following the responses is the final concluding discussion from this writer regarding insights gained and how this project has addressed the concern or suggestion and/or how the issue identified might be addressed in the future. With permission granted to this writer via email by each respondent, each initial response also includes an identifying name and title.

The Premise and Questions

Unlike healthcare environments where a professional discipline of spiritual care is often required and active within interdisciplinary teams, the addiction treatment field and most addiction treatment environments do not include integrated spiritual care practitioners. This omission of direct spiritual care exists despite research revealing that most individuals participating in addiction treatment express a desire for greater focus on spirituality/faith, and despite the reality that matters of spirituality/faith are self-evidently thick within the traditions and everyday realities of addiction treatment and care.

(1) As an addiction treatment provider or practitioner, what problems/concerns do you see regarding an integrated discipline of spiritual care?

(2) What benefits or value outcomes would you expect from an integrated discipline of spiritual care within addiction treatment environments?

(3) And last, what avenues or approaches do you see as the best means of advocating for the integration of spiritual care practitioners within addiction treatment environments?[230]

Responses to Question One

As an addiction treatment provider, what problems/concerns do you see regarding an integrated discipline of spiritual care?

"The reason why it's easier to integrate spirituality in physical health care is because it is less of a dialogue back and forth and more about the provider affirming that being spiritual, or even participating in an organized religion, is something that is an insulated factor for people. In mental health and in addiction treatment it is more of a conversation about how spirituality helps and what you believe. So, I think some folks shy away from it (spiritual care) due to the hyper polarization in our culture these days. The only thing I would want to warn against is that sometimes practitioners let their own value systems and personal beliefs guide the conversation. So, when we are talking about spirituality… we need to make sure the workforce is educated about spirituality…and we need to give them the tools to have objective conversations with the person who is exploring these concepts and an opportunity to make their own decisions."[231]

- James Button, C.E.O. of Citizen Advocates in Saranac Lake, New York

"The ignorance and reluctance of medical professionals to consider bio-psycho-social-spiritual rather than just bio-psycho-social."[232]

- Dr. Raju Hajela, President and Medical Director, Health Upwardly Mobile Inc. in Calgary, Alberta

"(1) The legal need to maintain non-sectarian status to remain eligible for all funding sources. (2) The need to avoid culture clashes in the workplace between colleagues who mis-apply spirituality and religion or particular tenants of one faith or another. (3) The need to avoid program participants from forming cells or cliques around one religion or another…. (4) Finding staff dedicated to this that are well informed, unbiased in their own beliefs and able to maintain boundaries."[233]

- Jeremy Klemanski, President and C.E.O. of Helio Health in Syracuse, New York

[230] This is the text included within the body of the email written by this author in solicitation of responses from addiction treatment providers and practitioners for the purpose of including responses within this dissertation.

[231] James D. Button, interview by author, Saranac Lake, New York, November 5th, 2021.

[232] Raju Hajela, email message to author, October 31, 2021.

[233] Jeremy Klemanski, email message to author, November 5, 2021.

"The problem is that there is a model for the integration of spiritual care in the house of medicine, but the treatment of addiction exists largely outside of the mainstream of healthcare. Only with the integration of addiction treatment into the mainstream of healthcare will models that exist in the rest of medicine have purchase in addiction care. Additionally, treatment for most medical conditions that evoke the integration of spiritual care are acute conditions, and when integration occurs in chronic care settings such as LTACs and nursing homes it is mostly focused on comfort, whereas spiritual care in addiction treatment is rightfully oriented toward support for change at depth using spiritual practices to move in that direction."[234]

- Dr. A. Kenison Roy, III, Associate Professor of Psychiatry and Addiction Medicine and Director of the Division of Addiction Medicine at Tulane University School of Medicine, New Orleans, LA

"Money is the issue. Our residential treatment programs can only afford a certain level of staffing. Our staffing includes nurses, doctors, therapists and aides. All essentially in delivering a quality program that is also safe. We partner with local volunteer resources to assist us in meeting the spiritual needs of our residents. In outpatient – spiritual care is not reimbursable as being 'medically necessary'. Without revenue we cannot hire these positions."[235]

- Anne Constantio, President and C.E.O. of Horizon Health Services, one of the largest providers of mental health and addiction treatment in Western New York

"I believe that many providers are overly concerned about the legalities of integrating spirituality within their program services. They mistakenly assume that separation of church and state prevents them from doing faith-based counseling. Also, when providing faith-based counseling there is the concern around the Practitioner forcing his or her personal religious beliefs on the participant. And then there is the fact that most educational institutions do not have faith-based counseling as part of their training curriculum for those seeking careers in SUD's."[236]

- Roy Kearse, Vice President of Recovery Services and Community Partnerships at Samaritan Daytop Village

"In theory, [substance-use disorder] SUD treatment is person-centered. However, many treatment programs focus on physical/mental major life areas and are unable or uncomfortable integrating spiritual healing into a truly person-centered model of care. Many people in recovery describe the "turning point" in their lives in spiritual terms. Sometimes those experiences occur within the context of a near-death experience (overdose, suicide attempt, violent victimization, family intervention, criminal justice involvement). Spirituality can be a challenging concept for SUD providers treating and patients seeking treatment in the evidence-based model for SUD care. Many SUD providers cite lack of training as a reason for avoiding the incorporation of spiritual

[234] A. Kenison Roy, III, email message to author, October 28, 2021
[235] Anne Constantio, email message to author, November 4, 2021.
[236] Roy Kearse, email message to author, November 4, 2021.

practices into patient care, and others cite lack of training as significant barriers. The separation between church and state has led to prohibitions against developing program curricula and there remains a lack of uniformity and evaluation for incorporating spirituality into the treatment delivery system. Many critics point to the history of sectarian indoctrination in earlier variations of SUD treatment that were harmful to our most vulnerable. In addition, difficulties in building outcome measurements into treatment modalities that incorporate spirituality into practice have discouraged behavioral health researchers from investigating how spirituality influences physical and mental healthcare. While there are pockets of providers directly involved in building spirituality into the treatment plans tailored to the needs of their patients, the role of spirituality continues to be a relatively neglected area in the treatment of addiction, despite the anecdotal and growing body of evidence that demonstrates benefits to recovery. However, among many treatment and recovery professionals, there is growing consensus that spiritual healing plays a prominent role in SUD recovery and should be considered in the design of spiritual-oriented interventions for individuals impacted by addiction."[237]

- Stephanie Campbell, New York State Behavioral Health Ombudsman Program Director

Responses to Question Two

What benefits or value outcomes would you expect from an integrated discipline of spiritual care within addiction treatment environments?

"The presence of an identified staff member who is the authority on spiritual matters will support the incorporation of spirituality groups and individual sessions that are now poorly actualized by existing disciplines and vary in content and emphasis by staff member. The presence of integrated spiritual care will emphasize the importance of spiritual growth to recovery from addiction and impart a singleness of message that will inform all staff."[238]

- Dr. A. Kenison Roy, III, Associate Professor of Psychiatry and Addiction Medicine and Director of the Division of Addiction Medicine at Tulane University School of Medicine, New Orleans, LA

"Moving from crisis to recovery involves a mindful transformation that identifies desired changes in character, values, identity, interpersonal relationships, and lifestyle. Integrating spiritual care into treatment involves creating a potential framework through which these transitions can be planned in treatment and retrospectively understood via story reconstruction. SUD providers can play an important role as a guide in this process and help patients construct a recovery-enhancing narrative of their lives to be used during and after treatment. A set of desired outcomes would result in patients' ability to articulate a greater meaning and purpose; awareness of inner freedom, a sense of well-

[237] Stephanie Campbell, email message to author, November 5, 2021.
[238] A. Kenison Roy, III, email message to author, October 28, 2021.

being and peace of mind; an increase in hope; and demonstrate goals for improvements in relationship with self, others; and connection to community."[239]

- Stephanie Campbell, New York State Behavioral Health Ombudsman Program Director

"Behavioral health affects mind, body and spirit. Access to and integration of all spiritual resources is essential for the wellbeing and recovery of our patients."[240]

- Anne Constantio, President and C.E.O of Horizon Health Services, one of the largest providers of mental health and addiction treatment in Western New York

"The ability to effectively network and socialize with others is also critical in sustained recovery. Spiritual care helps one to feel better about themselves and therefore worthy of participating with others in life discussions because the question of one's value is validated in spirituality…."[241]

- Roy Kearse, Vice President of Recovery Services and Community Partnerships at Samaritan Daytop Village

"As providers, we are absolutely missing the mark on this in terms of offering spiritual care. This is a missed opportunity for us to provide self-care and self-maintenance for people. And in terms of value outcomes, I do think I can tie spirituality to dollars. I do think I can tie spirituality to value-based payments. It's like a carpenter who is building a house. They have a hammer and other tools, but they don't have the right screwdriver for the screws required to build the house. Not tackling spirituality is like leaving one of the key tools behind when you go to work. I don't think anything stands in the way [of integrating a discipline of spiritual care], other than a lack of prioritization. If someone came to us saying they want to pursue this role, I would be all in for it. It is something that is just not on my radar unless someone asks about it…. So, I think the only thing standing the way for our organization is the fact that no one is focused on it."[242]

- James Button, C.E.O. of Citizen Advocates in Saranac Lake, New York

"Better outcomes by at least 5-15% to make the effort worth the added cost. Probably more like 10-15% to be candid, because less than 5% is not better than what we could get by hiring more peers for example."[243]

- Jeremy Klemanski, President and C.E.O. of Helio Health in Syracuse, New York

"Spirituality refers to values and meaning for me and my patients. I have been using the bio-psycho-social-spiritual framework for 35 years now! I also talk about spirituality from the perspective of physics - unified field = consciousness, which is the basis for everything that exists. Psychology (energy) and biology (matter) arise from

[239] Stephanie Campbell, email message to author, November 5, 2021.
[240] Anne Constantio, email message to author, November 4, 2021.
[241] Roy Kearse, email message to author, November 4, 2021.
[242] James D. Button, interview by author, Saranac Lake, New York, November 5, 2021.
[243] Jeremy Klemanski, email message to author, November 5, 2021.

consciousness in an individual (bio-psycho-spiritual = being) that can interact with the environment (behavior = becoming) in a social system (belonging)! Patients understand this and apply it to their life enthusiastically. Professional colleagues are an entirely different kettle of fish...."[244]

- Dr. Raju Hajela, President and Medical Director, Health Upwardly Mobile Inc. in Calgary, Alberta

Responses to Question Three

And last, what avenues or approaches do you see as the best means of advocating for the integration of spiritual care practitioners within addiction treatment environments?

"I think many facilities would engage professionals versed and credentialed in spiritual health, spiritual growth, and spiritual practice if there were such practitioners available. I emphasize *spiritual* to distinguish that from religion, as many patients on entry to treatment are recovering from their religion of origin or are not accepting of religion as significantly related to spirituality. So, religious credentials would not be sufficient alone. (Since I don't know anything about the training requirements for integrated spiritual care professionals, I don't know if areligious spirituality is part of the curriculum)."[245]

- Dr. A. Kenison Roy, III, Associate Professor of Psychiatry and Addiction Medicine and Director of the Division of Addiction Medicine at Tulane University School of Medicine, New Orleans, LA

"In short, stories of success. We can take a page out of our physical health colleagues in terms of the great comfort and the positive outcomes that have resulted from hiring and employing a chaplain. But I also think it would be great if providers within a region could co-employee such roles to address the spiritual needs of our clients."[246]

- James Button, C.E.O. of Citizen Advocates in Saranac Lake, New York

"Advocacy for fully integrated on site spiritual care would require dedicated resources (money) for this purpose. For spiritual care to become mainstream we need data to determine the impact on health and regulations that would recognize and reimburse for this care."[247]

- Anne Constantio, President and C.E.O. of Horizon Health Services, one of the largest providers of mental health and addiction treatment in Western New York

"Education of professionals within facilities (in-service) and changes in professional schools, professional organizations and regulatory bodies to endorse bio-psycho-social-spiritual. In Canada, the College of Family Physicians of Canada and the Canadian Society of Addiction Medicine did that in the 1990s. However, professionals still remain

[244] Raju Hajela, email message to author, October 31, 2021.
[245] A. Kenison Roy, III, email message to author, October 28, 2021
[246] James D. Button, interview by author, Saranac Lake, New York, November 5, 2021.
[247] Anne Constantio, email message to author, November 4, 2021.

hesitant and tentative... The American Society of Addiction Medicine did that in 2011 but then backtracked in 2019!"[248]

- Dr. Raju Hajela, President and Medical Director, Health Upwardly Mobile Inc. in Calgary, Alberta

"Show how effective spiritual only rehab programs are without clinical to make the point, and challenge clinical programs to want that gain… Run a control group in an agency showing the improved outcomes in both improved health status and quality of life [scales] (QOLS) or another measurement tool."[249]

- Jeremy Klemanski, President and C.E.O. of Helio Health in Syracuse, New York

"We must first begin to have more discussions amongst ourselves as providers about the value of spiritual care, secondly providers have to understand what is spiritual care. We as a society tend to fear what we don't understand. This was true with Medically assisted treatment, and harm reduction services, both of which are now accepted integrated practice! Finally, we need to have more data about successful outcomes of people who received either faith-based services or spiritual care services."[250]

- Roy Kearse, Vice President of Recovery Services and Community Partnerships at Samaritan Daytop Village

"Treatment providers should inquire about patients' spiritual concerns during initial admission assessments. Practitioners could develop a needs assessment for integrating spirituality into treatment planning. Ongoing training for cultural competence and sensitivity to diversity should be made available to staff. This includes the development of clear guidelines for such trainings and developing a consensus tailored to the educational needs of staff. On the state level, OASAS could develop a systematic process for providing a competency-based framework for curricula development and program evaluation. Included in such a process would be the creation of a panel of experts to make recommendations tailored to meet the needs of individuals and families seeking treatment. Trainings could focus on knowledge, skill and attitude competencies for incorporating patient-centered spiritual care into treatment. Trainings might include: establishing an inclusive definition of spirituality that includes meaning and purpose; providing a framework of spirituality in person-centered care that includes meaning and purpose, and an appreciation of the diverse spectrum of spiritual beliefs and the influence of those beliefs on patient care; identifying and discussing the roles of resources for spiritual care: ie: clergy, faith-based communities, spiritual practices; etc.); describing potential ethical concerns regarding dis-concordant beliefs and values of patients and providers' providing a basic understanding of the evidence-based literature on spirituality and health; examining potential clinical applications and limitations; identifying spiritually relevant elements and incorporating those in a culturally sensitive, patient-centered way; using patient narratives/stories to gather information regarding spiritual beliefs, values and concerns; summarize and communicate relevant spiritual information

[248] Raju Hajela, email message to author, October 31, 2021.
[249] Jeremy Klemanski, email message to author, November 5, 2021.
[250] Roy Kearse, email message to author, November 4, 2021.

> including patients' spiritual needs and potential resources; demonstrate empathy and attentiveness to patients; identify and enable patients to use self-care strategies; modify treatment plans by incorporating an understanding of the patient's spiritual issues and concerns; include spiritual-care specialists in patient care. Imbedded in trainings should be a nonjudgmental and respectful attitude towards patients, family and other members of the treatment team; an ability to recognize how one's spiritual beliefs and perspectives influence patient interactions and the efficacy of treatment; and an understanding of practices that contribute to maintaining mindfulness and healing intention during care."[251]
>
> - Stephanie Campbell, New York State Behavioral Health Ombudsman Program Director

Concluding Discussion of Next Steps

The above responses from addiction treatment providers and administrators are an insightful and helpful beginning to the needed conversation between spiritual care and addiction treatment. Most of the identified concerns about integrating spiritual care practitioners in addiction treatment environments have been directly addressed within this project, however, this concluding section will highlight two remaining issues identified within the feedback but not directly addressed within this project. And last, this section will discuss the crucial next steps to impel integration.

Within the responses to the questions, there is a common inference to "needing to remain non-sectarian" in order to protect funding streams and a representation of the thought that the "separation of church and state" is required in state-funded treatment. This represents a prevalent misunderstanding of the policies designed to protect the client and a fundamental misunderstanding of the discipline of spiritual care. A few respondents recognize this misinterpretation and rightly identify that such policies are designed to ensure state funded programs do not build program curriculums that require residents to assent to a particular doctrine or faith practice. However, this does not prevent or limit programs or treatment

[251] Stephanie Campbell, email message to author, November 5, 2021.

environments from providing spiritual care that is woven into the treatment plans and tailored within a person-centered approach. This limiting interpretation of the policy needs further review and education to remove the stigma it has created.

Another issue identified by the respondents and not directly addressed within this project is the stumbling block of funding. In a field that generally operates on budgets determined by reimbursable services, spiritual care is not recognized by Medicare/Medicaid or most insurance companies as a direct billable service. This has been a significant block for the integration of spiritual care within the addiction treatment field. However, there is significant movement and change presently happening in the field regarding reimbursement. The shift to value-based payments that are determined by patient outcomes and patient satisfaction is substantially disrupting the strategy and revenue planning of treatment providers. It appears that value-based payments will require treatment programs to practice an intensive awareness of the treatment goals and recovery pathways desired by their clients. The movement to value-based care must be carefully watched and seems to provide a compelling opportunity for the integration of spiritual care practitioners in response to the measurements of patient satisfaction and treatment outcomes.

Also revealed in the comments are several valuable and expert insights for developing the next steps on the pathway toward actualizing the integration of spiritual care practitioners in addiction treatment environments. The following discussion reviews the important next steps for the ongoing advocation of this urgent project.

It seems the most direct pathway to ensuring the integration of a discipline of spiritual care in addiction treatment environments would be for national accrediting bodies like The Joint

Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) to fully recognize and require spiritual care within their standards for programs that provide addiction treatment like they require a discipline of spiritual care within hospital environments. Another option would be for state-related agencies[252] to recognize and include spiritual care within their standards for treatment providers. This top-down pathway is highly unlikely given the political biases and administrative climate of the field. Rather than national accrediting bodies or state certifying bodies being the entry gate, the recognition and inclusion of spiritual care within national or state regulations must be the end goal and will be the evidenced success of the advocation for the integration of spiritual care within the addiction field.

With that in mind, it seems the pathway must begin at the ground level of the lived experience and reality of persons participating in treatment. It is the active stories of recovery and transformation that must lead the way forward. Assessments and data will help tell a person-centered story that the addiction treatment field will listen to. Therefore, it seems the first step forward is to further identify a consensus of the spiritual concerns and desires within initial admission assessments of persons participating in addiction treatment. Data across a collection of treatment providers should be gathered to determine the desire for spiritually focused treatment. Alongside of the initial interest, per and post treatment assessments should measure satisfaction of services and an identification of the specific services provided. It is assumed, yet waiting to be fully evidenced, that the desire for spiritually focused treatment and the subsequent satisfaction regarding provision of treatment will demonstrate a need for integrating spiritual care professionals.

[252] In New York State the Office of Addiction Services and Supports (OASAS) regulates the standards of addiction treatment and their certification and oversight are required to operate as an addiction treatment program within the state.

Simultaneously, identifying and connecting the few actively integrated spiritual care practitioners within the field is urgent. A broader conversation must begin regarding the development of a standardized approach and language for spiritual care across the field. The formation of a group of active spiritual care practitioners would create an advocating platform and a team of experts who can assist in finalizing standards of care for practitioners within addiction treatment environments and help design and complete subsequent research projects specific to the delivery of spiritual care and outcomes of treatment. Identifying programs with actively integrated spiritual care practitioners would also allow for measurement of satisfaction outcomes between programs with and without an embodied professional practitioner of spiritual care.

A second step in the pathway toward the integration of spiritual care practitioners in addiction treatment environments is the development of an endorsement process or a certification of spiritual care specific to addiction treatment. There are several groups or associations that could be helpful in this regard. The peer movement of recovery could adopt a certification alongside its certified peer recovery advocates. Professional chaplaincy could include a CPE unit specializing in providing care within addiction treatment environments. And even spiritual direction certification programs could partner with addiction treatment provider agencies to provide specialized practice and certification. The development of an endorsement or certification process is vital in the pathway toward full integration.

A third step is the participation of addiction treatment providers and administrative individuals who hold the responsibility to ensure the residents in their care receive ethical and effective person-centered care. Providers are the key advocates within addiction treatment. Providers can specifically ask their clients about their spirituality and faith treatment goals and

subsequently examine if their current programs and personnel are providing effective and professional spiritual care. If not, providers can engage a qualified spiritual care practitioner who can provide the necessary care. It is not only the clients who will benefit from this provision of care. With the ongoing discussion and development of value-based payments, providers may also benefit their financial bottom lines with the increase of patient satisfaction, improved reputation with clients, and treatment outcomes. This, of course, also requires the identification of a pool of qualified practitioners who are experienced and qualified for providers to engage. Such a pool of spiritual care practitioners is already present within the rapidly growing fields of spiritual direction and professional chaplaincy, yet it is up to providers to use the provided information and language within this project to begin seeking qualified practitioners.

The above outlined approach and the transformative proposal of this dissertation regarding how spirituality and faith are at work upon and within persons is intended to help clarify a new way of imagining spiritual care and thus impel addiction treatment providers toward the action of integrating spiritual care practitioners in their respective treatment environments. The lived experience and the active seeking of persons within the care of addiction treatment necessitates a response.

Bibliography

"About ACPE." *ACPE: The Standard for Spiritual Care & Education*. Accessed November 14, 2021. https://acpe.edu/about-acpe.

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism. 4th ed. New York, NY: Alcoholics Anonymous World Services, 2001.

"American Society of Addiction Medicine Releases New Definition of Addiction to Advance Greater Understanding of the Complex, Chronic Disease." *American Society of Addiction Medicine*. October 22, 2019. https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512_4

Andersen, Ditte. "Stories of Change in Drug Treatment: A Narrative Analysis of 'Whats' and 'Hows' in Institutional Storytelling." *Sociology of Health & Illness* 37, no. 5 (June 2015): 668–682.

Arnold, Ruth M., S. Kelly Avants, Arthur Margolin, and David Marcotte. "Patient Attitudes Concerning the Inclusion of Spirituality into Addiction Treatment." *Journal of Substance Abuse Treatment* 23, no. 4 (2002): 319-326. https://www.sciencedirect.com/science/article/abs/pii/S0740547202002829.

Barry, William A. *Spiritual Direction and the Encounter with God: A Theological Inquiry*. rev. ed. Mahwah, NJ: Paulist Press, 2004.

Barry, William A., and William J. Connolly. *The Practice of Spiritual Direction*. rev. ed. New York, NY: HarperOne, 2009.

Best, David, Melinda Beckwith, Catherine Haslam, S. Alexander Haslam, Jolanda Jetten, Emily Mawson, and Dan I. Lubman. "Overcoming Alcohol and Other Drug Addiction as a Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR)." *Addiction Research & Theory* 24, no. 2 (March 3, 2016): 111–123.

Cashdan, Sheldon. *Object Relations Therapy: Using the Relationship*. 1st ed. New York, NY: Norton, 1988.

Cook, Christopher C. H. "Addiction and Spirituality." *Addiction* 99, no. 5 (May 2004): 539–551.

Cotter, Wendy. *Miracles in Greco-Roman Antiquity: A Sourcebook for the Study of New Testament Miracle Stories*. New York, NY: Routledge, 2012.

Dahl, Silje Louise. "Remaining a User While Cutting Down: The Relationship between Cannabis Use and Identity." *Drugs: Education, Prevention and Policy* 22, no. 3 (May 4, 2015): 175–184.

DiClemente, Carlo C. *Addiction and Change: How Addictions Develop and Addicted People Recover*. New York, NY: Guilford Press, 2003.

Doehring, Carrie. *The Practice of Pastoral Care: A Postmodern Approach*. rev. ed. Louisville, KY: Westminster John Knox Press, 2015.

Dow, Keith. *Formed Together: Mystery, Narrative, and Virtue in Christian Caregiving*. Waco, TX: Baylor University, 2021.

Dufault-Hunter, Erin Elizabeth. *The Transformative Power of Faith: A Narrative Approach to Conversion*. Lanham, MD: Lexington Books, 2012.

Dyckman, Katherine Marie, and L. Patrick Carroll. *Inviting the Mystic, Supporting the Prophet: An Introduction to Spiritual Direction*. New York, NY: Paulist Press, 1981.

Ellor, James W., F. Ellen Netting, and Jane M. Thibault. *Understanding Religious and Spiritual Aspects of Human Service Practice*. Columbia, SC: University of South Carolina, 1999.

Etherington, Kim. "Understanding Drug Misuse and Changing Identities: A Life Story Approach." *Drugs: Education, Prevention and Policy* 13, no. 3 (January 2006): 233–245.

Fletcher, Jean, ed. *Chaplaincy and Spiritual Care in Mental Health Settings*. Philadelphia, PA: Jessica Kingsley Publishers, 2019.

Fromm, Erich. *The Art of Being*. London: Constable, 2007.

Galanter, Marc. "Spirituality and Addiction: A Research and Clinical Perspective." *American Journal on Addictions* 15, no. 4 (January 2006): 286–292.

Ganje-Fling, Marilyn A., and Patricia R. McCarthy. "A Comparative Analysis of Spiritual Direction and Psychotherapy." *Journal of Psychology and Theology* 19, no. 1 (March 1991): 103–116.

Gedge, Elisabeth, and Deirdre Querney. "The Silent Dimension: Speaking of Spirituality in Addictions Treatment." *Journal of Social Work Values and Ethics* 11, no. 2 (Fall 2014): 41–51.

Grim, Brian J., and Melissa E. Grim. "Belief, Behavior, and Belonging: How Faith Is Indispensable in Preventing and Recovering from Substance Abuse." *Journal of Religion and Health* 58, no. 5 (July 2019): 1713–1750.

Guenther, Margaret. *Holy Listening: The Art of Spiritual Direction*. Cambridge, MA: Cowley Publications, 1992.

"Guidelines for Ethical Conduct." rev. ed. *Spiritual Directors International*. Accessed November 15, 2021. https://www.sdicompanions.org/docs/guidelines/Flip/guidelines_ethical_conduct.html.

Hamilton, N. Gregory. *Self and Others: Object Relations Theory in Practice*. Northvale, NJ: Aronson, 1988.

Harborne, Lynette. *Psychotherapy and Spiritual Direction: Two Languages, One Voice?* London: Karnac, 2012.

"Hashpa'ah: Training Program for Jewish Spiritual Directors." *Aleph Ordination Program.* Accessed October 25, 2021. https://aleph.org/aop/hashpaah-training-program-for-jewish-spiritual-directors/.

Heinz, Adrienne J., Elizabeth R. Disney, David H. Epstein, Louise A. Glezen, Pamela I. Clark, and Kenzie L. Preston. "A Focus-Group Study on Spirituality and Substance-User Treatment." *Substance Use & Misuse* 45, no. 1–2 (January 2010): 134–153.

Herman, Judith Lewis. *Trauma and Recovery: The Aftermath of Violence —From Domestic Abuse to Political Terror*. New York, NY: BasicBooks, 2015.

"Historical Data: The Birth of A.A. and Its Growth in the U.S./Canada." *Alcoholics Anonymous.* Accessed October 14, 2021. https://www.aa.org/pages/en_us/historical-data-the-birth-of-aa-and-its-growth-in-the-uscanada.

Hodge, D. R. "Alcohol Treatment and Cognitive-Behavioral Therapy: Enhancing Effectiveness by Incorporating Spirituality and Religion." *Social Work* 56, no. 1 (January 1, 2011): 21–31.

"The Impact of Professional Spiritual Care." ACPE, et al. Accessed November 15, 2021. https://www.professionalchaplains.org/Files/resources/The%20Impact%20of%20Professional%20Spiritual%20Care_PDF.pdf.

Janoff-Bulman, Ronnie. *Shattered Assumptions: Towards a New Psychology of Trauma*. New York, NY: Maxwell Macmillan International, 1992.

Johansen, Ayna B., Håvar Brendryen, Farnad J. Darnell, and Dag K. Wennesland. "Practical Support Aids Addiction Recovery: The Positive Identity Model of Change." *BMC Psychiatry* 13, no. 1 (December 2013): 201.

Jones, Serene. *Trauma and Grace: Theology in a Ruptured World*. Louisville, KY: Westminster John Knox Press, 2009.

Kearney, Richard. *Strangers, Gods, and Monsters: Interpreting Otherness*. New York, NY: Routledge, 2003.

Kelly, Ewan, and John Swinton, eds. *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care*. Philadelphia, PA: Jessica Kingsley Publishers, 2020.

Lewis, Marc D. *The Biology of Desire: Why Addiction Is Not a Disease*. 1st ed. New York, NY: PublicAffairs, 2015.

Lucchetti, Giancarlo, and Alessandra Lamas Granero Lucchetti. "Spirituality, Religion, and Health: Over the Last 15 Years of Field Research (1999–2013)." *The International Journal of Psychiatry in Medicine* 48, no. 3 (October 2014): 199–215.

Luhrmann, T. M. *How God Becomes Real: Kindling the Presence of Invisible Others*. Princeton, NJ: Princeton University, 2020.

Luhrmann, Tanya Marie. “About the Author: An Anthropologist Studying the Mind.” *Tanya Luhrmann*. Accessed October 24, 2021. https://www.tanyaluhrmann.com/about.

Marx, Christopher, Cord Benecke, and Antje Gumz. “Talking Cure Models: A Framework of Analysis.” *Frontiers in Psychology* 8 (September 13, 2017): 1589.

May, Gerald G. *Addiction and Grace: Love and Spirituality in the Healing of Addictions*. New York, NY: Harper, 1991.

May, Gerald G. *Simply Sane: The Spirituality of Mental Health*. rev. ed. New York, NY: Crossroad, 1993.

McClure, Barbara J. *Moving Beyond Individualism in Pastoral Care and Counseling: Reflections on Theory, Theology, and Practice*. Eugene, OR: Cascade Books, 2010.

McKeganey, James, and Neil McIntosh. “Identity and Recovery from Dependent Drug Use: The Addict’s Perspective.” *Drugs: Education, Prevention and Policy* 8, no. 1 (January 2001): 47–59.

Mearns D., and Thorne B.. *Person-Centered Approach to Therapeutic Change* (London: Sage Publications, 2000), 217.

Meissner, Christopher. “Prayer or Prison: The Unconstitutionality of Mandatory Faith-Based Substance Abuse Treatment,” *Cleveland State Law Review* 54 (no. 4): 671.

Mee-Lee, David and American Society of Addiction Medicine, eds. *The ASAM Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions*, Third edition. Chevy Chase, MD: American Society of Addiction Medicine, 2013.

Miller, William R., ed. *Integrating Spirituality into Treatment: Resources for Practitioners*. 1st ed. Washington, DC: American Psychological Association, 1999.

Miller, William R., and Kathleen Carroll, eds. *Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It*. New York, NY: Guilford Press, 2006.

Miller, William R., Alyssa Forcehimes, Mary O’Leary, and Marnie D. LaNoue. “Spiritual Direction in Addiction Treatment: Two Clinical Trials.” *National Institutes of Health*. December 2008. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600849/pdf/nihms77787.pdf.

Murphy, David, and Stephen Joseph, eds. *Trauma and the Therapeutic Relationship: Approaches to Process and Practice*. Basingstoke, England: Palgrave Macmillan, 2013.

“Murshid.” *Lexico.* Accessed October 26, 2021. https://www.lexico.com/en/definition/murshid.

Myers, Ched. *Binding the Strong Man: A Political Reading of Mark’s Story of Jesus*. Maryknoll, NY: Orbis Books, 1988.

Nouwen, Henri J. M., Michael J. Christensen, and Rebecca Laird. *Spiritual Direction: Wisdom for the Long Walk of Faith*. 1st ed. San Francisco, CA: Harper San Francisco, 2006.

O'Donohue, John. *Anam Ċara: A Book of Celtic Wisdom*. New York, NY: Harper Perennial, 2004.

Pargament, Kenneth I. *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*. New York, NY: Guilford Press, 2007.

"Portrait of a Spiritual Director." *Presence: An International Journal of Spiritual Direction* 24, no. 4 (December 2018): 40–41.

"Public Policy Statement: Definition of Addiction." *American Society of Addiction Medicine*. Accessed October 25, 2021. https://www.asam.org//docs/default-source/public-policy-statements/1definition_of_addiction_long_4-11.pdf?sfvrsn=a8f64512_4.

Reith, Gerda, and Fiona Dobbie. "Lost in the Game: Narratives of Addiction and Identity in Recovery from Problem Gambling." *Addiction Research & Theory* 20, no. 6 (December 2012): 511–521.

Ricœur, Paul. *Memory, History, Forgetting*. Chicago, IL: University of Chicago, 2004.

Ricœur, Paul, and Kathleen Blamey. *Oneself as Another*. Chicago, IL: University of Chicago, 2008.

Ricœur, Paul, and Mark I. Wallace. *Figuring the Sacred: Religion, Narrative, and Imagination*. Minneapolis, MN: Fortress Press, 1995.

Roberts, Nicholas. *Addiction and Pastoral Care*. London: Canterbury Press Norwich, 2018.

Roberts, Stephen, ed. *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook*. Woodstock, VT: SkyLight Paths, 2012.

Rohr, Richard. *Immortal Diamond: The Search for Our True Self*. 1st ed. San Francisco, CA: Jossey-Bass, 2013.

Root, Andrew. *The Pastor in a Secular Age: Ministry to People Who No Longer Need a God*. Grand Rapids, MI: Baker Publishing Group, 2019.

Scarry, Elaine. *The Body in Pain: The Making and Unmaking of the World*. New York, NY: Oxford University Press, 1987.

Schafer, Roy. *Retelling a Life: Narration and Dialogue in Psychoanalysis*. New York, NY: BasicBooks, 1992.

"SDI: The Home of Spiritual Direction and Spiritual Companionship." Accessed October 25, 2021. https://www.sdicompanions.org/.

Sheldrake, Philip. "Constructing Spirituality." *Religion & Theology* 23, no. 1–2 (2016): 15–34.

"Significant Events in the History of Addiction Treatment and Recovery in America." *William White Papers*. Accessed October 25, 2021. http://www.williamwhitepapers.com//pr/AddictionTreatment&RecoveryInAmerica.pdf.

Solomon, Anne. "Describing Spiritual Direction." *Spiritual-Life*. Last modified March 20, 2015. Accessed October 25, 2021. https://www.spiritual-life.co.uk/single-post/2017/04/18/describing-spiritual-direction.

St. Joseph's Addiction Treatment & Recovery Centers, Inc., *Assessment/Test - STJ BPS Test 1*, September 18, 2021.

"Standards of Practice for Professional Chaplains," *Association of Professional Chaplains*, October 22, 2015, 1-2, https://www.professionalchaplains.org/Files/professional_standards/standards_of_practice/Standards_of_Practice_for_Professional_Chaplains_102215.pdf.

Sussman, Steve, Joel Milam, Thalida E. Arpawong, Jennifer Tsai, David S. Black, and Thomas A. Wills. "Spirituality in Addictions Treatment: Wisdom to Know…What It Is." *Substance Use & Misuse* 48, no. 12 (October 15, 2013): 1203–1217.

Szalavitz, Maia. *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*. 1st ed. New York, NY: St. Martin's Press, 2016.

"Traumatic Stress and Substance Abuse Problems," *International Society for Traumatic Stress*, Accessed October 31, 2021. https://istss.org/ISTSS_Main/media/Documents/ISTSS_TraumaStressandSubstanceAbuseProb_English_FNL.pdf.

Van der Kolk, Bessel A. *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. New York, NY: Penguin Books, 2015.

Van Huyssteen, J. Wentzel. *Alone in the World?: Human Uniqueness in Science and Theology*. Grand Rapids, MI: William B. Eerdmans, 2006.

Vest, Norvene, ed. *Still Listening: New Horizons in Spiritual Direction*. Harrisburg, PA: Morehouse, 2000.

Wagner, Nick, ed. *Spiritual Direction in Context*. Harrisburg, PA: Morehouse, 2006.

Waters, Sonia E. *Addiction and Pastoral Care*. Grand Rapids, MI: Eerdmans Publishing, 2019.

"What Does Spirituality Mean To Us?: A Study of Spirituality in the United States." *Fetzer Institute*. Accessed October 26, 2021. https://spiritualitystudy.fetzer.org/sites/default/files/2020-09/What-Does-Spirituality-Mean-To-Us_%20A-Study-of-Spirituality-in-the-United-States.pdf.

White, William L. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. 2nd ed. Chicago, IL: Chestnut Health Systems, 2014.

White, William L. "Spiritual Guidance, Addiction Treatment, and Long-Term Recovery." *Journal of Substance Abuse Treatment* 35, no. 4 (December 2008): 443.

White, William, and David Whiters. "Faith-Based Recovery: It's Historical Roots." *Counselor* 6, no. 5 (2005): 58–62.

Wilson, Louise. "The Impact of Power Dynamics When Counselling Clients with Problematic Substance Use," *Psychotherapy and Politics International* 19, no. 2 (June 2021): 2, https://onlinelibrary.wiley.com/doi/10.1002/ppi.1572.