Guest House Institute
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What are they saying about trauma and addiction??

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Abstract

Following an extended case study, this essay lays out what is known regarding prevalence, co-occurrence, characteristics, and common dynamics of trauma and recovery. It examines new information regarding adverse childhood experiences and the multiple impacts of trauma on individuals and families. It explores the psychological formula of substance use as "self-medication," and then makes several recommendations for those involved with human and spiritual formation.

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I. An Extended Case & Discussion

Fr. Joe was a disaster waiting to happen. Although he brought impressive qualities and skills to the practice of ministry – a gift for contemplative prayer, commitment to service, a natural sense of compassion, intelligence, and qualities of leadership – he also had hidden vulnerabilities.

Born into a family stressed by marital discord and his mother's mental illness, he carried the scars of maternal neglect and a need for closeness and attachment into adulthood. In addition this wounded minister experienced a life-threatening accident at 9 years old, requiring a long recuperation in the care of others away from his family and providing a myth of surviving for a special purpose. His vocation to priesthood was formed in this crucible of emotional abandonment, trauma and special purpose.

Fr. Joe's parents came from difficult circumstances. His father was a passive and not-very-ambitious man, raised in a family where anger and undertones of violence were pervasive. His mother's depression emerged within an Irish alcoholic family where instability and fear held sway. All the men in her family succumbed to alcoholism. Having a priest in the family was important for the family's sense of dignity and played into the myth of Joe's special purpose for all concerned.

The case of Father Joe* introduces us in short order to the very human aspects of a vocation to ministry. The call to priesthood or religious life comes to very human people, often living in troubled social and familial circumstances. As we all know, the power of the Holy Spirit works with candidates and ministers in the "messiness" of their lives. St. Paul says, "we have this treasure in earthen vessels" (2 Cor 4.7). This is God's way with us, whether it involves a vocation to religious life, priesthood, and ministry or the universal call to holiness of all the faithful.

Fr. Joe's case has distinctive aspects (for example, marital stress, mental illness, alcoholism, parental neglect, a traumatic accident) that add specific dimensions for consideration. However, one or another of these elements can also be part of the presentation of many candidates for formation and describe the backgrounds of many religious, ministers and even church leadership. Vocations are not incubated in a vacuum. Persons often come to formation and ministry with significant personal vulnerabilities.

* "Father Joe" is a compilation of several clergy clients seen for counseling over the years by the first author. Names and information have been disguised to protect confidentiality.

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Even formation for the priesthood must face up to the manifold symptoms of the imbalance rooted in the heart of man, which is symptomized [sic] in a particular way in the contradictions between the ideal of self-giving to which the candidate consciously aspires and the life he actually leads. Formation must also deal with the difficulties inherent in the gradual development of the moral virtues….

The help of the spiritual director and confessor is fundamental and absolutely necessary for overcoming the difficulties with the grace of God. In some cases, however, the development of these moral qualities can be blocked by certain psychological wounds of the past that have not yet been resolved.

… Among the candidates can be found some who come from particular experiences – human, family, professional, intellectual or affective – which in various ways have left psychological wounds that are not yet healed and that cause disturbances.

Guidelines for the use of psychology in the admission and formation of candidates for the priesthood *(Rome, June 2008).*

"… contradictions between the ideal of self-giving to which the candidate *consciously aspires* and the life he *actually leads*" (*italics* ours). This article will address the contributions of certain vulnerabilities to processes of religious and priestly formation as well as overall human development. It will examine the challenges of "special needs" that candidates bring to formation today. In particular we will explore what is known about addiction and trauma, and we will make some recommendations for ongoing human and spiritual development.

Through a series of initial interviews Fr. Joe's story unfolded for the counselor and the reasons for seeking therapy became apparent.

All through the time of priestly formation, Fr. Joe led a double life. Bright and creative, he excelled in his studies and his spiritual directors were pleased with his progress in prayer and understanding of the pastoral life. He was a self-starter in pursuing opportunities for ministry. He wore the public role of future priest quite well.

He was plagued, however, by hidden needs for closeness, self-soothing, and intimacy. These needs became intense when coupled with drinking, which quickly escalated into early chemical abuse and subsequent addiction. Throughout his seminary training and early priesthood, he also had a series of

sexual relationships that gnawed at his conscience. Each time he had a "fall from grace" (as he experienced it), he would bring it to prayer and confession. Each time he would resolve to do better, especially in the face of his desire for priesthood.

At one point he revealed a particularly long and ongoing sexual relationship to his spiritual director and formation director. They spoke to him about frailty, about God's forgiveness and power for transformation, about fidelity. They never explored to see if there was a ***pattern*** *of such behavior, and they never again raised this "mistake" in subsequent interviews. Formation continued as before.*

Joe wanted to be a priest and was relieved that he could continue in formation. He resolved to do better… yet again. He did not, however, connect the dots and see the presence of a behavioral and emotional pattern. This occurred early in a 20-year history of formation and ministry over which time he had more than 20 sexual relationships.

From an addiction counseling point of view this story is familiar. Here is a person who functions quite well in the external world. His talents and gifts match the career path he has chosen.

His family environment trained this bright young man to be generous and open to God's call. However, in counseling it often seemed as though he had been "selected" to be the one to bring respect and dignity to his family; selected by more than the Holy Spirit. He was sensitive to the needs of others, having learned responsiveness to the pain, and fear, and stresses of others around him, particularly in his family. Growing up with mental illness, marital discord, and (second-generation) alcoholic family dynamics often predisposes children to develop empathic attunement to the feelings and needs of others and a style of caretaking that accompanies them into adulthood.† Fr. Joe brought these qualities to ministry.

Persons in this situation often bring a lack of clear boundaries and hidden needs into adulthood as well. Having learned to function and survive in emotional chaos, they can often be unclear about whose feelings they are experiencing, about whose needs are being addressed. And, they are often unpracticed at caring for themselves in a balanced way. They come to adulthood with severe deficits in self-care and self-worth.

† Many of these characteristics have been labeled as "codependency" in the addiction literature.

Not infrequently, they will enter a cycle of expending energy to appear "good" and will perform above-and-beyond. They will "binge" on caring for others and contributing to worthy projects, only to collapse later, emotionally spent and exhausted. This cycle often sets the stage for a different kind of behavior, an alternating and darker cycle. The person seeks relaxation or replenishment through hidden satisfactions such as alcohol or drug abuse, sexual intimacy, cybersex, pornography, overeating. In some persons the darker cycle will be characterized by pursuit of power or authority, wealth, or fame as antidotes to, or rewards for, over-functioning.‡ Over-functioning and addiction often "serve as powerful antidotes to the inner sense of emptiness, disharmony, and dis-ease such people experience" (Khantzian, 1999, p. 223). These excesses bolster a sense of self-worth and competence.

"Impaired ministers" such as Fr. Joe, who struggle with alcoholism and drug addiction, sexual and other compulsions (e.g. gambling, overeating), often lead a double life of compulsion and active addiction on the one hand and over-functioning in ministry on the other. Many formerly impaired ministers in recovery acknowledge that a variety of sexual issues and compulsions accompanied their decline into abuse and addiction.

The increasing isolation and shame that are associated with this double-life of alternating cycles compound the need to seek relief. In very powerful ways the use of alcohol, other drugs, and compulsive processes as well as a kind of brittle driven-ness and over-functioning help internally to ameliorate the impact of the negative effects of isolation and shame. They provide needed relief and the illusion of meaningful contributions. These cycles reinforce and mutually intensify each other. They delay recognition of the need to seek help. How, after all, can one have a problem if he or she is doing such good work?

Compulsion, isolation, shame, illusion. These are the engines that drive a double-life, and they are NOT easy to acknowledge or confront. Impaired clergy and religious are even less inclined to be honest about their difficulties than most troubled and addicted persons. In the first place, they themselves are largely unaware of the full

‡ Spiritual Directors will recognize these satisfactions as classic "inordinate attachments," enemies of spiritual growth and development.

extent of the problem. This is called "denial," and in the case of impaired religious, repression. Partly because of their role and symbolic presence in the Church and society, partly because of the Catholic community's fair and unfair expectations of them, and of course partly because of their expectations of themselves, impaired clergy and religious carry a special stigma and shame about their condition over and above what a normal person struggling with addiction or compulsion might experience (Grant, 1994-1995; 2008b). They learn particularly ingenious and automatic defensive strategies.

Hiding their pain becomes second nature; they even hide it from themselves. They collude with their social and cultural, even religious milieu in denying their own broken humanity. Few places are more isolating today than being on a pedestal. The religious culture fosters an idealization of ministers. Their "humanity" becomes increasingly hidden, not just by their formal pastoral roles but also by a web of fear, unfulfilled expectations, secret activities, and toxic shame.

As their condition in active addiction and accompanying compulsions worsens, it is characterized by what has been called an insidious and progressive "awful bondage of ethical deterioration" about which they are only dimly aware (Fichter, 1982, p. 133) and a "general disintegration of the personality" (Ford, 1949, p. 16). This is part of the spiritual decline that characterizes active addiction. They feel themselves to be "peculiarly deviant" and believe that there is no way out (Fichter, 1982). Not for them.

Their defensiveness and secretiveness, then, about their condition is understandable. Perhaps their condition is even more understandable in the context of a perceived non-acceptance (some might say "zero-tolerance") of frailty and wounded humanity within the Church itself, especially after the clergy and leadership misconduct matter of recent years. To whom could they talk and open up the pain and shame in their lives? They are not likely to come forward easily to seek help and recovery. They understand that we in the Church rhapsodize about "wounded healers" but we don't really want to know the details or effects of their wounds. In the current situation those who are "wounded" are more likely to be disciplined or excluded from ministry than helped and forgiven.

Often, such a person is able to maintain alternating cycles even though others may guess at their presence. In clergy as well as in men and women religious, these dysfunctional patterns are often allowed to progress over a number of years, and interestingly for a number of years longer than for other professional women and men. Colleagues and superiors know about the problem and live with the problem for a period of anywhere from 7 to 12 years before effectively confronting and dealing with it (Center for Applied Research in the Apostolate, or CARA, 1995).

The Church as a system – whether due to fear or ignorance, apathy or indifference, or even a subtle moralism – behaves like an alcoholic family system, accommodating to its "problem children" for far too long and helping to create an atmosphere where addiction can continue and grow (Grant, 1994-1995; 2008b). And yet, the Church also fosters within clerical ranks a fear to acknowledge one's own humanity and a reluctance to be honest, either with oneself or with authorities. This creates another vicious cycle of secretiveness, shame, and efforts to control addictions and accompanying compulsions without really seeking to overthrow them.

Unfortunately, between the time when the effects of the disease are noticed and effective action is taken – namely, during that last 7 to 12 year hiatus of active addiction and compulsion – the impaired religious, deacon, or clergy-person becomes more deeply mired in physical, emotional, sexual, and sometimes legal and health problems. Impaired ministers become distorted versions of themselves. These are the most destructive years of the double-life, damaging to the individual to be sure, but also to others whose lives she or he touches, and to the Church as a whole.

> *Following his mother's death, Fr. Joe experienced a number of embarrassing and blatantly negative events involving alcohol and sexual compulsion. Something "broke through his denial," as he explained it in counseling, and he had sought help for addiction to alcohol. This began a long and slow process of increasing honesty with himself and a gradual distaste for any kind of a double-life. Recovery gradually took hold and he experienced a spiritual renewal that he never thought possible.*
>
> *It did not, however, bring an immediate end to his deep-seated attachment and intimacy needs, and thus his sexual compulsions continued. This was the cause of his seeking professional counseling.*
>
> *Fr. Joe had been in a solid recovery through A.A. for ten years. He was a respected pastor, both in church settings and within the recovering community.*

He was being considered by his local church leadership for a job in human and spiritual formation, but knew that something was wrong. He came to therapy with the goal of sorting out his vocation and coming to some conclusions about whether to stay in ministry or leave the priesthood.

Within the counseling process, Fr. Joe began to explore issues of personal brokenness (alcoholism, sexual compulsions, anxiety), family history, and his own needs for intimacy and closeness. In the counseling setting, he was able to see and acknowledge the patterns that were the core of his double life. He came to understand his own experiences with trauma and the "hidden engines" of his addictions and compulsions.

While Fr. Joe understood his life-threatening accident to be a traumatic event for himself and for his family, he did not appreciate fully the extent of his trauma story. In coming to grips with (a) early and ongoing experiences of loss and abandonment due to his mother's mental illness, with (b) the chronic fear and embarrassment that accompanied his parents' marital discord, with (c) the lack of trust and safety that characterized family relations due to alcoholic system dynamics, and (d) the obvious trauma of his "accident" and subsequent survivorship, Fr. Joe came to a deeper appreciation of the multiple traumas that formed the background of his needs, desires, and vulnerabilities.

He came to understand and re-write his personal story from one of simple "survivorship for a special purpose" to a more nuanced claiming of multiple and intersecting traumas ("compound fractures") that created a set of psychological and affective vulnerabilities that had shaped his life. Comprehension – and with it freedom – began to dawn that a choice for full-time ministry, along with a hierarchically organized and authority-based community, characterized by celibacy and clerical privilege might not be a good lifestyle "fit" for him any more, given his vulnerabilities. This lifestyle had served a purpose earlier in his life, providing community, spirituality and a sense of meaning and devotion. With a deepened sense of his needs and gifts, however, Joe experienced a different call. He moved closer to a decision to leave priesthood and pursue intimacy in more honest and fulfilling ways.

Perhaps it needs to be said up-front that there is a distinction in clinical and ethical thinking between *explanation* and *exoneration*. Understanding the deeper realities of one's life (explanation) does not necessarily lead to condoning or approving of any particular actions or destructive choices (exoneration). Persons struggling with addictions and the aftereffects of trauma are not exempt from the challenges of ethical living, and they can and should be held accountable for poor choices. However, compassionate understanding can help us all to appreciate fully the

background of those choices and the multiple challenges people face. It can help us to temper our judgments with true compassion and empathy.

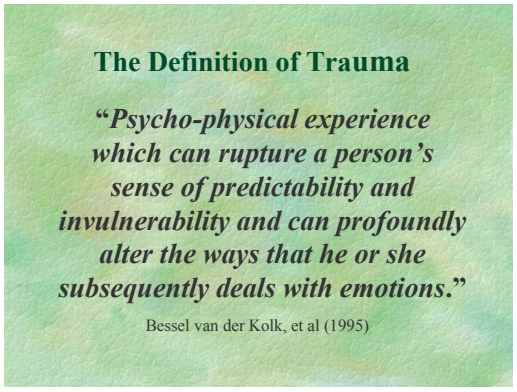
In what follows we address the multiple traumas that shaped so much of Fr. Joe's life. We define and describe traumatic wounds, using the currently accepted and broadened viewpoint of modern human science. We describe the potentially long-lasting aftereffects of trauma in people's lives.

Next we turn our attention to a particularly helpful way to understand the addiction process. We will look at the current knowledge-base suggesting the intimate linkages between trauma and addiction. Abuse and addiction can serve as a way to "medicate" psychic and emotional pain and to distract from current difficulties as well as from deeper insight into the problem. That is, addiction can serve as a *solution* (temporary, even destructive) to human suffering.

Finally we will make some cautious recommendations for those who work in human and spiritual formation of priests as well as women and men religious.

II. What Do We Mean By Trauma?

Trauma has been described as a "*…psycho-physical experience which can rupture a person's sense of predictability and invulnerability and can profoundly alter the ways that he or she subsequently deals with emotions*" (van der Kolk, et al. 1995). For the victim who has been traumatized, it is like "*time stops at the moment of* [the] *trauma…* [as] *the child becomes fixated or developmentally arrested at the age at which the trauma occurred and even as an adult is stuck in a time warp of childlike helplessness*"(Herman, 1992).



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Trauma has been recognized as a psychological disorder since the early 1980's. It is defined by the American Psychiatric Association (APA, 2000), as "…*an event or event(s) that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others.*" Many events in people's lives can qualify as a traumatic experience such as combat, a natural disaster, life-threatening illness, physical or sexual abuse (child or adult), rape, terrorist attacks; these are only a few examples. Since the 1980s we have come to understand just how pervasive these experiences are in people's lives worldwide (Hien, 2004).

Most persons (!) in the United States experience some form of trauma with lifetime prevalence approaching 60% for men and 50% for women (Breslau, 2009; Najavits, 2007).§ It is estimated that 20% to 30% of those who experience trauma develop the full clinical picture of PTSD symptoms (listed below) following the event (Najavits, 2007). Many other people, however, are known to suffer from a variety of sub-clinical symptoms. The exact number of those experiencing less severe yet challenging symptoms is unknown.

Posttraumatic Stress Disorder or PTSD is a clinical syndrome or group of symptoms that can result from traumatic experiences. PTSD is characterized by clusters of symptoms that include: (a) ***re-experiencing*** of the trauma through nightmares, flashbacks, or disturbing thoughts and images; (b) the ***avoidance*** of any reminders of the trauma through *dissociation* or *numbing* behaviors; and, (c) ***hyper-arousal*** or increased and excessive anxiety related to exposure to any actual or perceived reminders of the trauma.

Clusters of Symptoms

re-experiencing	*avoidance*	*hyperarousal*
nightmares, flashbacks	isolation dissociation	emotional sensitivity
disturbing images, memories	loss of energy, interests	easily irritated, angered
paranoia	hopelessness	impulsivity
viewing self as *victim*	tension reduction behaviors	poor concentration
sense of inadequacy	substance abuse, cutting, eating	somatic disturbances

§ A 1998 study using APA criteria found the actual exposure to a qualifying trauma event to be closer to **89%** (Ouimette & Brown, 2003).

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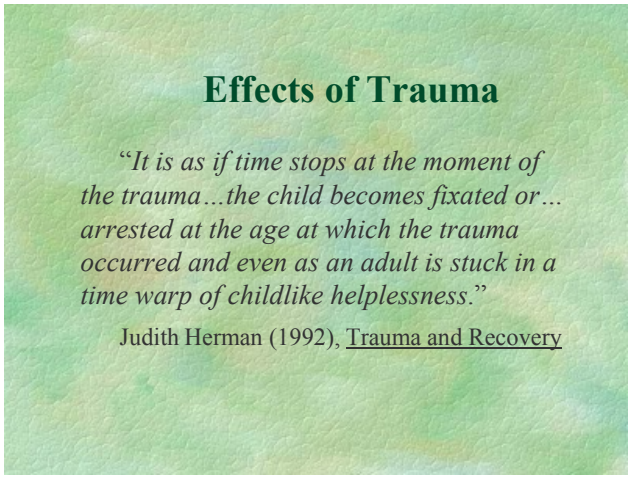
The effects of trauma are influenced by several variables. Among these include the age of the victim at the time of the trauma and the nature and length of the trauma. Also affecting the outcome is the response and support received from loved ones. Finally, other developmental issues that were occurring prior to or at the time of the trauma can have a profound impact on the victim and his/her ability - or inability - to resolve the effects. The long-term effects of *unresolved* trauma can influence the victim's sense oneself and one's future, relationships with others, approach towards actual or perceived stressors, and personal spirituality.

Trauma can be classified into two different and distinct categories or types. *Simple trauma*, which is most commonly recognized, is related to a single event caused by accidents or other natural causes and usually experienced by someone during their adulthood. The survivor is usually provided with appropriate and sufficient validation and support. *Complex trauma* occurs repetitively over an extended period of time (usually during childhood) and is related to deliberate acts that are committed by others, often someone close to the victim, at a vulnerable time during the victim's life. Denial and secrecy are the usual responses by those closest to the victim.



Adverse Childhood Experiences (ACE)

Speaking of variables, such as age and developmental level, which can moderate or exacerbate how an individual copes with traumatic experiences, reminds us of

common trauma experiences that can impact religious and priestly formation. Many *formators* tell us that time and again they see the impact of early experiences on candidates and young priests/religious, but don't fully understand the impact of these experiences or how to deal with them.

New research can help to shed some light.** Published by the Centers for Disease Control and Prevention under the title of "adverse childhood experiences,"†† this research is helping us to unravel the complex and intertwined effects, short-term and long-term, as well as the connections and potential pathways of trauma. *Adverse childhood experiences* (ACEs) are understood to be trauma exposures that constitute a frequent and "common pathway" to "social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality as people age and develop" (Anda, 2008, p. 3). ACEs are understood to be the "hidden engine" underneath many of the Nation's leading health and social problems. They may also help to "drive" many of the problems that are seen in religious and clergy formation.

The ACE studies broaden our understanding of traumatic experiences. The CDC assessed the prevalence and impact of 10 categories of traumatic childhood experiences and cross-referenced them with a variety of later health and social consequences (Anda, 2008).

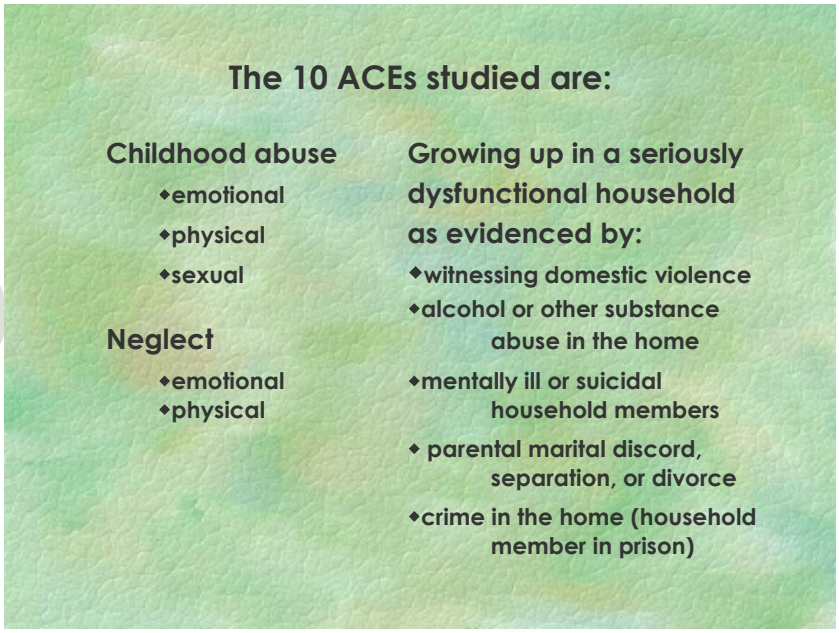
Their findings confirm that risks for trauma experiences are neither evenly nor randomly distributed over the population, but rather tend to occur in clusters, that is, those who experience trauma tend to experience more than one kind and in fact receive multiple "doses." For example, 81% of those who grew up with household substance abuse reported at least one (and often more) additional ACEs (Anda, 2008). The relevant childhood stressors are interrelated, often co-occurring in the same homes and increasing the "dose" of trauma to family members.

** Reports from the Adverse Childhood Experiences studies of the Centers for Disease Control and Prevention were published in the 2nd issue of *Guest House Review* (September, 2008), the Guest House ejournal. Other articles in that "special issue" on Trauma & Addiction convey a more comprehensive sense of the science here. Interested readers should go to http://guesthouseinstitute.org/GH%20Review%20Archive.html.

†† http://www.cdc.gov/nccdphp/ACE/.

The ACE categories of traumatic experiences include such things as growing up abused or neglected, witnessing parental marital discord or domestic violence, or living with substance abusing, mentally ill, or criminal household members. The effects of these experiences are seen to be powerful, long-term, and cumulative. "The experiences of childhood — specifically stressful or traumatic experiences that can negatively affect childhood development — are fundamental and often "hidden" underpinnings of the occurrence of multiple health and social problems" over a lifetime (Anda, 2008, p. 4).‡‡

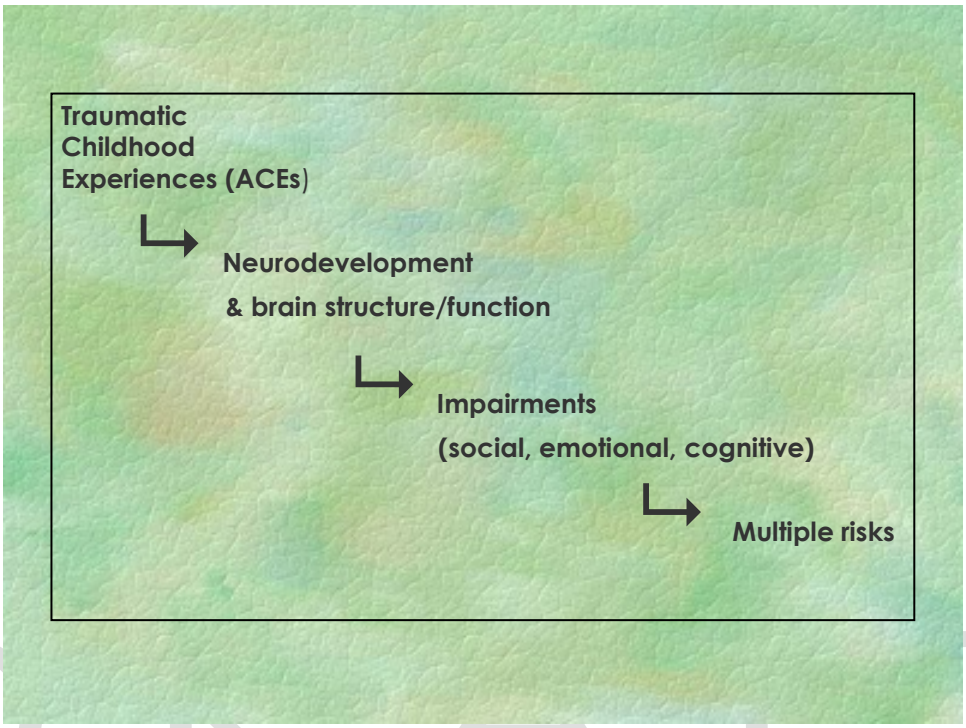
Table A: Range of *Adverse Childhood Experiences* (ACEs)



Importantly, the ACE studies document that ACEs have a profound and lasting impact many years later, although transformed from psychosocial experiences into organic disease, poor social functioning, mental illness, and addiction (Anda, 2008).

‡‡ We believe that it is critical for *formators*, spiritual directors, vocation directors, seminary rectors, novice directors, and other formation personnel to ask themselves how many of their candidates for priesthood or religious life come from homes or situations that are described in the ACE studies. We believe it is also critical for these personnel to ask themselves whether (or not) they even know in any detail the kinds of early formative experiences that their candidates have had. How might formation personnel, processes, and structures begin to grapple with the effects of these experiences?

Figure 1: ACEs as a "common pathway" to multiple risks and problems in living



What does this mean? And, why does it matter? The ACE investigators, in collaboration with a number of trauma researchers, are uncovering evidence of an association between these social and environmental experiences (trauma exposures) and the process of neurodevelopment.§§ More and more it seems that stressful and traumatic childhood and adolescent experiences literally become "biology," affecting brain structure and function (as well as endocrine, immune, and other biologic functions), thus leading to persistent effects (Anda, 2008, p. 17). For example, there appears to be a *split* within the brain that occurs in response to a trauma that is not fully resolved. As a result, memories (cognitive part of brain) are not fully integrated, while

§§ Neuroscientists, for example, have linked childhood maltreatment to long-term changes in *brain structure and function*. These include changes in the prefrontal cortex, corpus callosum, and amygdala. Early stress is associated with lasting alterations in *stress-responsive neurobiological systems*. These lasting effects on the developing brain would be expected to affect numerous human functions into adulthood including (but not limited to) emotional regulation, somatic signal processing (body sensations), substance abuse, sexuality, memory, arousal, and aggression. (See Anda, 2008).

emotions (affective part of brain) are left intact and take on a life of their own. This forms *parts* of the brain or *states of mind*, that is, networks or patterns (schema) of thinking/feeling related to the trauma. These contain aspects of the original experience such as memories, thoughts, emotions, and somatic symptoms, which are easily re-activated in response to mental images and sensations. Smells, sounds, sensations directly or indirectly related to the original trauma can all be triggers for a defensive or coping response. And, it is not uncommon for coping to involve "pain-killers" (alcohol or other drugs), distractions (gambling, sex), or other counter-productive strategies.

This is one more piece of the puzzle implicating childhood maltreatment to long-term changes in brain structure, function, behavior and long-term responses to stress (Bremner & Vermetten, 2001; DeBellis & Thomas, 2003). The cumulative impact on physiological stress-responsive systems and the subsequent & multiple impacts on behavior and coping are extensive and far-reaching. Trauma can set the stage for later difficulties. It sets the terms of engagement for struggling with ongoing development, maturity, and personal and spiritual growth.

Case Reflection: Fr. Joe

If we think of trauma only as horrific events such as rape or child abuse, we can miss the more subtle and common, but no less threatening, events enumerated within the broadened ACE categories. Growing up in alcoholic homes, being stressed by acute or chronic illnesses in oneself or one's family, witnessing the rage and contempt that can affect struggling marriages — all of these can be experienced as "life-threatening" and traumatic by children. They can set the stage for a lifetime of lingering effects and unresolved suffering.

Likewise, if we think only of traumatic effects as the extreme symptoms of re-experiencing, avoidance, and hyper-arousal, then we can be blinded to the pervasive and life-compromising sub-clinical effects that often characterize the struggles of trauma victims.

As a boy and young man, Joe grew up in a family that was warm and competent at providing basic necessities. They were solidly middle-class in a close-knit small town. They were the picture of a good Catholic family, and in curious ways this made things more difficult. Underneath what was visible was a pervasive undertone of lonely isolation and unpredictability. The mental illness and fear at the core of this family ruled everything. Joe's mother was, in the end, unable to be emotionally

available to him and the eruptions of grief, paranoia, and depression she experienced became more frequent over time, while everyone "understood" that none of this was to be known outside the home. Keeping the appearances of a good home was a critical element of self-respect. So was Joe's priesthood. These helped to reinforce the secret of mental illness and pain at the heart of the family.

Within this environment he, himself experienced multiple traumas. From his earliest days he knew that his parents had a troubled marriage. And, while he loved the times when they could be close, he experienced the increasing (and increasingly public) fighting with dread, shame, and confusion. He rarely spoke about these feelings with anyone else in the family, let alone with outsiders. The alcoholism that surrounded everything – the active drinking at extended family gatherings; the periodic intrusion of uncles who were tossed from their own homes and welcomed into his; the underlying shame and grief of his grandfather's death as a street derelict – became a family albatross that Joe felt quite personally. He learned early on to keep secrets, to lead a double life.

The obvious trauma of his life-threatening accident and lengthy recovery solidified his need for closeness and affection, but also left him feeling oddly alone and vulnerable. With the core issues of life, he knew that he could not really trust anyone; all those around him had their own vulnerabilities and "clay feet." Gradually, he learned to rely on God and developed an active prayer life, yet some part of him remained isolated, lonely, and in deep need of physical warmth and affection.

Over time Joe developed a pattern of alcohol misuse and sex. He learned that they anesthetized his yearning and pain. While he knew that these twin misbehaviors were dangerous to him, he was unable to control them. Each time he "fell" he resolved to get back up again and do better next time. It was not until he came to understand that the misuse of alcohol was blocking him from a deeper relationship to God, that he began recovery. Sometime later he came to understand something similar about his sexual needs and behaviors.

His desires to serve God and belong to a faith community were strong. And yet, if he had looked at the entire pattern of his emotional and behavioral "falls from grace," he would have understood that a life of celibate loving might not be life-giving for him. How many other seminarians and religious have come to understand that their desire for conjugal love and marriage were at odds with faithful, chaste, celibate living? And yet, Joe (and those conducting formation with him) never fully connected the dots or saw the "neediness" of the pattern he was acting out. Until his own denial and repression were broken, he was unable to recognize his predicament and begin to address it. At this point he would be able to dislodge the compulsions eating at his integrity, and be free to discern a proper course of action.

IV. "Brother and Sister"

It remains for us to take one more step to understand something of the connections and pathways between trauma and addiction. These two conditions share a kind of "family resemblance" with similar traits and characteristics, frequent co-occurrence, and a powerful mutual toxicity that challenges standard treatment delivery. They have been called "brother and sister" maladies (Grant, 2008a, p. 5). Lifelong healing may require similar recovery approaches.

The estimates of *co-occurring* substance use disorders or SUDs (abuse and addiction) along with trauma and PTSD are disquieting (Hutton, 2007). Among those persons who develop PTSD, 52% of men (28% of women) are estimated to develop an alcohol use disorder as well, while 35% (27% of women) develop a drug use disorder (Najavits, 2007). Moreover, even higher rates of co-morbidity have been documented both in clinical settings and among those with particular lifestyle vulnerabilities, such as veterans, prisoners, victims of domestic violence, "first responders" (police, firemen), and so forth (Najavits, 2007; 2004a & b).

Overall, those with PTSD are estimated to be at three to four times greater risk for developing substance use disorders than those without PTSD (Chilcoat & Menard, 2003), while 30% of those with substance use disorders meet criteria for current PTSD (Ouimette, Moos & Brown, 2003). Importantly, those with **both** PTSD and Substance Use Disorders tend to have earlier histories with alcohol and drugs, more severe use, and poor treatment adherence (Khantzian & Albanese, 2008). "PTSD renders substance abuse patients more vulnerable to poorer short- and long-term treatment outcomes" (Ouimette, Moos & Brown, 2003, p. 92). Emerging data confirm the clinical impressions of many that the existence of trauma histories as well as criteria for PTSD heighten the likelihood of addiction relapse, and multiple relapses are very often associated with a history of trauma (Norman, Tate, Anderson & Brown, 2007). Failure to appropriately address the impact of clients' trauma histories has been cited as one factor that contributes to clients' relapse.

Consequently, trauma (and PTSD) and addiction (SUDs) are seen as co-occurring often; many times they set the stage for one another. Practitioners are coming to expect one when discovering the other (Grant, 2008a). And yet, even up to

the present day, trauma and addiction are perhaps the two most *under-diagnosed* and *mis-diagnosed* conditions we face as clinical practitioners (Davidson, 2001; Najavits, 2004a). It may not be too far a stretch to suggest that pastoral and formation practitioners may also be "missing" the hidden suffering of trauma and/or addictions as they encounter it. It is certainly clear that, to the extent that vocation directors and seminary admissions boards rely on clinical psychological assessments of candidates' suitability, the myopia of clinicians toward trauma and addiction may be a cause for concern.

Alcoholism & Addiction: Substance Use Disorders

It is interesting to note that "adverse childhood experiences" have been found to have a "particularly strong association with alcohol abuse" (Anda, 2008, p. 9) and in fact account for a large portion of risk for adult alcohol abuse *regardless of parental alcoholism (!)*. It is not surprising, then, that Felitti (2003/2004) and other ACE researchers (see Felitti et al., 1998) have demonstrated the relationships between ACEs and smoking (250% increased risk over children without ACEs), alcoholism (500% increase in self-acknowledged alcoholism), and injection drug abuse (46-fold increased risk).

Substance use disorders (SUDs), including both substance abuse and substance dependence (or addiction), refer to a collection of physical, cognitive, affective, and behavioral symptoms and patterns that result in a variety of negative consequences and continued engagement in chemical use despite these consequences (APA, 2000). Some compulsive behaviors, such as pathological gambling, may also be viewed in an addiction framework (APA, 2000). Both impairment of personal, social, or work functioning (substance abuse) and experiences of physical and psychosocial deficits as well as issues of control over use (substance dependence) fit together with the recurrent and destructive consequences to form the diagnostic criteria for SUD.

It is important to remember that no one starts out drinking or using a chemical – or eating or expressing sexuality, for that matter – with the intent to become addicted. Rather, individuals use or "experiment," and discover that they are drawn to the experience. Often, the addict-to-be discovers that the drug interacts with painful feelings, needs, and personality to bestow pleasure (euphoria), pain relief (analgesia),

or distraction from his or her suffering (Khantzian & Albanese, 2008). The object or process of abuse, and the experience of using, present themselves as "solutions"… often to years of suffering. When the lingering effects of trauma come calling, the addict knows where to re-turn.

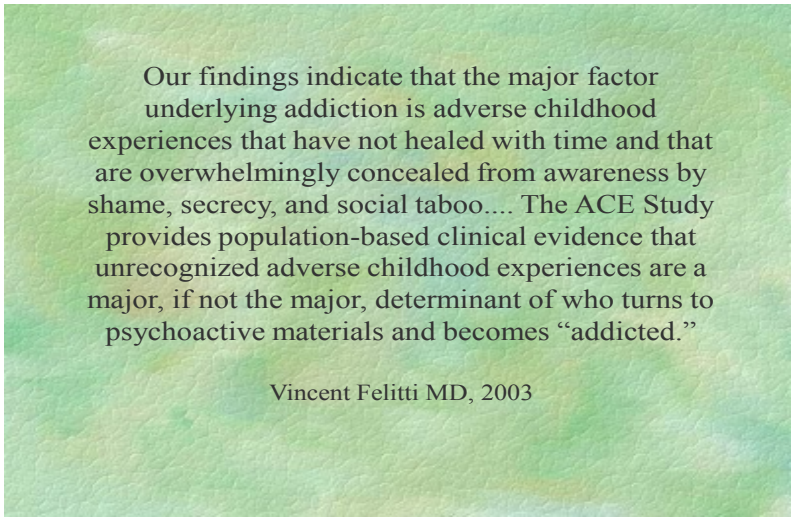
The lifestyle of active addiction is, in and of itself, traumatizing, of course. In coping with their own pain, loneliness, isolation, and shame addicts reach out and cling to anything that promises an end to suffering. The addict experiences a sense of alienation, estrangement, loneliness, unloveability and hopelessness, often felt as a sense of being "different from" or "less than" others. In the face of this pain of living (Doweiko, 1999), the addict turns to pills, bottles, needles, sex, and the like as "magical solutions." "Psychological pain is at the heart of addictive behavior… vulnerable individuals resort to their addiction because they discover that the addictive substance or behavior gives short-term and otherwise unobtainable relief, comfort, or change from their distress" (Khantzian & Albanese, 2008, p. xvi). The addict turns to chemical or behavioral "solutions" as a way to "narcotize" internal pain (Doweiko, 1999, p. 40).

In theological terms addiction may be seen as a form of *idolatry*. The alcoholic or addict believes that alcohol (or some other external substitute) will soothe, comfort, narcotize the pain of living, liberate from troubles, and overcome the suffering and loneliness in one's life. Likewise, persons with other addictions use their substance, object, relationship to deceive themselves that they can overcome life's problems and happiness by false means. The objects of their addictions function as "false saviors" or "pseudo-messiahs" to deliver people from their struggles, which are perceived as ultimate reality (Jordan, 1986; Morgan & Jordan, 1999).

Over time there is a decline in the ability to cope with life, compounded by a steady personal and moral degradation (Morgan, 1992). Looking back, recovering addicts describe themselves in their addiction in non-human terms, referring to themselves as living like animals or behaving like machines (Morgan, 1992). Many of our works of fiction and film, as well as the autobiographies published by persons in recovery, poignantly depict this growing degradation. Sacred scripture even describes the human degradation that comes from such idolatry:

> The idols of the nations are silver and gold,
> The handiwork of men [*sic*].
> They have mouths but speak not;
> They have eyes but see not;
> They have ears but hear not;
> Nor is there breath in their mouths.
> Their makers shall be like them,
> Everyone who trusts in them. (Ps 135.15-18 NAB)

Persons who have experienced trauma and been unable to resolve its after-effects often turn to substances or addictive processes to cope with the lingering consequences of trauma exposure.



V. ADDICTION AS SELF-MEDICATION

The propensity for self-medication is particularly evident in those who suffer traumatic life events.
(Milkman & Sunderwirth, 2010, p. 87).

Traumatic life events and their after-effects often engender long-term pain and an inability to cope with the pain effectively. Substance abuse can often be the preferred choice of trauma victims/survivors as a kind of "self-medication" and as a means of exerting some measure of control over intolerable feelings and intrusive thoughts (Khantzian, 1999; Khantzian & Albanese, 2008).

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There can be many reasons why those who have experienced trauma also abuse substances. These include the inability to access feelings or memories productively (although feelings & memories can often come unbidden and at inconvenient times) and to compensate for the emotional pain associated with trauma. While persons struggling with trauma often experience a host of unwanted difficulties – relationship problems, anxieties, intrusive thoughts, emotional flooding, low self-worth – they seem unable to deal with the traumatic events in their past fully and directly. Often the victim relies on substances to function on a daily basis and to cope with associated stresses.

Trauma victims/survivors engage in ***numbing*** as adults in response to cues in their environment that trigger intrusive thoughts and disturbing emotions. This is something that became ingrained earlier in their lives due to their exposure to trauma, which rendered them helpless, unable to fight or flee, and subsequently in a *frozen state*. All of the elements (such as images, feelings, thoughts, physical sensations) of the original trauma remain suspended and unresolved within *internal networks*, only to become re-activated whenever the survivor comes in contact with associations to the original event, however direct or remote they might be.

Traumatic memories are recalled and experienced as vivid sensations with all of the original emotional intensity, due to an increase in neuro-chemicals, anxiety responses, and memory associations. This creates internal disturbance, conflict, and turmoil for the survivor, who begins looking for any way to escape and/or compensate. Engagement in the abuse of mood-altering chemicals or other self-destructive behaviors provides that escape as it produces a reduction in the person's physiological response, thus lessening his or her internal tension.

Numbing is one strategic use of drugs or behaviors as "self-medication." Many clinicians routinely think of drug use in this way. So do persons struggling with abuse or addiction. It has a kind of "face validity," an intuitive correctness for many people. It also continues to be advanced in a number of research studies (for example, Miranda, Meyerson, Long, Marx, & Simpson, 2002).

Another more subtle way of thinking about "self-medication" understands that many abusers and addicts use their drugs as a kind of "structural prosthetic" to shore up poor ego and self functions that disturb their ability to relate to others (Brehm &

Khantzian, 1992, p. 109; Khantzian, 1981). Addicts, we believe, are haunted by deficits in "self-care;" that is, contrary to others, many of those struggling with trauma and addiction are deficient in emotional self-regulation, self-development, self-esteem, and self-object relationships. These self-regulation difficulties lead to a set of vulnerabilities in terms of both self-cohesion and interpersonal relationships. This vulnerability is exquisitely painful for addicts and motivates them to seek relief. Threats to self-cohesion and one's own psychological structure are tantamount to extinction; addicts learn to rely on drug use as a (literal) means to survival.

> *Many addictions are reactions to untreated trauma. They are attempts to cope with post-abuse or post-traumatic reactions that threaten to annihilate the victim's internal sense of self. The last statement is meant literally and not metaphorically. The destructive effects of trauma can literally make one feel as if s/he is going to "lose his/her mind" or internal sense of cohesion. Most victims, rather than have a glimpse of this type of experience, choose the addictive or self-medicating alternative. This is an attempt to hold back the sensation of being overwhelmed by feelings of terror, helplessness, self-loathing, shame, unbearable loneliness and, in some cases, rage.*
>
> *Codependency, as well as all other addictions, is a symptom of a higher order injury, i.e. some form of psychological and/or physical trauma (Grant, 1994-1995, p. 108).*

Addicts seem to prefer one of three styles of coping in this way – *relaxation* (compulsive "search for tranquility"), *excitement* (compulsive arousal or thrill seekers), or *fantasy* ("compulsive fantastication") – and these roughly correspond to each of the three main classes of drugs and drug experiences: depressants, stimulants, marijuana & hallucinogens (Milkman & Sunderwirth, 2010). Altering or changing one's brain chemistry becomes ***a way of coping*** with dystonic moods and relational difficulties; it helps one to endure. Persons seek relief from psychic pain through the use of chemicals that change neurotransmission, and hence alter one's ability to cope. "*The use of drugs is a way to self-treat or manage an internal psychological problem*" (Dodes, 2002, p. 131).

Many in the general public often ask the question, "What does the use of drugs DO for you?" As we look at self-medication, a clear response seems to emerge.

Addicts use alcohol and other drugs – and continue to use in spite of terribly destructive consequences – as a way to *numb* their long-term suffering and to *survive* in the face of potential extinction. Understanding these motivations is essential both for compassion and for effective treatment.

Ultimately, however, the individual is gradually committing "slow suicide." This observation has led some to define addiction as "self-induced changes in neurotransmission that result in problem behaviors" (Milkman & Sunderwirth, 2010, p. 6). The model of self-medication views the use of addictive chemicals and processes as "misguided attempts to cope with feelings of discomfort, lack of meaning, and a fragmented sense of self… [as well as] unfulfilled longings for intimacy" (Milkman & Sunderwirth, 2010, p. 114). The price for coping and survival, as we have seen in Fr. Joe's story and the real life narratives of so many others, is another kind of pain and death, for the struggling person and for others with whom s/he comes in contact.

The trauma victim/survivor often grew up in substance-abusing or toxic home environments, and is apathetic about taking care of the self, physically and/or emotionally. It is not uncommon for victims/survivors to mimic these toxic home environments as adults, in their own homes, work environments, relationships (Anda, 2008). This both replicates and extends the effects of trauma into a new family system and the next generation. These toxic environments can be – and often are – duplicated as well in rectories, convents, religious communities, seminaries, chanceries, and even dioceses.

Secrecy and *control* are main themes of both disorders. Secrecy is related to a deep sense of shame and a wish to keep things from others. Control relates to the need to deny the consequences of one's usage, as well as the inherent need to keep an image of "looking good" and avoiding any real intimacy with others.

Several patterns are common related to both. Trauma can lead to substance abuse as a means of overcoming the overwhelming symptoms inherent in this disorder as the victim may use to "self-medicate." Substance abuse can lead to trauma as the victim who abuses substances becomes more vulnerable to dangerous (and often, embarrassing, illegal, and/or unethical) situations. Trauma and substance abuse may

have occurred together as some victims grew up in a home where family members abused substances and also hurt each other.

V. Recommendations For Human and Spiritual Formation

It should not surprise us that ministry and community are attractive career options for persons affected by trauma and potential addiction. After all, sensitivity to the needs and emotional states of others, willingness to provide caretaking and service toward others, a need for supportive relationships and mentoring into a mission that provides meaning and a sense of purpose, are all available within the Church's ministries. A theology of vocation and discipleship community undergirds these ministries with a spiritual vision of closeness to, and participation in, the person and cause of Jesus. Emotionally wounded persons can find warmth, safety, purpose, and consolation in a religious or priestly vocation. Living out such a vocation is a powerful and positive way to cope and even thrive in response to earlier trauma and life's ongoing challenges.

However, it is difficult at best to judge **when** and **whether** any particular person is ready (or able) to pursue such a life. Some part of our candidates for formation will always remain a mystery… to us and to themselves. It is often not possible to escape the challenges of one's vulnerabilities simply by committing oneself to a life of self-less service. A person must be in possession of her- or him-self in order to fully and freely give it away. There are no shortcuts to human and spiritual growth. Grace builds on nature. As a wise guide once said: The only way "out" is "through." And often, this takes both work and time.

Part of the rationale for human and spiritual formation is to provide both time and work with the multiple dimensions of one's self. And yet, some number of those engaged in formation are unable to invest the trust, honesty, willingness, personal insight, and spiritual fortitude that are needed for formation to succeed in its lofty tasks. And, later ministry brings its own stresses and challenges that can trigger hidden or dormant frailties.

As we have seen, some persons in formation are unable (or unwilling) to reveal themselves to *formators*, superiors, or even confessors. Their struggles remain unspoken,

and only life after formation and early ministry reveals the work to be done. This perhaps places the work of human and spiritual formation within its proper context; it is, by and large, a very difficult ministry. We appreciate the challenges presented to *formators* by each candidate who enters the Church's seminaries, novitiates, and houses of formation. The recommendations presented below are meant to provide assistance and be the catalysts for conversation about "best practices" in programs of formation.

Recommendations

What are our recommendations? The following offer a modest beginning for conversations among *formators*, religious superiors, assessment and formation teams, psychological and addiction treatment personnel, trauma specialists, and spiritual directors. The recommendations below are not an exhaustive list, but they offer instead a place to begin.[***]

1. It is important for dioceses, religious orders, and formation teams to construct a set of **policies and procedures** that address their attitudes toward, and procedures for, revelations of abuse, trauma, and addiction among candidates, seminarians, novices, and others involved in formation.[†††] Having labored to produce such a set of policies, it is critical that these documents are shared publicly with all those seeking formation within the diocese or order.

   We believe that it is the responsibility of every diocese, religious community, and program of formation to state publicly its understanding and basic approach to issues of trauma and addiction. There are two essential

[***] Robert Grant, Ph.D. has offered insightful and thorough recommendations in the area of abuse, trauma, addiction and formation ((1994-1995). Persons interested in pursuing this conversation more deeply should consult his work.

[†††] A very helpful example of such a policy was published in the first issue of *Guest House Review*. It is available online at http://guesthouseinstitute.org/GHI%20EJ/Archive%202.8/Feature%202.pdf. It is titled, ***SET FREE TO PRAISE, TO BLESS, TO PREACH:*** Care for Our Brothers Suffering from Addictions To Alcohol and Other Drugs (Friars of the Order of Preachers, Province of Saint Joseph in the United States, 4th Edition).

benefits of such an approach. First, it demands that the diocese or community engage in learning, conversation, and discernment about the pastoral approach that is proper to these two difficult challenges. The process of learning and then bringing the result to forming policy and procedures allows all involved to develop empathic understanding and wise guidelines. This creates an environment that is conducive to honest and caring engagement with those who struggle.

Second, the publication of policies and procedures signals to candidates and those already in formation that there is safety in their being honest and forthright about their struggles. Persons are much more likely to examine their own past wounds and current challenges if they know ahead of time how these will be addressed. No one does so without safety. While a number of religious orders have put such procedures in place, it behooves all programs of formation to do so. Every so often, these approaches and procedures should be re-visited and updated.

2. Having engaged in such a process, dioceses, communities and programs of formation will be much more likely to assess for these vulnerabilities, and to seek training to assist their *formators* in dealing with vulnerabilities once they arise. This is a crucial second step, namely that programs of formation **detect and then assess** the need to address trauma and/or abuse/addiction within their midst.

Without a willingness to look for these issues and knowledge about how to address them, so much can escape notice and a "conspiracy of silence" becomes more likely. Understanding the symptoms, background profiles, and behaviors that characterize victims of trauma is a crucial first step in assessment and training for formation personnel. Having an available cadré of psychological and spiritual supports – who know the world of trauma and addiction, and can serve as referral sources for treatment – is also important. The work to lay such a foundation of understanding and services pays large dividends in the care of those who are troubled.

As Grant states: "Many conscientious men and women in clerical and religious life who dedicate their lives to the care of others are in desperate need

of care for themselves…. Until the effects of abuse and trauma re acknowledged, accepted, and treated with compassion, understanding and support, The Church will continue to unknowingly allow abuse victims to pass through clerical and religious life without receiving care or treatment. As a result new victims will be created both in ad outside the Church" (1994-1995, pp. 174, 186).

3. Policies and procedures set a tone. Understanding, assessment and resources for addressing challenges help with needed care. A third necessary element is the **attitude** that we adopt toward those who are struggling. As Grant and other experts continually remind us, when speaking of those in formation and ministry, we are talking about our brothers and sisters. They, like us, came to religious life and ministry to serve and draw close to the ministry of Jesus. They, like us, struggle with human and spiritual growth. They, like us, need compassion and understanding. How shall we treat them?

Persons affected by the multiple impacts of trauma and addiction pose a significant challenge to human and spiritual formation. Taking our cue from a series of addresses and homilies by Pope John Paul II, delivered in reference to those struggling with addiction, we see the Parable of the Good Samaritan in Luke's gospel as the basis for a powerful "pastoral attitude" toward those struggling with addiction and trauma (Morgan, 1997, 1998).

John Paul invariably referred to the "human dignity" of those violated by addiction (trauma). The roots of this dignity live in the creative love of God; it motivates us toward Christian solidarity with, and service of, victims/survivors. The biblical metaphor of the Good Samaritan (Who is my neighbor?) guides authentic pastoral action. Acting as the Samaritan does is offered by Jesus – and John Paul – as a norm for conduct.

Very often, when thinking of the victims of drugs and alcohol – generally young people, though their spread among adults is a source of growing concern – I am led to recall the man in the Gospel parable who, when assaulted by criminals, was robbed and left half dead along the road to Jericho. In fact, these, too, strike me as people 'on a journey' who are searching for something in which to believe in order to live; they instead ru up against the merchants of

death, who assault them with the allurement of illusory freedoms and false prospects for happiness. These victims are men and women who, unfortunately, find themselves robbed of the most precious values, profoundly wounded in both body and in spirit, violated in the depth of their consciences and offended in their dignity as persons.
…. Today, too, as in the Gospel parable, Good Samaritans are not lacking who, with personal sacrifice and sometimes at a risk to themselves, are able to "become the neighbor" of those in difficulty (1991, p.8).

To whom will we act as a neighbor? If our basic attitude toward those who are wounded by trauma and addiction is care and concern toward brothers and sisters, we will act one way. If we act as though such persons, especially in view of how harmful their own attitudes and actions may be, are essentially "different from us," or need to be taught a lesson, or need to suffer the consequences of their actions, or need to be prevented from ministry, then our attitudes will be quite different. This is a question that must be faced. It is to be hoped that an attitude of inclusion, solidarity and caring outreach is not too much to expect in the community of Jesus disciples. Such an attitude creates "redemptive fellowship."

4. We have come a long way within the clinical and human sciences in recent years, particularly in our understanding and applications to the twin disorders of trauma and addiction. Understanding, early identification, assessment, treatment and recovery are available. Utilizing the best of our science with the best of our pastoral attitudes may bring us to a helpful and edifying outcome for suffering brothers and sisters.

Treatment, ongoing support and recovery are possible in these areas. Perhaps in facing the demands of such work, the Church itself will be able to function as a "wounded healer," comfortable with its own frailties, willing and able to help others in their search for human and spiritual growth.

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