

8 The Role of Spirituality in the Recovery Process

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Though innovative approaches to working with substance-abusing parents of maltreated children have emerged within the last few years, child welfare agencies continue to be challenged by the chronic nature of addictive diseases. This article discusses the often ignored element of spirituality as a critical component of recovery for parents. It also highlights how the regulation of spirituality by parents has a significant influence on their ability to responsibly care for their children.

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Spirituality is one of the essential foundations for the remediation of an addictive disease, but it is the one that child welfare professionals understand the least. Many addiction treatment counselors believe that when individuals are reconnected to a positive spiritual momentum, they are more likely to take control of their lives. These addiction counselors believe that the classic treatment models that ignore spirituality have had limited success. They advocate instead for a more holistic approach, which integrates the spiritual, the physiological (biological), and the psychosocial components of a person's life. In fact, evidence exists that individuals in recovery who have participated in spiritually based programs have made the most significant progress in their recovery from addiction [Green et al. 1998]. Based on the belief that addictive diseases consume every aspect of an individual's life, successful recovery is also more likely to be developmental in scope. By underestimating or totally ignoring the spiritual dimensions of an addicted parent's recovery, child welfare caseworkers are likely to remain frustrated in their attempts to provide a safe and stable environment for children.

This article highlights the descriptive characteristics of spirituality and the losses experienced by people, particularly women, living an active addiction. The addict's physical and emotional deterioration can lead to a distortion of the spiritual self and contributes to the inability of the parent to act responsibly or in a caring, nurturing manner. Caseworkers can play an important role in assisting clients who are trying to find their way back to a spiritual balance and to a nurturing parenthood.

Defining Spirituality

In the past, many social workers, including child welfare professionals, avoided any discussion of spirituality because they confuse the concept with religion [Bullis 1996]. Since the profession of social work encourages a nonjudgmental and nondirective

approach, such avoidance is understandable. Nonetheless, a significant difference exists between religion (a discrete value system and set of traditions) and spirituality.

Addiction treatment professionals and recovering individuals describe spirituality in a variety of ways. Several themes, however, are common to these descriptions. One addiction counselor describes spirituality as "the very essence of who we are ... the total of ... mental, emotional and physical well-being..." [Booth 2000]. Others who have focused on spiritual aspects of recovery offer additional insight into what spirituality is, and how it translates into daily life, even if unrecognized by the name spirituality. Twerski [1997] points out that the spiritual life of an individual includes the ability of the person to be responsible, to be trusting, to achieve deeper levels of intimacy, and to realize his or her potential for growth. What constitutes our spirit is our ability to contemplate the purpose of our existence, ways to better ourselves, to delay our gratification, and to think about the long-term consequences of our actions. It is the spirit that enhances the individual's capacity to make moral decisions. Twerski also feels that it is possible to be spiritual without being religious, since there appears to be no innate human imperative to practice religion. Alexander [1997], who has studied Buddhism in addition to working with people in recovery, quotes the Buddhist monk Thich Nhat Hanh in his description of mindfulness (spirituality) as "keeping our appointment with life."

Addicted parents of maltreated children can be described as having reached a spiritual dead-end—a spiritual void that contributes to the risk of the individual becoming totally lost. This void provides the context for why and how addicted parents can be either terribly cruel or totally neglectful toward their children. Although this state does not provide an excuse for such behavior, it does help to explain sometimes unspeakable maltreatment.

The notion of spirituality involves a complexity of feelings, thoughts, and attitudes about oneself in the world. When positive, they work to regulate the individual's sense of self-esteem

in a healthy manner. Individuals struggling to meet the responsibilities of everyday life, who have little ability to regulate this process, however, will continue a descent into destructive behavior. Alexander [1997] writes that, "as an active alcoholic or addict, you lived in a state of chronic apartness, separated from the gods, from the people who loved you." Though experienced child welfare professionals can be horrified by the actions of an addicted person, the sometimes harsh and unusual behavior can be understood within the context of this detachment from the spiritual self and from the wider social community.

As an addictive disease progresses and the biological imperative to use takes over, the loss of spirituality becomes more pronounced. Not only are individuals physically addicted to substances, they risk experiencing a permanent separation between themselves and their ability to love, trust, mature, and most importantly, act responsibly in the role of a parent. This progression highlights the danger in waiting for a parent to "hit bottom" before implementing a meaningful treatment plan. At that stage of the disease, many addicts have become physically and spiritually unable to respond.

Perceptions of Addiction

Historically, the public and the treatment community viewed addicts as morally impaired (either for starting alcohol or drug use or for continuing it in the face of negative consequences). More recent perceptions see addicts as having psychological problems that lead to self-medication or as having a disease that may have a biological component [Siegler & Osmond 1974]. A survey of Americans found that while 85% of the public believe that addiction is a disease, many people also believe some aspects of addiction to be a moral failing [Caetano 1987]. This is understandable in light of the difficulty of defining addictive disease. Even the Alcoholics Anonymous (AA) model, which has been instru-

mental in framing addiction as a disease, wrestles with cause and effect. Siegler and Osmond sum up AA's philosophy of causality as a loop: "Alcoholics are emotionally impaired people who drink to compensate for their inadequacies, and then, because of their body chemistry, become addicted to alcohol, creating a circular process of further inadequacy and further drinking." Regardless of etiology, recent research on the brain has contributed new understanding to what is actually occurring on a physiological level once heavy substance abuse begins.

Instinct, The Unconscious, and Behavior

Only recently has the field begun to understand the nature of the brain disease underlying the addictive process [Leshner 1997]. That knowledge starts with an understanding of the different functions of different parts of the brain. The cerebrum and cerebral cortex (white matter) make the human brain unique and are the source of our abilities to understand, communicate, and create [Ornstein & Thompson 1984]. The white matter assists in making decisions and explains much of the human behavior patterns. It does not determine or decide all of human behavior, however.

Directly under the cerebrum are the more primitive structures, shared with other animals, which are responsible for habitual and even automatic actions. These structures—the cerebellum, the limbic system, and the brainstem—carry out many of life's tasks while humans are thinking about other things. Ornstein and Thompson [1984] provide a summary of the functions of each of these brain areas. The cerebellum is the part of the brain that allows us to tie shoelaces, drive cars, walk down the street, and engage in countless habits. It does not have the power to think about itself, question its motives, or even question the morality of its behavior. The limbic system or mammalian brain regulates maintenance behaviors such as eating, drinking, and sleeping, and is the source of many emotional reactions relating to survival. The brainstem

or reptilian brain is responsible for the basics of survival—breathing, heart rate, and scanning the environment for important cues.

These instinctual areas of the brain are responsible for directing survival behaviors. When these areas of the brain sense that humans need food or water, they direct attention by setting off an alarm. The alarm is at first subtle, but soon it becomes an imperative command: "Get me food now!" Once this signal is given, the rest of the structures of the brain begin to focus attention, thought, and behavior toward meeting these needs [Wilner & Scheel-Kruger 1991]. The brain begins to scan intently for the needed object and begins to ignore all other stimuli. If the need is met, a strong feeling of reward is given to the organism through one neurotransmitter, and a feeling of satiety is experienced through another neurotransmitter [Ruden 1997]. If the need is not met, however, the signal alarm continues and grows to overwhelming proportions, causing seemingly irrational behavior that is unaware of consequences.

Through a combination of genetic susceptibility, stress reaction, and exposure to the appropriate drug, these instinctual areas of the brain begin to respond as if the drug itself were necessary for survival [McFarland 1987]. The drug activates and sensitizes the system to begin acting as if obtaining and consuming the drug were a matter of life and death. In a number of now-famous experiments, groups of monkeys were given indwelling intravenous catheters through which cocaine could be injected if the proper lever were pressed [Aigner & Balster 1978; Deneau et al. 1969]. They could also obtain food and water if other levers were pressed. Soon, the animals began to press the cocaine levers almost exclusively and began to ignore levers for food and water. In the earliest experiment, all of the monkeys died within 30 days [Deneau et al. 1969]; in Aigner and Balster's research, the experiment was terminated after only eight days because the monkeys were starving to death. Similar results were found with rats given unlimited access to cocaine [Bozarth & Wise 1985].

These experiments indicated that addictive drugs could commandeer the instinctual areas of the brain, and they could override the instinctual mechanisms for survival. From these experiments and from observations of human addictive behavior, it appeared both animals and humans could be made to act in ways antithetical to their survival. Metaphorically, this leaves the white matter of the brain helpless to do much of anything except try to create rational explanations for irrational behavior.

Companion Mechanisms

It is not just the overwhelmingly painful drive to obtain alcohol and other drugs (AOD) that works against the addict. Neural adaptation begins to take place and changes at all levels—molecular, cellular, structural, and functional—begin to develop in the brain [Leshner 1997; Self 1998]. These adaptations establish an intense focus on anything having to do with AOD. Associations are made with objects, people, and places that reinforce the craving. In the primitive brain this association would have a great deal of survival value as it would aid in obtaining food or water. Likewise, the brain begins to develop a stimulus barrier against anything that is irrelevant to AOD or that interferes with AOD behavior. Affiliative behavior, or the connection to other people, decreases unless that behavior helps gain access to AOD [Ruden 1997]. Subsequently, affiliative behavior begins to become exploitive. The addict becomes unaware of commitments, responsibility, and loved ones. But it is in relationship to these same commitments, responsibility, and loved ones that the spiritual being is established. When people experience themselves in positive relation to these objects, they experience a positive sense of self. When they are no longer in touch with these objects, their sense of self becomes tenuous. When the relationship to these objects becomes negative, so does the experience of the “spiritual being.”

Additionally, as alcoholics or drug addicts continue to use, they become cognitively impaired, making it more difficult for them to understand what is happening to them. Thus, practically the whole of the brain becomes involved in what it believes to be survival. Although "denial" as a psychological defense mechanism comes into play, it may not be as significant as the neurobiological changes that take place as the organism attempts to adapt to survive. If this psychological mechanism is used to do anything, it is used to deny how frighteningly out of control the individual has become.

The Need for a Recovery Program

As the addiction progresses, new neural connections grow in the brain, and old connections are broken through a combination of stress and abnormal reward [Leshner 1998]. Neurons are literally killed off in this process, leaving permanent scars and altered function. The addict now has a brain that often functions as if the drug were more important than all other forms of sustenance [Ruden 1997]. Even though the addict may deeply desire to stop this self-defeating behavior, the brain continues to function in an emergency survival mode. It will continue to crave the drug, scan the environment for signs of the drug, react to the drug, and justify irrational behavior.

At this point, a program of recovery is necessary; conventional willpower alone will not succeed. Addicts who have experienced permanently altered brain function must know and understand that the disease will continue to operate without their permission, and they cannot will it to be otherwise [Leshner 1998]. They need to begin the process of affiliation with others who have the same problem, who can provide them with a sense of belonging and direction. It can take the brain years to undo the physiological effects produced by the addictive substance, which contributes to the chronic nature of the disease. Recovering addicts may need to be assessed for medications that can change chemi-

cal patterns and block cravings [Ruden 1997; Leshner 1998]. At some point along the continuum of physiological recovery, the brain can leave its emergency survival mode. Not until this point is reached, however, are most individuals ready to become reunited with their spiritual selves.

The Relationship Between Substance Abuse and Child Maltreatment

Both anecdotal evidence and research illustrate the connection between substance use disorders and a diminished capacity to parent. Young and colleagues [1998] note that several studies have found that 40% to 80% of families involved with child welfare services have substance abuse problems that affect parenting.

The links between substance use disorders and child maltreatment are complex and not fully understood. Ammerman et al. [1999] describe five factors that may explain the connection between child maltreatment and substance abuse: (1) alcohol or other drugs, or withdrawal from those substances, may cause increased anger and decreased frustration tolerance; (2) substances can lower inhibitions against aggression; (3) substances can interfere with judgment; (4) substances can lead to a single-minded focus on obtaining the drug; (5) and, substance use in one parent affects the sober parent, creating an unhealthy atmosphere and "undermining caregiving."

Dore [1998] characterizes the connection between substance abuse and "maladaptive parenting" in three broad areas:

1. **The direct effect of substances on behavior.** Mind- and mood-altering chemicals profoundly impact the ability of the parent to function as a parent, which requires sensitivity to the needs of the child and consistency in responding to those needs.
2. **The family and environmental context of substance abuse.** The kind of home and neighborhood the family lives in, the partners a substance-using parent chooses, and the loss of

badly needed financial resources spent on AOD can create a context in which the child is at risk.

3. The possibility that the substance abuse may actually be due, in part, to the parent's *own* history of abuse as a child and the fact that the parent may have ongoing, untreated posttraumatic stress disorder. The issue of childhood trauma is particularly important because of the widespread prevalence of sexual abuse in the histories of women with substance abuse problems. Nearly 100% of female addicts have experienced some form of trauma, and 44% have experienced childhood sexual abuse [Luthar & Walsh 1995]. When those issues are not treated, the parent is likely to show both emotional numbing and reduced problem-solving capacity (both of which contribute to child abuse and neglect), as well as AOD use. This is especially true for mothers who have survived childhood maltreatment.

This last point may have the most relevance for child welfare professionals. Data from states that participate in the National Child Abuse and Neglect Data System (NCANDS) show that the majority of child abuse and neglect cases (62%) involve female caregivers, often mothers. This is particularly true for neglect, where 74% of cases involve female caregivers [U.S. Department of Health and Human Services 1999]. Many mothers who neglect or abuse their children were also victims of abuse in their own childhood [Dore 1998; Ammerman et al. 1999; Jasinski et al. 2000]. Some experts contend that certain behaviors in women's addictive patterns are posttraumatic coping responses. This behavior is seen as an attempt to numb the pain and shame of childhood maltreatment [Sun 2000]. Sun [2000] suggests, as the mother's substance abuse progresses, she is more likely to become isolated from the natural and therapeutic supports she needs to overcome the compulsion to drink or use drugs. Both the painful feelings stemming from unresolved trauma and the isolation can lead to a loss of spirituality and the inability to adequately parent and maintain an appropriate environment for children.

AOD Treatment Issues for Mothers and Other Women

Recovery from substance abuse problems, particularly for mothers in the child welfare system, depends on both the availability of treatment and the responsiveness of treatment to their practical needs. An increasing number of programs provide treatment for mothers as well as child care for their young children, they are not universally available. Traditional AOD treatment, using mixed gender groups and discouraging discussion of parenting issues, has been problematic for women. A survey of women in recovery by Nelson-Zlupko and colleagues [1996] found that clients wanted child care, parenting classes, and information on pregnancy and other health issues—none of which they felt they were getting in standard treatment programs. Additionally, the women surveyed said that the most significant factor in their recovery was the relationship with the counselor. If the counselor was a poor listener, showed no respect or compassion, or did not seem to have time, women were more likely to drop out. The best counselors were good listeners, treated the clients with respect, and saw their strengths. As one woman said, "I can't think of a better feeling than someone who believes in you more than you believe in yourself, so that you're able to learn to believe in yourself."

Similar results were found in a recent study by Sun [2000] of substance-abusing mothers in the child welfare system. From qualitative interviews with eight mothers, Sun found that child protective services (CPS) involvement could be a key step in turning crisis into opportunity. Several of the mothers acknowledged that they would have never gotten out of the cycle of addiction without court intervention. One mother said, "it was just like you are sucked into a powerful drain—you want to get out, but you can't." Others describe the feeling of the brain that has become focused on drugs: "You now needed the drugs more than you wanted them," and "Drugs are the center of your life ... You are controlled by the drugs. All you think of is drugs." From the in-

terviews, Sun developed four general practice guidelines for CPS workers:

1. Put mothers and children in treatment together—providing opportunities for mothers to relearn their parenting skills and to reconnect to their parenting instincts.
2. Encourage social networks, particularly Alcoholics Anonymous or Narcotics Anonymous, that have a substantial spiritual foundation of acceptance, repentance, and eventually “giving back” to others in need.
3. Provide case management (help with transportation, housing, child care, and health care) and life skills training, and stress personal responsibility, which reconnects clients with their spiritual being.
4. Create a therapeutic relationship by maintaining a nonjudgmental attitude, caring about and having faith in the client, having a feasible case plan, and helping clients recognize their dreams.

Responding to the Spiritual Crisis

Cohen [2000] provides an integrated approach to working with addicted women on the recovery process. Many of the suggestions for work with women in general apply as well to mothers seen by child protective services.

Child welfare workers who must assess a mother's ability to responsibly care for children when substance abuse is a concern should have enough training to be comfortable asking about substance use and substance-related problems. Cohen recognizes that many people, even helping professionals, view women addicts as somehow more reprehensible than male addicts, and includes specific exercises for staff training around these issues. Child welfare workers should also be aware of the strong links between substance use and a mother's own history of being abused, either in childhood or in a current relationship. They should know

what kind of progress is likely in early recovery, compared to later stages. In early recovery, when the client is still detoxifying from the effects of substance abuse and may experience many mood swings, Cohen suggests she will need to work on basic issues such as nutrition, housing, transportation, self-esteem, and connection with a positive support system to stay sober. In later recovery, the client may be better prepared emotionally to explore her own history of abuse and patterns of relationships and work on changing those patterns. Understanding the physiological issues and the history of abuse, as well as the recovering woman's experiences of losses and alienation from self, can help child welfare workers understand the place of a spiritual component in the recovery process or in any healing process [Bullis 1996]. Keeping spirituality in mind as one aspect of successful recovery, caseworkers can also structure specific tasks that reduce the chances for continued reabuse and increase safety:

- The caseworker can help parents move toward full acceptance of their addiction and its consequences. Simply acknowledging that there is a problem with substance abuse is not enough. Acceptance by the parents of their illness is evidenced in part by their understanding that they have lost control of drug use and their ability to make reasonable decisions on behalf of their children. The caseworker does this by continuing to bring the focus back to substance abuse and recovery. When the caseworkers frames the issues within the context of brain disease, parents are provided with an opportunity to accept the gravity of the situation while at the same time realizing that there is hope for recovery.
- The caseworker can articulate measurable ways for parents to repair and rebuild their social network and their parenting skills. This should include the ability to care for their children in a developmentally appropriate manner with the help of friends, family, and professionals. The plan

should include specific actions the parents will take in cooperation with others to reassume their parental role. Further, the plan should reflect a proactive response to their situation and the possibility of relapse, which will be done in concert with nonaddicted individuals able to assist the parent with recovery of body, mind, and spirit.

- The caseworker and the parent's treatment counselor should document successful efforts to address the emotional challenges of abstinence from all substances, issues of self-esteem and dependency, and in later recovery, traumatic issues from any history of childhood maltreatment. Related to this is the need for parents in recovery to acquire more appropriate ways to manage their emotions, especially in relation to their children's behavior. These therapeutic tasks should be reflected in the oral and written communications between the caseworker and the addictions counselor.
- The caseworker and the parent should have a clear understanding of the possibility of relapse and a corresponding plan to address this if it occurs. Correspondingly, child welfare professionals need to recognize any recurrence of addictive thinking as an early indication of relapse. Relapse that leads to recurrence of maltreatment does not necessarily have to be characterized by renewed drinking or drug use. Rather, it unfolds when any area of the body, mind, and spirit begins to break down, increasing the likelihood that the parent might revert to maltreating behaviors. The treatment plan should emphasize the dual strategies of personal responsibility on the part of the parent and the need to remain connected to a positive recovery network for ongoing support.
- The caseworker can encourage the parent to pursue her own spiritual path. As Cohen [2000] reminds us in a final chapter on spirituality and wellness in recovery:

Whether [the client] reads; meditates, prays; or participates in healing groups, spiritual communities, or AA/NA, she will feel a sense of belonging and connection that is markedly different from the isolation she lived with a consequence of drinking or taking drugs.

Conclusion

Addictive processes are complex phenomena, without clear cause or origin, that envelop the whole person—body, mind, and spirit. Any attempts to ensure the safety and permanence of a child living with an addicted parent must include a comprehensive effort to treat the parent in a holistic manner. Though the child welfare system cannot be expected to remediate all addiction-related problems in a family, child welfare professionals should be better equipped with an understanding of the parent's spiritual crisis and the place of spiritual recovery in the rebuilding of family relationships. ♦

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