

EMBRACING LIFE AS IT COMES

HANDBOOK OF
**LATIN AMERICAN
PASTORAL**

*CARE FOR ADDICTION
ACCOMPANIMENT AND PREVENTION*



P.L.A.P.A
PROGRAMA LATINOAMERICANO DE ACOMPAÑAMIENTO PASTORAL

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PART I

The Starting Point

How this manual was born

CHAPTER 1

Gateway

1.1 | Presentation

This Addictions Pastoral Manual is born from the cry of our peoples and from the commitment of a Church that, in Latin America and the Caribbean, has decided not to look the other way in the face of the suffering caused by the use of psychoactive substances. It is the fruit of a shared ecclesial journey, marked by listening to reality and communal discernment, in permanent dialogue with the pastoral experiences that accompany the wounded lives of individuals, families, and communities.

The phenomenon of psychoactive substance use constitutes today one of the most painful expressions of social exclusion. As expressed in the Aparecida Document, it is a reality that spreads like an "oil stain," particularly affecting the poorest and most vulnerable sectors. We are not facing a merely individual or exclusively health-related problem, but rather a social and cultural wound that directly challenges the evangelizing mission of the Church.

In this context, the Latin American Church has been developing various pastoral responses aimed at preventing, accompanying, and rebuilding lives from an integral perspective. This Manual gathers that ecclesial journey, especially valuing the experiences that arise in communities and that, often with scarce resources, sustain processes of care, accompaniment, and hope. It is not a text drafted from a desk, but a tool that springs from contact with reality and from a pastoral reflection that is born from the people and with the people, in continuity with the Latin American theological tradition promoted by CELAM.

This Manual is explicitly inscribed in the path of the Latin American Pastoral Ministry of Addictions PLAPA, promoted by CELAM as a space for discernment and pastoral unity in the face of this complex reality. In harmony with the founding document of PLAPA, and with the Letter to the Church of Latin America and the Caribbean, an integral, communitarian, and territorial perspective is adopted, which places the dignity of the person at the center and promotes networking with other social actors.

The process of elaborating this Manual was carried out in a synodal key, based on the contributions of pastoral agents, territorial teams, consecrated men and women, priests, bishops, and committed professionals. The result does not aim to offer closed answers or unique models, but to share pastoral criteria and guidelines that help accompany life processes in diverse contexts.

This Manual is intended for parish communities, Catholic schools, dioceses, movements, and ecclesial organizations that wish to get involved—or continue deepening—in the prevention and accompaniment of people in situations of substance use. It aims to be a support for the formation of agents and the review of pastoral practices, avoiding both moralism and naivety, and always placing the dignity of the human person at the center.

It should be clarified that this Manual, although it attempts to bring the contributions of science and faith into dialogue, is not a clinical protocol nor a specialized technical instrument. Nor does it seek to replace the contributions of health sciences or the inalienable responsibility of States in the design and implementation of public policies. Its specific contribution is pastoral: to offer an evangelizing horizon and to encourage concrete practices of care and community accompaniment.

1.2 | How to use this manual?

This manual has been conceived not only as a theoretical document, but as a living and dynamic tool for accompaniment in the field of addictions and social vulnerability on the part of the Church. By its nature, this material offers two complementary reading modes, adapting to the times and needs of each community or pastoral agent.

- First, the manual can be read linearly, from beginning to end, like a textbook. This mode allows for a deep and systematic understanding of the proposal, following the logical path that goes from the analysis of reality to the implementation of concrete responses. It is the ideal

path for those who are beginning in this pastoral ministry or who wish to ground their practice on a solid theoretical basis.

- Second, the manual is designed to be consulted according to emerging needs and questions. We understand that the work in the field is urgent and that, often, the pastoral agent faces specific challenges that require immediate responses. Therefore, the material functions as a quick reference resource, where specific sections can be searched according to the issue being faced at the moment. The digital version of the manual offers good opportunities in this regard.

The flexibility we propose is directly reflected in the methodological structure we used for its development, and is recorded in the three main parts of the manual:

1. **Receiving Reality (See):** Here, the perspective of the various pastoral agents of our region is systematized. It is not an abstract description, but the reflection of what our brothers and sisters are seeing today in the neighborhoods, parishes, and accompaniment centers. It is the necessary starting point for situating our action.
2. **Discernment (Judge):** This section is the theoretical heart of the manual and is built entirely around the questions that arise in the heart and practice of a pastoral agent. Instead of offering closed truths, we propose a path of reflection that helps illuminate reality from our faith and our social commitment, responding to the questions that daily practice poses to us.
3. **The Response (Act):** Here we present concrete proposals for intervention. These are proven lines of action and practical suggestions to transform the reality observed in Part 1 (See), in light of the discernment carried out in Part 2 (Judge).

Finally, aware that the problem of addictions requires an integral approach, we have incorporated in the digital version a system of hyperlinks that relate the contents to each other. This network of connections allows the reader to see the topics not as watertight compartments, but as interconnected dimensions of the same reality. By clicking on these links, one can navigate between concepts, tools, and testimonies, fostering an overall vision that is indispensable for a pastoral response that aspires to integrality.

Lastly, this manual aspires to be a *rolling release* material, that is, continuously updated, so that from PLAPA we will implement mechanisms for active

participation, which, as will be understood, will always be reflected updated first in the digital version. To this end, we will create a team responsible for evaluating and incorporating corrections from the community.

We hope that this manual will be a companion along the way that strengthens the hope and effectiveness of our mission in the field.

1.3 | Prologue

The drug problem is like an oil stain that invades everything. It recognizes no borders, neither geographic nor human. It attacks rich and poor countries alike, children, youth, adults, and the elderly, men and women. The Church cannot remain indifferent to this scourge that is destroying humanity, especially the new generations. Its work is directed especially in three areas: prevention, accompaniment, and support of government policies to suppress this pandemic.

Aparecida Document N° 422

With these words, already in 2007, our pastors pointed to the need for the Church to get involved in the drug problem. *The Church cannot remain indifferent*, they said. Almost 20 years later, we observe with sorrow that the problem has deepened, and that in the Church it is very difficult for us to get involved.

It would seem that getting into the drug problem means entering the terrain of specialists; that it is a very complex issue and that we have nothing to contribute. It would seem that it is a matter reserved for certain people called in a particular way or who discovered that specific vocation, but that in general our communities have nothing to do.

We do not think so, and that is the reason we embarked on the difficult task of writing this manual. We want to say that our communities, parishes, schools, and pastoral ministries have a great deal to contribute, and that there are things that if we do not do them, no one else will. That the pain and death brought by psychoactive substances are a privileged occasion to encounter the crucified one, and that in that place the resurrection is discovered. We even dare to say that in our openness to the wounds of society, our salvation is at stake, because in those wounds dwells Jesus Christ himself.

Pope Francis said:

Sometimes we feel the temptation of being Christians while keeping a prudent distance from the wounds of the Lord. But Jesus wants us to touch human misery, to touch the suffering flesh of others. He expects us to give up seeking those personal or communal shelters that allow us to keep our distance from the knot of the human storm, so that we truly accept entering into contact with the concrete existence of others and come to know the power of tenderness. When we do so, life always becomes wonderfully complicated and we live the intense experience of being a people, the experience of belonging to a people.

Evangelii Gaudium N° 270

The problem of drugs and the addiction of our brothers and sisters is, without a doubt, one of those wounds of the Lord that Pope Francis pointed to. Sometimes it can make us afraid, or insecure. There are so many elements to consider that it seems difficult to get involved and do things right. However, the Church calls us to commit ourselves.

That is why it is important to say: The Church does not engage in this issue with the logic of efficacy. The relationship of Christians with the sick is not the same as that of the doctor. The doctor relates in order to treat and cure, or failing that, to make the pain more bearable. The Church, although it wants to help people overcome the ills that afflict them, in its way of accompanying, praying, and being lovingly by their side, discovers that the logic of efficacy falls silent at the foot of the cross, giving way to a deeper mode of presence. This is what we saw in the scene of the crucifixion: *one of the criminals hanging there hurled insults at him: Are you not the Christ? Save yourself and us!* (Lk 23, 39). The poor man had heard so much about the miraculous healings and the signs that Jesus had performed, that he even came from his anger to demand it of him. He would have wanted that encounter with the crucified Jesus to quickly translate into terms of efficacy. However, that was not the path he was invited to walk. The other thief understood, and in his openness he found consolation: *Truly I tell you, today you will be with me in Paradise.* (Lk 23, 43).

We always want people to recover, families to be healed, our communities to be safe spaces, and our schools free from problems. But we do not always manage to reach those goals. What is important is to discover the light along the way, which is what nourishes our hope, and that we embark on these tasks. It is important to work for one's own recovery, to go out again to seek the lost, to receive again, to work for families, for our communities, for our schools, for society. If we do not discover the light along the way, then sooner or later

frustration will overcome us, or we will feed our hope with the light of those who made it, and we will think that those who could not is because they did not put forth all their will and means.

Sometimes, a person feels the particular call to be a volunteer or chaplain at a hospital. Some congregations even dedicated their lives to the care of the sick and created hospitals. But no, ordinary Christians simply feel that the words of Jesus resonate in a hospital bed: *I was sick and you visited me* (Mt 25, 36). In the same way, we Christians get involved in the drug problem simply to accompany. Some community will feel called to create recovery spaces that have, like the doctor in the life of the sick person, the desire to cure or treat. But most of the time, the Church gets involved in this issue simply to accompany, to listen, to pray. Like Mary at the foot of the cross: remaining by the side with tenderness.

In the pages that follow, we will try to help look at the problem in all its dimensions, and to understand how the Church can commit itself. The method we follow is that of the Latin American Church: see (receive), judge (discern), and act (proposals).

Fr. Carlos Olivero
Coordinator of PLAPA
Bogotá, June 2026

CHAPTER 2

The methodology used

2.1 | The challenges

The challenge of creating a manual for the Church's addictions pastoral ministry is great and complex. Upon understanding that we had to do it, we encountered several tensions that were important to resolve:

1. The integration of synodal participation and specific knowledge:

The first challenge we discovered was to make the manual a space of encounter between community participation and specialized knowledge. Pastoral ministry cannot ignore scientific evidence at the risk of becoming ineffective. At the same time, we see that when science and its techniques ignore the community, they become cold, detached, and disembodied. The challenge, then, is to find the bridges between specific knowledge and the experience of our ecclesial communities that work daily with these issues and seek answers.

2. The particularity of perspectives and integral positioning:

The phenomenon of addictions is complex, and therefore there are multiple perspectives from which to look. In the same way, the responses are highly varied and emphasize different elements of the issue. The challenge of bringing the different experiences and their different perspectives into dialogue in a manual is great. In this manual, we take on the challenge of maintaining the most integral perspective possible. The positioning cannot be fragmentary; we understand that the person is an indivisible

unity. For that reason, the manual has the challenge of avoiding falling into any reductionism.

3. The dialogue between theory and practice:

When writing a manual, the challenge arises of not being excessively theoretical or merely instrumental. Our challenge is praxis: a critical reflection on action. Every concept presented here must find its counterpart in the mud of everyday reality, and every suggested practice must be illuminated by a solid foundation that gives it meaning and direction.

4. The articulation of knowledge and interdisciplinarity:

Addictions cannot be resolved from a single discipline. The challenge here is articulation: getting theological knowledge to embrace social sciences and medicine. We do not seek a sum of isolated chapters, but a fabric where different kinds of knowledge dialogue with each other, recognizing that the truth about human suffering lies at the intersection of all these voices.

5. Toward an ascending and integrating epistemology:

Perhaps the most profound challenge is the paradigm shift in the construction of knowledge. At this point, we attempt to move away from a descending epistemology that imposes theories from above and ends up fragmenting the reality of the subject. In its place, this manual opts for an ascending epistemology. This means that knowledge is born from listening, from direct contact with the territory, and from the experience of those who walk alongside the suffering, and from there it asks about theory to find answers. It is a perspective that integrates the pieces of broken life to restore dignity, instead of analyzing the individual as a study object divided into categories.

2.2 | The choices and the method

To respond to these challenges, we made choices throughout the entire development process. The main ones were:

1. To try to make the manual the fruit of a great synodal effort. For this reason, we invited as many pastoral agents as possible to participate. Nearly 300 pastoral agents from across the region collaborated with their perspectives, knowledge, experiences, and contributions.
2. To use the methodology of the Latin American Church: see - judge - act.

3. We invited all these pastoral agents to two large virtual meetings in which more than 250 people participated in each. In those meetings, we divided into groups and analyzed different elements of the issue. Those small group meetings were recorded and transcribed. In this way, we recovered everything that had been said in each of those groups. The transcriptions from each group were systematized with artificial intelligence tools, which made it possible to process the volume of contributions without losing the richness of each territorial voice. Based on that systematization, the coordinating team drafted the See section. We understood that with this methodology we were safeguarding the synodal spirit.
4. To use as a basis the Addictions Curriculum for Faith Leaders, developed by CICAD/OAS. We sent the Curriculum to all participants so that they could evaluate it, and we convened two more large virtual meetings, in which the participants divided into groups and pointed out what they felt was missing from the CICAD Curriculum, what they disagreed with, and the elements that in their view should appear differently. We recorded and transcribed those meetings, systematized the contributions with artificial intelligence tools, and drafted the Judge section. In this way, we tried to bring into dialogue the academic knowledge that prevails in the CICAD manual with the knowledge and experience of our pastoral agents.
5. For the drafting of the Judge section, we considered it appropriate to use the structure of the scholastic method, which organizes discernment around a question, raises objections, provides a criterion, and responds to the difficulties. It is necessary to clarify how this format is articulated with the ascending epistemology that structures the manual, since at first glance they might seem incompatible: the scholastic method is an expository tool of deductive tradition, while the ascending epistemology proposes to build knowledge from the territory toward theory. The compatibility lies in a key distinction: the ascending approach operates in the genesis of the questions — which are born entirely from the See and from synodal listening —, while the scholastic approach operates in the organization of the responses — offering a clear structure that allows the pastoral agent to quickly find the discernment they need. Put another way: the questions rise from the mud of the territory; the responses are organized with the rigor of an intellectual tradition that the Church has tested over centuries. The scholastic method does not impose the questions from above; it receives them from below and organizes them so that discernment is accessible.
6. Those who wished to contribute to a first correction were called, and 35

CICAD is the Inter-American Drug Abuse Control Commission of the OAS, Organization of American States.

people came forward, making more than 150 corrections. Some of those corrections were substantive, others conceptual, others stylistic. The corrections were incorporated.

7. Training was developed for regional representatives on the content of the manual and pastoral animation, and they were invited to collaborate in drafting the Proposals. In this way, we drafted the Act section.
8. The representatives designated by the Episcopal Conferences were called and invited to review, correct, and make contributions to the manual.
9. The entire process was guided by the coordinating team of PLAPA.

On sources and references. This manual is a pastoral document and not an academic treatise. For this reason, the explicit references are limited to the sources of the Magisterium of the Church, ecclesial documents, and Sacred Scripture, which constitute the framework of authority proper to this text. The content from health sciences, neurobiology, psychology, and social sciences integrated throughout the manual reflects the current consensus of the disciplines involved, as collected and verified by the coordinating team based on the Addictions Curriculum for Faith Leaders developed by CICAD/OAS, the professional experience of the participants, and dialogue with specialists. The choice not to include an academic citation apparatus responds to the nature and the audience of the document: a manual designed for pastoral agents, parish communities, and territorial teams, not for publication in scientific journals. The reader who wishes to delve deeper into the scientific foundations gathered here may consult the CICAD Curriculum, which served as the technical reference base for the development of the Judge section.

On the use of artificial intelligence tools. It is appropriate to clarify the scope and limits of the use of artificial intelligence in the development of this manual. AI tools were used at two moments in the process: first, for the systematization of the transcriptions from the synodal meetings, organizing and synthesizing the volume of contributions generated by the nearly 300 participants; second, as an assistance tool in drafting, conceptual review, and text correction throughout the development process. In all cases, the direction of the content, the evaluation of theological and pastoral relevance, doctrinal positions, criteria of discernment, and the final approval of each article were the exclusive responsibility of the human team that coordinated the process, in dialogue with the participants and the representatives of the Episcopal Conferences. The tool assisted the writing; the team directed it. Likewise, a review of the final text was conducted to verify that the document did not

contain formulations or language registers attributable to the tool that had not been duly integrated by the editors. This transparency responds to a conviction: artificial intelligence can be a legitimate tool at the service of pastoral development, but the word that emerges from that process is always a human and ecclesial act, not an algorithmic product.

CHAPTER 3

An image for the pastoral ministry

Throughout history, Christians have been representing the paschal mystery in many forms. Each artistic school knew how to convey to its works the imprint, sensitivity, and questions of its era. Painting, sculpture, theater, music... all the arts spoke of a mystery that is inexhaustible, each one emphasizing its own quest.

But have you ever seen an addicted crucified one? Have you ever imagined the possibility that on the scaffold hung a Christ with lips cracked by crack cocaine, or arms pierced by heroin needles?

Probably not. And if such a work existed, it would surely cause scandal. The fact is that in our mental representations, the innocence of the Crucified and the moral burden of the life of the person in a situation of dependence seem contradictory. However, we need to immerse ourselves not only in the mystery of our Savior, but also in that of the human being.

The Catechism of the Catholic Church teaches that for a sin to be mortal, three conditions are required: *Mortal sin is sin whose object is grave matter and which is also committed with full knowledge and deliberate consent.*

CCC N° 1857

Are we sure that those three conditions are met in all addicted persons? Are there not constraints on freedom that arise from the wounds of life, the lack of opportunities, from a miserable life, what was learned during childhood, genetics, contexts, or the disease itself? Is there full knowledge when growing up in a society that only values consumption, or in a family with two or three generations of addicts, or when beginning substance use at 7, 8, or 9 years old?

We do not know. What we are sure of is that addiction involves enormous suffering, and that our Lord *bore our sufferings... was pierced for our transgressions* (Isa 53, 4-5), thus assuming the consequences of our sin. We are certain that *God made him who had no sin to be sin for us* (2 Cor 5, 21).

Then probably there could indeed be a crucified Christ with the marks of addiction, not so much because He himself was the cause, but because of the fact that He assumed our condition.

Something similar can be found in the Isenheim Altarpiece, an extraordinary work that, as we shall see, is a powerful symbol for our addictions pastoral ministry.

3.1 | The Isenheim Altarpiece



Figure 3.1: The Isenheim Altarpiece, by Matthias Grünewald

In the sixteenth century, in a small town called Isenheim, near what today would be the border between France and Germany, the Monastery of Saint Anthony stood. It was not merely a place of prayer. The Antonine Order was dedicated to the care of the sick, especially those suffering from ergotism, popularly known as *Saint Anthony's fire*.

Ergotism was a terrible disease caused by chronic intoxication with the toxic

alkaloids of a parasitic fungus of rye called *Claviceps purpurea*. By ingesting bread made with the contaminated grain, men and women fell ill. It was a terrible affliction, whose condition manifested mainly in two forms:

- **The gangrenous form:** which caused severe vasoconstriction, leading to very intense pain, necrosis (death of tissues), and loss of limbs.
- **The convulsive form:** which caused spasms, hallucinations, convulsions, and mental disorders.

The infection had become popularly known as *Saint Anthony's fire* because, due to the extreme vasoconstriction of the gangrenous form, the disease caused intense burning as if the person were being burned alive. That same form progressively developed skin ulcers, ultimately resulting in the death of tissues, and even of limbs.

The Antonine order, which through prayer and delicate care was dedicated to tending to these sick, had opened its monastery to receive the ill.

The artist Matthias Grünewald was commissioned by the abbot to create the altarpiece for the Monastery's Church, which had become an infectious disease hospital. For this reason, wanting to express to the sick that the Lord shared their suffering, he painted at the center of the altarpiece a crucified Christ with the marks of ergotism: ulcerated skin, hands expressing extreme suffering, undergoing spasms as a consequence of neuromuscular symptoms, exaggerating the tension of the tendons.

At the center of the painting, we can see a cross bearing so much weight that the ends of the horizontal beam can barely support it, twisting almost to the point of breaking. A Christ with ergotism, to speak to the sick of ergotism. A crucified one deformed by the cross of disease, who in his very horrible being manages to convey the utmost compassion and the boundless love of God.

This image of the crucified Christ, which reveals God's compassion for those infected by Saint Anthony's fire, is also a symbol for our time. In the image, we see a suffering Christ who shares the affliction of so many men and women with addiction problems. Nailed and powerless, he is there, expressing his love.

Today, there are countless men and women who, deformed, walk like zombies through the streets of our cities. The world judges them, stigmatizes them, and turns its back on them. Even many times in our communities we do the same, depriving them of the good news of the Gospel. More than ever, we must find again the way and the language to say that our Lord does not judge them or distance himself, but on the contrary, emptying himself, he draws near and

shares their condition. Grünewald and the Antonines found it. The charity of the monks allowed the artist to interpret the mystery in an image so luminous that, five centuries later, it continues to move us.

The altarpiece does not end there; everything in it speaks to us of the fabric of a redemption wrought by the mercy of God. It is composed of four well-defined scenes. Each of them presents different figures. The central scene presents the crucified one; to his left are his mother and the beloved disciple together, and kneeling and weeping, Mary Magdalene. To the right of the cross, we can see Saint John the Baptist and the Lamb of God. In the left scene, we discover Saint Sebastian, patron saint invoked against the plague. In the right scene, we recognize Saint Anthony the Abbot, founder of eremitic monasticism and patron of the Antonine order. In the lower scene, we can see the mother, the beloved disciple, and the Magdalene at the burial of Jesus.

The unity of all the elements and figures of the altarpiece lies not in the painting, but in the overall meaning of the work. What do Saint Sebastian, Saint Anthony the Abbot, the crucified one, the urinals, John the Baptist, and the wife of Clopas have to do with each other? They are not even contemporaries. As we shall see, all these figures and elements are connected in the artist's message to the sick: *God shares and redeems your pain; here too a spiritual battle is waged.*

3.2 | The mother and the beloved disciple

In the Isenheim Altarpiece, the figures of the Virgin Mary and the beloved disciple embody one of the most profound responses to the mystery of suffering, offering a mirror for the suffering of so many mothers who faint from the addiction of their children and for those pastoral agents who decide to accompany them.

The representation of Mary in the central panel of the Crucifixion is of an extreme pallor, almost as white as the tunic and mantle that envelop her from head to the ground. With eyes closed and hands tightly clasped in a gesture of prayer, Mary collapses backward, appearing before the viewer as someone who is more dead than alive. This anguished mother today symbolizes those mothers who witness the destruction of their children by substance use, feeling that the life of those they brought into the world slips through their fingers like sand without anything they can do to stop the process.

In the context of the Isenheim hospital, Mary served as a model for the terminally ill, demonstrating that even in emotional collapse it is possible to maintain an attitude of mystical surrender and acceptance. She represents the

mother who has no more words, who can only cry and pray before the broken son, being the image of a Church that learns to weep for its children before a world that often closes itself to them. Francis says: *Almost without being aware of it, we end up being incapable of feeling compassion at the outcry of others, we no longer weep at the drama of others nor are we interested in caring for them, as if everything were someone else's responsibility that does not concern us.* Her figure is the testimony of pure pain that does not flee from the cross, remaining present even when the son's life seems to have become a shadow.

Evangelii Gaudium N°
54

Physically supporting the mother in her faint is the beloved disciple. His face is marked by pain and sorrow, weeping with his mouth open, but he leans his whole body solicitously and carefully toward Mary. While Mary's color is cold and pale, John's is an intense red, creating a contrast that underscores his role as vital support. He personifies the community or the support network that does not abandon the mother in her darkest hour.

The deep identity of Saint John at the foot of the cross is that of knowing how to remain. In the reality of addictions, where the environment usually seeks quick or effective solutions, John teaches that to love means to stay beside the mother and the son when it is not possible to resolve the problem immediately. His presence, together with Mary's, is for the crucified Jesus the only wholesome place where he can look, seek rest, and find consolation in the midst of torment.

Both figures, united by pain and tenderness, propose a model of accompaniment that ignores the social judgment on addiction. In the final gaze of this painting, the mother and the friend do not attempt to *bring the son down from the cross* by force, but rather they accompany him. Through loving contemplation, they recognize the sacred dignity of the wounded life until the very last moment.

3.3 | Mary Magdalene

In the Altarpiece, the figure of Mary Magdalene offers a representation of pain in its most acute and desperate state, serving today as a mirror for the reality of many women —so many Magdalenes— who go through situations of violence, sexual exploitation, abuse, and marginalization, related to substance use.

Unlike the Virgin Mary, whose response is mystical acceptance, Grünewald's Magdalene writhes in uncontrollable despair and shock. He depicts her kneeling, with her head tilted back as she weeps and her hands clasped with such force that her fingers appear rigid and tense.

These gestures express the deep intention of clinging to something. In the

current reading, she symbolizes the women who see how their only refuge and anchor —represented in the painting by Jesus— is slipping away from them. For the Magdalene, Jesus was the only person who loved her well and did not want to use her, a painful contrast with the reality of many women today who have received from society only violence, contempt, and abuse.

Visually, the Magdalene stands out for her long dress in a warm red tone, which creates a chromatic link with Saint John and stands out against the dark background of Golgotha. Unlike the Virgin, who appears wrapped in white and almost lifeless, the Magdalene is shown with her long blond hair under a semi-transparent veil, looking much more adorned. This aesthetic detail is not superficial; in contemporary interpretation, it represents the women whom society often places in the position of objects and then judges severely. They are women who, despite their wounds, maintain a sacred dignity that society often fails to see, but who remain in the heart of Jesus. In the addictions pastoral ministry, she embodies the women condemned for not being able to give their own children the affection or care that they themselves never received from their environment.

At the Magdalene's feet lies her traditional attribute: the perfume jar. In the original context of the Isenheim hospital, this vessel not only recalled the loving gesture of the woman who anointed Jesus, but bore a direct relationship with the monastery's pharmacy. The jar painted by Grünewald resembles the medical flasks used by pharmacists of the era to contain healing elixirs and ointments.

For the sick of ergotism (Saint Anthony's fire) and for the broken of today, the Magdalene represents the act of anointing and caring for the wounded body. She is the symbol of the hope of restoration; just as she brought balms to anoint the body of Christ, her figure invites the community not to look away from the pain and to offer consolation through presence and service, recognizing that even in the total stripping of the cross, love is the only possible relief.

3.4 | John the Baptist and the Lamb of God

In the Altarpiece, the figures of John the Baptist and the Lamb of God fulfill a different function from that of the mourners on the left side: while Mary and the Magdalene represent the emotional impact of suffering, the Baptist and the Lamb provide the theological meaning and the key to salvation.

John the Baptist is the witness who gives meaning to the chaos. He appears to the right of the cross anachronistically, since he had already died by the time of

the Crucifixion. His presence is purely symbolic: he is the witness who remains outside of natural time to invite a deeper understanding of the events.

His most distinctive feature is the index finger, depicted as disproportionately long or preternatural, pointing fixedly at the Crucified. In our context, the Baptist represents the theological role of this pastoral ministry, which aims to remind the Church that in the most broken persons, the same crucified Christ lives, who takes on our ailments to save us.

Sometimes embodied in a therapist, a spiritual guide, a peer companion, or a family member, he does not seek to be the protagonist, but rather limits himself to pointing out the sacred dignity of the suffering son, and reminds us that even in that broken body full of sores, the possibility of redemption dwells.

He must increase, reads the Latin inscription beside him. *Illum oportet crescere, me autem minui* (He must increase, but I must decrease), summarizes the stripping of ego necessary both in faith and in accompaniment. For the families of people with addiction, it also recalls the renunciation of personal control, to let the healing process and the grace of God take center stage.

At the Baptist's feet is a white lamb holding a small cross, whose blood flows directly from its chest into a golden chalice. The Lamb of God, immolated, which for our pastoral ministry connects our work in accompaniment with the mystery of the Eucharist.

The blood that falls into the chalice represents sacramental consolation and the healing that springs from the very heart of suffering. In the addictions pastoral ministry, this suggests that suffering, when brought into contact with the community and faith, ceases to be a fire that only destroys and becomes a place of encounter and transformation.

The lamb is not a passive figure; it represents the Lord who identifies with the last in line, with the one who is torn to shreds by their dependencies. Just as the Christ of Isenheim shows the marks of disease on his skin, the lamb shows its open wound, symbolizing a divine solidarity with the marginalized. For the person in a situation of dependence, the lamb is the image that God does not watch from afar, but internally shares their suffering.

John the Baptist holds the open book of the Scriptures, which dialogue with the raw reality of the cross. It is the contemplative and prayerful gaze, which, grounded in the Word of God, allows us to discern the scenes of the cross that we live and accompany. It is *the Word, which gives us back the word* that we lost in addiction.

3.5 | Saint Sebastian

In the Isenheim Altarpiece, the figure of Saint Sebastian represents the testimony and the silent martyrdom of those who decide to give their lives to the care of today's «broken christs».

Saint Sebastian is the protector against the new «plagues». Traditionally, the saint was the patron of the sick and was invoked for protection against the plague. In our current reading, the arrows that pierce his body symbolize the modern plagues, such as addiction, drug trafficking, organized crime... which deeply wound the social and family fabric. Just as Sebastian remains standing despite the wounds, this figure represents the resilience of those who face these painful realities.

Saint Sebastian embodies today's martyrs within the community: laypeople, religious, and family members who place their entire existence at the service of those crucified by addiction. He represents that silent self-giving, often ignored by society, where one's life is entirely spent to embrace and accompany those who suffer in the streets or in shelters.

The saint appears on a pedestal, with hands raised in prayer and his gaze directed toward the central Crucifixion. This teaches that the identity of the companion is not that of a mere manager, but that of a witness. His position reminds us that the true place of Christian witness is found precisely where the cross is, remaining faithful beside the broken son.

There is a traditional belief that Grünewald portrayed himself in the figure of Saint Sebastian. In the addictions pastoral ministry, this takes on a profound meaning: the artist (or in our case, the caregiver) does not look at the pain from outside, but places himself in the painting. The addictions pastoral ministry is not organized around therapeutic distances that allow objectivity. Francis said: *the evangelizing community gets involved by word and deed in people's daily lives; it bridges distances, it is willing to abase itself if necessary, and it embraces human life, touching the suffering flesh of Christ in others. Evangelizers thus take on the "smell of the sheep" and the sheep are willing to hear their voice.*

Evangelii
Gaudium N° 24

Behind Sebastian, a window shows angels holding a golden crown above his head. This detail offers hope to mothers and companions: although the path of accompanying a person in a situation of dependence may be a martyrdom full of arrows of misunderstanding and exhaustion, that effort has a sacred dignity in the eyes of God and is a source of light in the midst of the darkness of Golgotha.

3.6 | Saint Anthony the Abbot

There is another figure that in the Altarpiece acquires a fundamental dimension. It is that of Saint Anthony the Abbot, representing not only the individual struggle against evil, but also the power of the praying Church that sustains the healing processes of young people in recovery.

In the side panel, Saint Anthony appears at peace, while a demon tries to break the glass behind him. The praying Church is personified. This image represents the men and women who, from silence and prayer, provide the root and spiritual support necessary for those who struggle to break the chains that bind them and those who work in the trenches of addictions. Just as the saint's peace is not disturbed by the external attack, this constant intercession helps young people remain steadfast against the voices of hopelessness that try to sabotage their paths to freedom.

This is the Temptations panel, and it shows the saint assailed by monsters that symbolize both vices and the hallucinations of the disease. In the addictions pastoral ministry, these demons represent the evil spirits that seek to disturb the mind of the person undergoing a recovery process in order to bring them back to a scene of self-destruction. The praying Church acts here as a force that helps to expel worldliness and the temptation to return to the onions of Egypt (cf. Num 11, 15) or to *move away from the knot of the human storm*.

cf. Evangelii
Gaudium N° 270

At the saint's feet, the paper with the inscription "*Where were you, good Jesus...?*" reflects the cry of the person in a situation of dependence who feels abandoned at the rawest moment of their withdrawal or relapse. The answer that Anthony receives—that God was always there to see his struggle—is the message that the praying Church conveys to young people: their process is a brave struggle where their spiritual dignity remains intact despite the physical or mental abuse of drugs.

Saint Anthony carries his staff in the shape of a Tau (T), a sign of healing power for the Antonines. In the analogy of accompaniment, this staff represents the community and the praying Church that serve as physical and spiritual support to prevent the broken son from completely collapsing, transforming a symbol of weakness into a tool of salvation and daily support.

3.7 | The burial of Jesus

The scene of the Burial of Jesus appears in the lower part of the Altarpiece, and constitutes the point of greatest realism and rawness, offering a powerful

analogy of the Church that accompanies the children broken by addiction, even in moments that seem like total defeat or death.

The scene displays the body of Jesus torn to shreds, with a greenish, cadaverous pallor, covered with sores and ulcerated wounds that indicate the symptoms of ergotism.

The Church that remains after the failure of efficacy. While society often abandons those who fail to recover, this scene of the Altarpiece shows Saint John, the Virgin, and the Magdalene holding and weeping over the lifeless body of Jesus, thus representing the Church that walks with broken people beyond the logic of efficacy. It is not the Church that is only present when there is success or healing, but the one that knows how to remain in the silence of the tomb, embracing the broken life even when there seems to be no immediate solution.

Just as the disciples prepare the body of Jesus with care and reverence, the community of faith also recognizes the sacred dignity of those persons who died on the street or from overdose. It is the Church that, far from judging, continues to pray and honor the memory of its children, trusting that no life is definitively lost to God.

For the people who go through the grief of seeing their loved ones depart, this image validates their feelings and comes to meet them at the moment of greatest pain. However, by placing that pain on the altar, the altarpiece teaches that the descent into the hell of addiction is a terrain already inhabited by Christ, becoming the necessary preceding step for the hope of the Resurrection that is revealed when the doors are opened.

In today's pastoral ministry, this scene is linked to the sanctuaries of mercy, where the faces of those who did not survive drugs remain present in the prayers of the community. The predella (lower part of the Altarpiece) is the reminder that the Church is a mother who does not let go of her children's hands, not even when the world has already buried them, for her faith rests on a God who was also buried and who promises the restoration of all wounded flesh.

PART II

See

Receiving reality

Receiving Reality

This section is an invitation to carry out an honest diagnosis of the reality experienced by our brothers and sisters throughout the region. We do not intend here to advance solutions or theoretical frameworks, but rather to fulfill the task of observing head-on what is happening in our neighborhoods, as it emerges from listening to the agents who walk the territory.

Observing is not simply collecting statistical data or technical reports. It is, above all, an act of reception; it is receiving in the heart and allowing oneself to be moved by the suffering face of those who inhabit the peripheries. Through this exercise, we recognize a complex social fabric where problematic use of substances appears as the visible symptom of much deeper wounds and relational fractures.

What the testimonies and experiences of the agents reveal is a social fabric frayed by the throwaway culture and functional orphanhood. In these pages, a harsh reality is described where drug trafficking attempts to organize daily life, where close-proximity institutions undergo crises of meaning, and where specific sectors of the population become trapped in cycles of extreme exclusion. The objective of this section is, therefore, to offer a synodal perspective that allows us to understand the magnitude of the challenge before attempting any response.

Fratelli Tutti No.
18-21

A methodological clarification is necessary before delving into this diagnosis. The pages that follow integrate two types of information that the reader must distinguish. On one hand, the perceptions, testimonies, and estimates that pastoral agents shared during the synodal process, which reflect what those who walk the territory daily see and experience. On the other hand,

certain epidemiological or statistical data from institutional sources that are incorporated to contextualize those perceptions. When a figure comes from a verifiable source, it is indicated. The quantitative data that appear in these pages come, for the most part, from the convergent perception of the pastoral agents who participated in the synodal process. When references to estimates from international organizations or to the health sciences literature are incorporated, they are identified as such. This methodological honesty does not weaken the diagnosis; it strengthens it, because the synodal perspective has its own authority that does not need to disguise itself as technical data to be heard.

CHAPTER 4

The crisis can no longer be concealed



Figure 4.1: The faces of the crisis

4.1 | Our neighborhoods

Our territories are marked today by a frayed social fabric, where the loss of roots and an extreme individualism erode the notion of a people. In these communities, the problem of substances is not an isolated fact, but a web that affects all the vital elements of coexistence. It is observed that drug trafficking has become the organizer of daily life in the face of the withdrawal or absence of state institutions, occupying a position of power that allows it to regulate everything from security to the domestic economy of families.

This narco-culture functions as a structure that imposes invisible borders in the neighborhood, where simply moving from one sector to another can represent a risk to life. In the most neglected slums, organized crime offers the only visible path of social advancement, transforming the work ethic into the logic of easy money. The reality is harsh: bunkers have become the new commercial reference points of the neighborhood, and the sale of substances has become so atomized that the users themselves are pushed into dealing in order to sustain their consumption.

Christus Vivit
No. 71-74

The most critical aspect of this diagnosis is the planned recruitment of children. Children and adolescents are used as links in the criminal chain under the figure of little soldiers or micro-traffickers. Territorial chronicles coincide in reporting cases of onset of use in popular neighborhoods from the age of 8 or 9, a reality that contrasts with national statistics—which usually place the average age of onset between 13 and 15—and that highlights the particular vulnerability of children in the most excluded sectors. Added to this is a marked feminization of poverty, where women face child-rearing alone in environments of violence, frequently becoming trapped between the need for subsistence and absolute lack of protection.

A fragmentation of institutional response is also detected. The State usually arrives late or through bureaucratic processes that are alien to the history and bonds of the people. The neighborhood has become a battleground for subjectivity, where the message of immediate consumption competes with the possibility of a dignified life. Currently, the reality of street corners and alleyways shows that a merely assistentialist approach is insufficient in the face of the profound rupture of social bonds and the desolation of entire communities that see the territory as a place of disposal.

4.2 | Our parishes

When observing the reality of our ecclesial communities, a persistent tension is detected between the mandate of the Gospel and the operational practice regarding substance use. Many parishes operate under a predominantly administrative or sacristy logic, withdrawn into the maintenance of internal order and keeping a prudent distance from the pain that inhabits their territories. This attitude frequently ignores the fact that the problem of addictions has already penetrated the lives of the faithful themselves, treating it as an alien reality that does not require a specific pastoral response.

There is a recurrent tendency to dialecticize reality, classifying people between

insiders and outsiders, or between the integrated and the excluded. This perspective tends to label the substance user under moral categories of sin or delinquency, which obscures their ontological dignity. It is observed that rigidity in schedules and institutional procedures often takes precedence over the existential chaos introduced by someone who arrives in a crisis situation. This dynamic generates an atmosphere that is perceived as expulsive by those who are broken, who find in the parish structure more of a control checkpoint than a welcoming home.

The diagnosis also reveals that the ecclesial response tends to be late. It is recognized that a young person's arrival at prison or a juvenile detention center is, in many cases, the result of a community that failed to offer a prior support network. This delay is deepened by a lack of understanding of the problem among pastoral agents, who often consider that the Church does not possess tools for this field and delegate responsibility exclusively to specialists, social workers, or the State. This disconnection not only mutilates the social dimension of the Christian message, but leaves in orphanhood the families who come to the churches seeking a consolation and accompaniment that they do not find in the state bureaucracy.

4.3 | Our schools

The educational sphere in the region is undergoing a crisis of meaning that manifests itself in a profound disconnection between the institution and the vital reality of young people. In the most vulnerable territories, agents report that in the most vulnerable contexts up to 50 percent of adolescents drop out of secondary school because the system fails to respond to their needs or offer an attractive horizon. The school, which should function as a primary agent of socialization, is often perceived as an alien space where academic content fails to enter into dialogue with the urgencies of the neighborhood.

It is detected with alarm that substance use has permeated school walls at increasingly early ages, with cases of problematic use reported even in the first years of primary education. Faced with this reality, the institutional response usually oscillates between indifference and fragmented over-intervention. In this latter scenario, various actors such as health centers, courts, and social agencies act upon the same child without any coordination, which leads to a dismemberment of their personal situation. This dynamic is not only ineffective but violates the privacy of students by circulating sensitive information throughout the entire community environment without criteria of comprehensive care.

The diagnosis also reveals a notable lack of preparation among teaching staff and administrators to accompany the complexity of addictions. In the absence of detection and intervention tools, stigmatizing labels are frequently used, which end up expelling the young person from the educational system, reinforcing their exclusion. Likewise, an institutional incoherence is observed in certain communities where, while attempting to prevent substance use, the presence and sale of alcohol at school events to raise funds is normalized, sending contradictory messages to minors.

Finally, the classroom is impacted by a disorganized macro-environment where poverty, malnutrition, and the absence of adult role models transform the school space into a mere place of transit. Education has been reduced in many cases to the mere transmission of data, losing its capacity for listening and for forming citizens with purpose. In the current state of affairs, the school shows itself weakened in its function of support, losing the battle for the subjectivity of young people against the immediate and evasive offer of substances.

4.4 | The particular situation of women

The experience of women affected by substance use in the region reveals a web of specific vulnerability that differs profoundly from the male experience. A double condemnation is observed, both social and moral: a woman is judged not only for her use of substances, but for the failure to fulfill the cultural role of mother and caretaker of the home. This stigma generates an internalization of rejection, where the person comes to perceive her situation as a personal shame, which feeds cycles of guilt and self-contempt that tend to paralyze the search for accompaniment.

In the relational sphere, a marked contrast with men is detected. While men usually have a female support network—mothers, wives, or sisters—during their processes, women frequently face abandonment by their partners and families when substance use becomes visible. Added to this structural solitude is the constant fear of state intervention; many mothers hide their problem out of fear that child protection agencies will take away custody of their children, perceiving the system more as a punitive rather than restorative instance.

From the biological dimension, the phenomenon known as the telescoping effect is identified, whereby women transit from first use to severe dependence and physical damage in a much more accelerated timeframe than men. Physiological factors, such as the greater proportion of adipose tissue where psychoactive substances remain impregnated, hinder and prolong detoxification

processes, increasing the risk of cirrhosis, dual pathologies, and premature organic deterioration.

The territorial diagnosis indicates that female substance use functions, to a large extent, as a self-therapeutic attempt in the face of complex traumas. Histories of gender violence, childhood abuse, neglect, and orphanhood constitute an internal fracture that the substance seeks to anesthetize. In contexts of feminization of poverty, the lack of access to land, shelter, and dignified work pushes many women toward high-risk survival strategies, such as small-scale drug dealing or prostitution, in order to sustain the family economy, which exposes them to new cycles of violence and substance use.

Finally, serious deficiencies in the public health system are noted. There is a critical lack of treatment centers specifically for women, and a strong stigma persists in general hospitals, where situations of mistreatment, humiliation, or segregation toward pregnant women or women with HIV are recorded. The institutional response tends to ignore the need for a comprehensive approach that considers motherhood and the repair of primary bonds as central axes of the diagnostic process.

4.5 | Families and the youngest

When observing the reality of the youngest in the territories, one of the deepest wounds of the region is identified: the drastic decrease in the age of onset of substance use, where pastoral agents report cases in popular sectors from the age of 8 or 9. This phenomenon manifests as the result of functional orphanhood, where children and adolescents grow up in environments in which the adult role models have ceased to be protective figures and have become absent or invisible. It is detected that families, which should constitute a safe harbor, are frequently fragmented or affected by the same problem of substance use, structural poverty, and overcrowding. This desolation pushes minors to the street not only in search of the substance, but as a way to escape unbearable pain or to find the affection and belonging they do not find in their homes.

Children's communities in these contexts are marked by complex trauma. Domestic abuse, neglect, and sexual abuse constitute a scenario that conditions development from early childhood. Within this framework, drug trafficking operates as a planned recruitment system, enlisting children between the ages of 12 and 16 to use them as little soldiers or micro-traffickers. This criminal structure presents itself as the only visible path of social advancement in the face of the withdrawal of state institutions, taking advantage of the biological

vulnerability of a developing brain whose immature prefrontal cortex lacks the necessary brakes to assess risk or resist group pressure.

In many cases, those who should be protective figures do not fully assume the role of father or mother. They present difficulties in establishing limits and adapting to the demands that family life and the arrival of children entail, without having developed the necessary skills to exercise adequate child-rearing. Generally, these adults were not prepared to form a family either: they come from similar experiences and cannot break the cycle that ends up repeating itself in their own experience as parents.

The diagnosis thus reveals a generational repetition of these stories, where many of the adults who today are affected by substance use are the wounded children of the past who never had an effective support network. Added to this situation is the impact of malnutrition and undernutrition which, combined with the use of highly toxic substances such as crack or cocaine paste, generate levels of cognitive deterioration and disability that compromise the future of thousands of minors in situations of exclusion. The feminization of poverty also plays a central role: mothers face child-rearing alone and bear the social stigma, which leads to a constant fear of being sanctioned by the state protection system.

Finally, the emergence of new forms of isolation within the home through the digital environment is recognized. International studies and territorial observation coincide in that children can spend more than eight hours a day in front of screens, exposing themselves to an overload of information and, increasingly, to gambling addiction through online betting. This environment generates a progressive disconnection from emotions and from primary family bonds. The constant release of dopamine triggered by electronic devices alters the brain's pleasure circuits in a manner analogous to chemical substances, deepening anxiety and isolation within the very heart of the home.

4.6 | New technologies

When observing the reality of our communities, the emergence of a new risk scenario is recognized: the digital territory. This space, although lacking physical geography, is where today a large part of the existence, identity, and bonds of young people are at stake. It is not merely about communication tools, but about an environment that shapes subjectivity through mechanisms of impulsivity and compulsivity that alter pleasure centers in a manner analogous to chemical substances.

An alarming colonization of time and attention is detected, where adolescents

spend several hours a day in front of screens, with international estimates exceeding eight hours in some contexts. This consumption generates a state of constant alertness due to the incessant flow of notifications—which can reach hundreds per day—feeding the phenomenon known as FOMO (fear of missing out). This information overload leads to a persistent anxiety for peer approval and a fragmentation of attention that hinders the development of deep reflective processes.

The mutation of entertainment toward online gambling addiction is observed with particular concern, particularly among minors. This path usually begins insidiously through seemingly free video games that introduce market and competition logics, later evolving into internet gambling. This form of behavioral addiction functions as an escape route to anesthetize emotional discomforts or daily life uncertainties, generating a secondary pain marked by guilt and absolute isolation within one's own room.

The impact of these technologies also manifests in physical health and the family fabric. Spinal problems and severe sleep disturbances linked to inadequate postures and schedules that alter the vital rhythm are reported. In the home, device dependency generates a disconnection from emotions and from primary bonds, substituting dialogue with constant entertainment that makes problems invisible to parents until the deterioration is severe. The diagnosis highlights that this system is designed to defeat the self-control of young people, whose prefrontal cortex—the biological brake on impulses—is still in the process of development.

4.7 | Health

When observing the physical health of persons affected by substance use, a reality of extreme fragility and systemic abandonment is recognized. The territorial diagnosis reveals a situation of care orphanhood, where the formal health system usually reaches a ceiling or limit in the face of marginality. It is detected that health institutions presuppose that the patient possesses baseline living conditions, such as shelter, food, or housing stability, whose absence nullifies the effectiveness of any medical treatment and expels the subjects from the circuit of care.

Access barriers manifest through a bureaucracy that is expulsive toward the poorest. The system frequently requires identity documents, compliance with rigid schedules, and costly travel that people living on the street or in peripheral neighborhoods cannot sustain. In rural or mountain areas, this situation is

aggravated by geographic remoteness and lack of planning, which interrupts the continuity of vital processes. It is observed that the system is fragmented and saturated, offering administrative responses that prioritize procedure over the urgency of the suffering person.

A critical element of the diagnosis is the stigma and discriminatory treatment within medical centers. The testimonies of the agents coincide in that health personnel often mistreat, segregate, or ignore persons in situations of substance use or persons with HIV. Situations have been recorded where pregnant mothers with substance use problems are segregated in the waiting rooms of general hospitals, a gesture of rejection that distances them from the possibility of seeking help. This stigma functions as an invisible barrier that deepens vulnerability and discourages the most vulnerable populations from approaching public health.

The physical deterioration derived from chronic substance use, especially of highly toxic substances such as crack or cocaine paste, generates severe neurological and cognitive damage, seriously compromising the immune system. This biological vulnerability facilitates the spread of diseases that are markers of poverty, such as tuberculosis, HIV/AIDS, and hepatitis. Diagnosis is usually late due to the lack of a preventive care network, which leads to many people arriving at hospitals in terminal stages. The result is an alarming rate of deaths that are described as shameful and absolutely preventable.

Finally, a specific problem in neonatal and childhood health is identified. An increase in babies born with neonatal abstinence syndrome, epilepsy, or disabilities linked to maternal substance use during pregnancy is noted. In women, the aforementioned telescoping effect accelerates organic damage, resulting in severe pathologies in much shorter timeframes than in men. This reality demonstrates that the health crisis in the territories is not only a problem of lack of medicines, but of an institutional structure that fails to recognize the dignity of those who inhabit the peripheries.

4.8 | Mental health

When observing the reality of our territories, it is recognized that mental health is a critical and frequently invisible component in the drama of addictions. The diagnosis reveals that, according to consistent estimates in the international clinical literature, approximately 50 percent of persons who suffer from a substance use disorder also present a co-occurring mental disorder, which constitutes the complexity of dual pathology. It is detected that substance

use is not the problem in itself, but the symptom of an internal fracture or a self-therapeutic attempt to anesthetize a life that has become intolerable due to deep wounds.

The problem is grounded in a dysregulation of the central nervous system in the face of stimuli that the subject cannot adequately process. Substance use then appears as a tool for escape or disconnection from a world perceived as threatening, especially when there are maladaptive memory networks that store traumas, abuse, or childhood abandonment. A significant prevalence of diverse personality organizations in the neighborhoods is identified, with borderline structures standing out, as well as psychotic conditions marked by great fragility and loss of reality testing.

It is observed with concern that the formal health system usually reaches a ceiling in the face of this marginality. Institutions often offer fragmented responses that ignore the need to address the integrity of the person, treating addiction and mental disorder as watertight compartments that do not communicate with each other. This lack of a comprehensive perspective leads to underlying psychiatric conditions and prior traumas being left unattended, which usually results in recurrent relapses that the system itself penalizes or misinterprets as a lack of willpower.

Finally, the diagnosis highlights the weight of stigma and shame. The patient usually internalizes social rejection, transforming it into a feeling of unworthiness that sabotages their own attempts at well-being. The reality of our brothers and sisters reveals that addiction is the visible manifestation of a profound emotional orphanhood, where the existential void and the lack of clear reference points leave the individual without the psychic tools to face the pain of their own history.

4.9 | The drama of work

In receiving the reality of our territories, we recognize that work is not just a means of subsistence, but the vertebral axis that grants dignity and meaning to daily life. However, today it pains us to observe that this axis is frequently fractured, becoming a scenario of profound suffering for our peoples. The drama of work manifests itself both in the anguish of unemployment and in the dehumanization of working conditions, realities that must be addressed as deep wounds in the integral health of the person.

The lack of employment must not be viewed solely from economic statistics; it is a true urgency that destructures the heart and mind. The absence of a task

that orders the day generates blocks of *empty time* that increase vulnerability to substance use, where drugs appear as a false anesthesia to mitigate the pain of helplessness. This situation pushes the brother or sister toward a *social drift* that usually culminates in the rupture of family bonds and, in the most extreme cases, in homelessness. For this pastoral ministry, unemployment is a predictor of relapse that requires a response of mercy and immediate justice.

The world of work is not always a space of fulfillment; it often presents conditions that make people ill and predispose them to substance use. We observe with pain how labor in extreme climates or at exhausting rhythms induces the use of substances to *endure* fatigue. Labor precariousness acts as a toxic pandemic that penetrates the subjectivity of workers, producing anxiety and a profound loneliness. In many sectors, a *privatization of exhaustion* is experienced, where systemic malaise is borne as a personal failure, concealing the structures of sin that dehumanize daily labor.

At the other extreme of unemployment, we encounter the phenomenon of *workaholism* or work addiction. It is a pathology that society tends to praise under the mask of success and efficiency, but which hides an uncontrollable need to fill existential voids. The person dependent on work bases their value solely on productivity, neglecting their health and their sacred bonds. It is vital that the pastoral agent be attentive to recovery processes, as often the compulsion for the substance is replaced by this compulsive work-dependency. This *concealed situation* is nothing but another form of dependence that inevitably leads to spiritual exhaustion and the loss of the meaning of life in community.

4.10 | Our brothers and sisters on the street

When observing the reality of those who inhabit the streets of our region, one of the most harsh expressions of the throwaway culture is recognized. This situation is not limited to a lack of economic resources, but responds to a trajectory of multiple vulnerability marked by profound ruptures in family bonds, early abandonment, and unprocessed grief. It is detected that many brothers and sisters perceive the street, paradoxically, as a space of false freedom; in the absence of norms and support networks, this apparent autonomy keeps them away from governmental agencies and perpetuates cycles of extreme marginalization.

In this context, the use of psychoactive substances functions as a self-therapeutic attempt to anesthetize a reality that has become intolerable. The substance is used as a tool to process the impact of cold, hunger, and loneliness, as well as the

emotional dysregulation caused by childhood wounds, abuse, and mistreatment. Substance use thus acts as a mechanism of escape and disconnection from an environment that the individual perceives as hostile and threatening.

The diagnosis reveals that the formal health system usually reaches a ceiling or limit in the face of street marginality. Health and social institutions frequently presuppose that the patient has their basic needs met, requiring for access to treatment conditions of housing stability, food, and documentation that the person does not possess. This bureaucratic rigidity is expulsive and leads to a high rate of absolutely preventable deaths from infectious diseases such as tuberculosis, HIV, and hepatitis C, since the system fails to make its protocols flexible enough to ensure treatment adherence under conditions of homelessness.

It is also observed that, in the face of the functional orphanhood of their homes of origin, people living on the street weave bonds of mutual support on the street itself, forming a relational network that operates as an alternative family. These bonds are so significant that they often become a factor of longing that hinders recovery processes if a similar community of belonging is not offered. Finally, the diagnosis highlights that social stigma renders them invisible to the citizenry, depriving them not only of access to basic rights such as housing, but of the fundamental recognition of being called by their own name.

4.11 | The travesti-trans population

When observing the reality of the travesti-trans population in the region, it is identified that identity, exclusion, and substance use form part of the same web of multiple vulnerability. The trajectories of these persons are usually marked by an early expulsion from the spaces that should have provided them with care, such as the family, school, the workplace, and the health system. This sustained exclusion leaves deep marks on their inner life, where substance use appears as a resource to try to alleviate the pain, loneliness, and lack of belonging generated by the systemic rejection of the social environment.

For a large part of this population, the system has operated under a restrictive binary that limits their possibilities of subsistence almost exclusively to sex work or informal sectors such as hairdressing, without offering real alternatives for training or employment. In this scenario, prostitution is closely linked to substance use, since the substance becomes a necessary survival tool to endure street conditions, cold, hunger, fear, and violence. It is also detected that this vulnerability is frequently exploited by third parties who promote drug use to facilitate situations of abuse or to ensure control over these persons.

The diagnosis also reveals a particular conflict linked to identity transition processes. It is observed that the gap between the desired mental image and physical reality can generate symbolic pain and a deep anxiety that trigger substance use as an escape route. Likewise, this population faces extreme fragmentation in access to health, where a stigma persists that makes them feel alien or singled out even in institutional and community settings. Substance use ultimately acts as a failed suture to anesthetize wounds of mistreatment and injustice accumulated throughout life.

From the spiritual dimension, a situation of institutional orphanhood is perceived. In the face of rejection or invisibility in traditional religious structures, many persons have sought refuge in alternative beliefs to find the protection that society denies them. Behind the armor of toughness they have built to survive the hostility of their environment, a fragile and exhausted essence is detected that reveals the lack of a support network that recognizes their fundamental dignity. The current state of affairs shows that the system drastically limits their life expectancy and their capacity to envision a future outside the margins of exclusion.

A pastoral clarification is necessary. This manual addresses the reality of the travesti-trans population from the specific perspective of its competence: the accompaniment and prevention of addictions in contexts of exclusion. The inclusion of this population in the diagnosis does not presuppose or imply a doctrinal position on contemporary theories of gender identity, whose discernment belongs to other spheres of ecclesial magisterium. What it does presuppose is an unequivocal option for the dignity and life of every human person, regardless of their condition, identity, or history. Pope Francis has been clear in this regard: pastoral care cannot be subordinated to a theoretical debate when there are people dying on the street without anyone asking their name. The task of this manual is precisely that: to ask them their name, to recognize their ontological dignity as children of God, and to offer the accompaniment that no other institution is providing them. That the Church accompanies these persons does not require having exhausted all the doctrinal questions that their reality poses; it requires having understood that no one can be left outside of pastoral care while living in suffering. As the Isenheim Altarpiece teaches, the Antonines did not ask for a diagnosis before opening the door of the monastery.

4.12 | Prisons

When observing the reality of the prison world in the region, a direct extension of the vulnerability that already inhabits the popular neighborhoods is identified. Prisons are populated mostly by persons in situations of poverty, which reveals a system where problematic use and the crime committed to sustain it trap the most excluded sectors in a cycle of recidivism. It is detected that incarceration, far from functioning as a space of resocialization, usually deepens the problem of addictions.

The internal dynamics of the prisons are characterized by the existence of a substance market where drugs function as currency and a tool of power. It is observed that substance use within confinement is chaotic and frequently linked to situations of violence. Internal structures exist that enslave inmates through debt; cases are reported where, upon an inmate's refusal to use or sell, physical violence is exerted against him to force his family to send money from outside. This reality turns the prison into a scenario of greater risk and vulnerability than the street itself.

In the area of juvenile detention centers, the diagnosis is even more critical. It is recorded that the vast majority of adolescents deprived of their liberty are detained for causes directly linked to substance use. The impact of substance use in prison generates irreversible damage to neurological development, considering that the human brain completes its maturation around age 25. Likewise, a barrier in access to mental health is detected: many inmates who suffer from psychiatric pathologies refuse the necessary medication out of fear that the judicial system will use that diagnosis to extend their sentences or deny them temporary releases under the label of mentally ill.

The diagnosis also includes the situation of prison personnel, who often work in conditions of precariousness similar to those of the inmates. It is observed that many officers are affected by the same problem of substance use, a reality that remains silenced by institutional stigma. This situation prevents the staff from acting as care role models and places them, on occasion, as part of the machinery of the internal substance market.

Finally, the phenomenon called the abyss of freedom is identified. The most complex stage of the process does not occur during incarceration, but at the moment of release. There is an absolute void in post-release accompaniment, where the State usually considers its intervention finished upon signing the release papers. The released person walks out the prison gate without economic resources, without employment, and frequently without a family network to

receive them. This structural abandonment pushes the individual to return to the same environment of substance use and criminal survival that initially led them to prison, revealing the lack of halfway houses or support networks that sustain the transition to life in community.

4.13 | Drug trafficking and the globalization of organized crime

When observing the reality of our region, it is recognized that drug trafficking is not an isolated or purely local criminal phenomenon, but a global network with a sophisticated economic engineering and a distribution logistics capitalized throughout the continent. This system operates as a transnational structure where substances produced in countries like Colombia or Peru transit through controlled routes in Paraguay and use strategic nodes, such as the river ports of the waterway system, for their export to international markets. It is estimated that the global illicit drug market represents about 1 percent of the world's Gross Domestic Product according to the United Nations, a figure that expands significantly when considering the full web of organized crime—which includes money laundering, human trafficking, arms trafficking, and institutional corruption—managing to infiltrate the legal economy through the complicity of banking institutions, hotel developments, supermarket chains, and law firms that facilitate the laundering of illicit capital.

In the most neglected slums, where the State has withdrawn or its presence is purely formal, drug trafficking has filled that void by becoming the new organizer of daily life. Its power is not limited to the commercialization of substances, but functions as a regulatory entity that lends money to neighbors in the absence of formal credit, provides private transportation for nighttime medical emergencies, and generates a source of informal and precarious employment for hundreds of people in a single territory. This territorial presence imposes its own laws and invisible borders that delimit the free movement of residents; it is observed that leaving a sector controlled by one gang to go to a health institution in another sector can represent a risk of death. The narco dictates the norms of coexistence, displacing legitimate authority with a modern dictatorship that kidnaps the peace of communities.

In this dispute over the territory and the subjectivity of our peoples, the *narco-culture* stands as the dark reverse of a true *ethics of care*. While the former imposes a narrative of death and ostentation, basing social advancement on violence and easy money, the ethics of care—embodied in our pastoral ministry—

proposes a *pedagogy of tenderness* that protects sacred life and rebuilds broken bonds against the logic of disposal.

The narco-culture offers young people a false belonging and an identity based on the power of weapons; in response, community care builds *shared tables* where orphanhood is healed with significant presence and bonding. While the narco traces invisible borders that divide and kill, care weaves networks of proximity (making oneself present in the life of the other, sharing their reality, listening to them and accompanying them from within their concrete situation) that integrate the brother or sister, restoring their ontological dignity as a child of God.

This system is sustained by extreme forms of cruelty and modern slavery. The territorial diagnosis reveals a planned recruitment of children, where children and adolescents between the ages of 12 and 16 are recruited as surveillance links or micro-traffickers under the promise of social advancement that is, in reality, a system of disposal. In rural areas, the use of children for crop processing tasks is detected with the consent of families mired in extreme poverty. Likewise, a profound violation of women is noted: in contexts of absolute lack of protection, girls and adolescents are used by trafficking networks or sold to drug traffickers as a strategy of economic survival. The consolidation of these structures has triggered the phenomenon of contract killing, where human life loses its intrinsic value and becomes a currency of exchange.

It is identified that the advance of organized crime represents a direct risk to the stability of institutions. The so-called narco-politics has generated parallel structures where judges, police, and prosecutors are captured by the financial power of trafficking, guaranteeing impunity and leaving the citizenry unprotected. This systemic corruption is supported by a narco-culture that imposes a narrative of death and ostentation, transforming the traditional values of the community into an ethics of violence and immediate consumption. The fear generated by this structural violence causes the withdrawal of civil institutions, leaving the public space at the mercy of the merchants of death.

Finally, the diagnosis highlights that drug trafficking profits from the internal fracture of its subjects and the desolation of the territories. It is observed that addiction is the fuel that feeds this perverse business, which takes advantage of the lack of horizons, education, and dignified work to turn young people into cannon fodder. The current scenario shows an organized evil that uses marginality to expand, creating a web of social sin that erodes democracy and nullifies the possibility of a dignified life project for the excluded majorities.

4.14 | States and public policies

When observing the relationship between state structures and the reality of the territories, the diagnosis reveals a marked apathy and governmental indifference. While organized crime consolidates through a global economic engineering, the State's responses are usually insufficient, late, or nonexistent. It is detected that, in the face of this institutional withdrawal, the task of accompaniment is de facto delegated to civil society and faith communities, demonstrating that state bureaucracy fails to inhabit the spaces of greatest vulnerability.

A critical element identified by the agents is the implementation of sanitizing policies. These actions focus on trying to clean public space under a punitive and criminalizing approach, considering persons in situations of substance use or homelessness as urban nuisances that must be removed or hidden. This logic prioritizes a misunderstood citizen security over the dignity of the subjects, exhausting public resources in the war against drug trafficking while completely neglecting the care of victims and demand reduction.

A profound administrative fragmentation is also observed. The State operates through watertight bureaucratic compartments—health, justice, housing, social development—that do not communicate with each other. This lack of coordination generates an expulsive system: to access medical treatment, requirements are demanded that the subject cannot meet, such as possessing an identity document or housing stability that the State itself does not guarantee. In this way, the formal system reaches a ceiling or limit in the face of marginality, since it presupposes baseline living conditions that the most neglected sectors do not possess.

The diagnosis warns of a situation of institutional orphanhood. Statistics indicate a disproportion in public spending, where prevention budgets are minimal compared to other areas. There is the observation that the State is capable of granting subsidies or administrative benefits, but lacks the flexibility necessary to generate community. Bureaucracy cannot build the bonds of trust, belonging, and affection that the territorial diagnosis identifies as the only elements capable of restoring the social fabric.

Finally, the impact of narco-politics on the weakening of the rule of law is recognized. The corruption of sectors of the judiciary, police, and political establishment allows drug trafficking to act as a social organizer in the face of the retreat of legitimate institutions. In this scenario, public policies lose their function as tools of justice and become instruments that deepen the exclusion and disposal of those in situations of greatest fragility.

CHAPTER 5

The Ecclesial Magisterium

In this section we propose to recover and systematize the fundamental positions of the Church on the phenomenon of addictions, focusing on the thought of Saint John Paul II and Pope Francis. Both pontiffs have addressed this problem with exceptional depth, contributing essential elements for understanding the reality we face today in our territories.

The magisterium of John Paul II, expressed in a systematization of more than eighty interventions, laid the anthropological foundations by defining addiction as a pathology of the spirit and a manifestation of what he called the culture of death. For his part, Pope Francis has mentioned the topic in 186 public appearances, including documents, homilies, and speeches. His magisterium has updated this perspective by placing the drama of addictions within the throwaway culture and by denouncing drug trafficking as a structure of sin that generates new forms of slavery.

Unlike them, the magisterium of Benedict XVI did not address the topic of drugs in a systematic way, and rather oriented his reflections primarily toward the roots of secularization and the global ethical crisis. For this reason, the development of social and pastoral doctrine on the problem of substances rests primarily on the axes traced by John Paul II and Francis, whose teachings allow us to deepen the diagnosis of this crisis that affects our peoples.

5.1 | Itinerary of ecclesial consciousness and new pastoral paradigms

The Church's response to the phenomenon of addictions and substance use has not been a static process, but the result of a progressive awakening of consciousness in dialogue with the signs of the times. This historical maturation has allowed a transition from a merely condemnatory or assistentialist perspective toward an approach of loving attention and comprehensive accompaniment. The following describes the four pillars that constitute this itinerary and the new paradigms that underpin current pastoral action.

1. Historical evolution of the Magisterium and pastoral action The path traveled by the Church over the last five decades can be structured into five fundamental milestones that mark the evolution of its perspective:

- **The 1970s and the Evangelization of the peripheries:** Under the impulse of the exhortation *Evangelii Nuntiandi* of Paul VI, the Church recognized that its deepest reason for being is to bring the Good News to all environments. This implied the need for evangelization to reach the “human peripheries,” identifying for the first time the urgency of going out to meet those populations marked by problematic use of substances.
- **The 1980s and the preventive role of the family:** During this period, the recognition of the family as the preventive nucleus par excellence was consolidated. Documents such as *Familiaris Consortio* (1981) and the guidelines of the Council for the Family in 1987 emphasized that a stable family environment is the most effective barrier against the advance of dependencies.
- **The 1990s and the moral-social approach:** The Catechism of the Catholic Church (1992) marked a milestone by defining the non-therapeutic use of substances as a “grave offense” and by qualifying producers and distributors as “traffickers of death.” This period strengthened moral theology applied to the phenomenon, urging dioceses to create pastoral processes that would not “leave behind” those who suffered this scourge.
- **The 2000s and the integrality of the person:** With the publication of the manual *Church: Drugs and Drug Addiction* (2001) and the Fifth Conference of the Latin American Episcopate at Aparecida (2007), a more structured approach was adopted. Aparecida, in particular, introduced the category of the “suffering faces” of Christ in persons with addictions,

calling on communities to be healing and inclusive spaces in the face of the “new forms of poverty.”

- **From 2010 to the present: The Revolution of Mercy:** The pontificate of Francis has proposed a culture of encounter based on the model of the *field hospital*. This vision demands a Church “going forth” that provides “loving attention” to those wounded along the road of life, recognizing in each person with addiction a child of God with an inalienable right to a new life.

Amoris Laetitia No.
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2. From “Reinsertion” to “Social Reintegration” This manual proposes a deep terminological and conceptual shift: to prefer the term **social reintegration** over reinsertion. The fundamental premise is that the person with problematic use **never becomes totally disconnected from the social fabric**, even when they find themselves on the margins of institutional life.

Today’s society often blames the individual for their substance use and denies them real opportunities, which generates an anxiety that feeds back into addiction. Therefore, the pastoral task does not consist of “putting someone back” into a system that expelled them, but of reintegrating their dignity and their rights in a community that must recognize them as its own. Reintegration implies healing the bonds with family, work, and the neighborhood, recognizing that the associated factors such as poverty, violence, and inequality require complex responses and not just individual willpower.

3. The universal risk factor: The anxious society An essential diagnosis for modern pastoral ministry is to recognize that we live in an **extremely anxious society**. This anxiety acts as a transversal risk factor that makes us all vulnerable: the object of addiction (whether chemical or behavioral) varies according to social class, geographic origin, and the opportunities that each person has been able to take advantage of or not.

This perspective allows us to demystify addiction as a problem exclusive to marginalized sectors or to “others” different from us. By understanding that society itself pushes toward high-risk lifestyles, community prevention becomes a collective task that seeks to modify social habits and reduce the existential stress that leads to seeking escape in substances or alienating behaviors.

4. The challenge of eliminating ecclesial and social stigma For the Church’s doctrine to be effective, it must be translated into **concrete gestures of mercy** that overcome the “nominalism” of documents. One of the

most persistent obstacles to reintegration is stigma. Persons with addictions carry social and labor prejudices, and even within the ecclesial communities themselves, they are often regarded with suspicion or indifference.

The manual assumes as a priority the fight against these stigmas, recalling that the Church is not a customs office, but an open house where each face reveals the dignity given by God. Community prevention cannot be limited to giving technical information; it must educate in values and in the capacity to say “no” to what dehumanizes, but always from a welcome that does not judge and that offers consolation, hope, and fraternity.

In conclusion, addressing addictions today demands a synodal and Latin American action that integrates prevention, treatment, and justice, rejecting simplistic solutions such as legalization without control and committing to the **full restoration of the human being** in all dimensions.

5.2 | The Existential Diagnosis: Drugs as a Pathology of the Spirit

The manual establishes that drug addiction should not be understood simply as a public health problem or a criminal phenomenon, but fundamentally as a symptom of a **profound malaise** that marks contemporary culture. For the sources, the central question is not technical, but anthropological: “**Why do people use drugs?**”.

Evangelium Vitae No. 12, 28

- **The Root of the Problem:** The manual cites John Paul II to define addiction as a “**pathology of the spirit**”. This arises from an “**existential void**” caused by the lack of values, the absence of clear reference points, and the conviction that life has no meaning. The recourse to “artificial paradises” is, in reality, a flight from a reality that the individual perceives as unbearable, noisy, and alienated.
- **The “Culture of Death”:** The phenomenon is situated within a broader framework that the Pope calls the “**culture of death**”, where violence and drug trafficking threaten the very foundations of society. Drug trafficking is described as an “**infamous trade**” managed by “**merchants of death**” who profit from the destruction of the personality of their brothers and sisters, enslaving them in a manner more fearsome than the ancient slave traders.
- **The Psychological Dimension:** The manual explains that the drug addict is, in essence, a “**person sick from lack of love**”. The search

for pleasure through chemical substances is a failed attempt to fill an affective and spiritual void, transforming an expectation of well-being into a cycle of suffering and affliction.

It is important to note that when John Paul II defines addiction as a *pathology of the spirit* he is not denying the biological or psychological dimension of the disorder, but rather identifying its deepest root. His diagnosis operates on a theological-pastoral register that seeks to answer the question of the ultimate why—the void of meaning, the orphanhood, the lack of love—without claiming to replace the answer that the health sciences give to the how—the neurobiological mechanisms, the maladaptive memory networks, the dysregulation of the nervous system. Both registers are complementary and indispensable. A pastoral ministry that ignores neuroscience becomes naive; a neuroscience that ignores the thirst for meaning becomes blind. The biopsychosocial-spiritual model that this manual adopts in its Judge section integrates both perspectives without subordinating one to the other.

5.3 | The Moral Judgment and the Critique of Liberalization

The position of the IDT manual on the licitness of substance use is categorical and is grounded in the dignity of the human person created in the image of God.

Church: Drugs and Drug Addiction (IDT)
Ch. II, n. 13-15

- **The Renunciation of Freedom:** Drug use is defined as **always illicit** because it implies an “**unjustified and irrational renunciation of thinking, willing, and acting as free persons**”. John Paul II categorically rejects the concept of a “right to drugs,” arguing that the human being has no right to harm oneself or to abdicate the dignity that God has granted.
- **The Deception of “Soft Drugs”:** One of the firmest points of *Church: Drugs and Drug Addiction* is the rejection of the distinction between **soft and hard drugs**. It is argued that this division is a “dead end” that minimizes the real risks, such as the diminishment of consciousness and the alienation of the will. John Paul II warns that even cannabis can cause psychological dependence, school failure, and severe psychic disorders in fragile persons.
- **Failure of Liberalization:** John Paul II maintains that legalization, even partial, does not produce the expected effects. On the contrary, it

generates a “**moral confusion**” by inducing the belief that what is legal is automatically normal and moral, which inevitably increases substance use and criminality. Likewise, he questions the use of **substitute drugs**—except as a strictly medical and temporary step toward total abstinence—considering that they do not resolve the underlying dependence.

5.4 | The Pastoral Response

Education and the Therapy of Hope

Faced with the advance of drug addiction, the Church proposes not only clinical methods, but a “**pedagogy of hope**” and a “**therapy of love**”.

- **Prevention and Family:** The IDT manual places the **family** as the first place of prevention. A stable family, based on the unique love of the spouses, offers the affective security necessary for children to grow without the need for chemical escapes. Parents are asked never to lose heart in the face of a child in a situation of dependence, maintaining dialogue and affection as tools of healing.
- **Knowing how to say “NO” in order to be free:** Education must be oriented toward strengthening the will and reason. The IDT manual explains that negative moral precepts (the “no”) mark an inviolable limit that protects freedom and allows the young person to mature in order to say “yes” to the higher values of goodness and truth.
- **The Emmaus Model:** The specific pastoral action is inspired by the passage of the **pilgrims of Emmaus**. Just as Jesus walked with the disoriented disciples, the Church must:
 1. **Walk with the person in a situation of dependence:** Accompany them in their reality without judging them at the outset.
 2. **Interpret their history:** Help them see that their failures and sufferings have meaning in the light of the Cross and the Resurrection.
 3. **Restore their dignity:** Lead them to discover that they are a child of God and that victory over drugs is possible.
- **Therapeutic Communities:** The value of Christian-inspired communities that base their rehabilitation on work, community life, and **sacramental life** (especially the Eucharist and Reconciliation) is highlighted, enabling the subject to recover their autonomy and responsibility.

In conclusion, the IDT manual reaffirms that the human being cannot be reduced to their biochemistry; definitive healing only arrives when the individual

recovers their **capacity to love and to use their freedom** for noble ends, breaking the chains of what the document calls this “new form of slavery.”

5.5 | The Global Diagnosis: Drug Trafficking as War and Structure of Sin

For Pope Francis, drugs are not an isolated health problem, but a “**wound in our society**” that traps people in networks of a “**new form of slavery**”. His analysis transcends the individual to denounce a criminal structure of global scale.

- **The “Assumed” and Silent War:** Francis describes drug trafficking as a “**war that has been accepted and poorly fought**” that silently claims the lives of millions of people. He defines those responsible as “**merchants of death**” who profit from human desperation, following the cold logic of power and money.
- **Institutional Corruption:** One of the sharpest points of his denunciation is that drug trafficking could not prosper without the “**complicity of a sector of the political, police, judicial, economic, and financial power**”. He warns that this corruption has generated a “**parallel structure**” that puts at risk the credibility of State institutions and of society itself.
- **The Link with Other Crimes Against Humanity:** Francis systematizes the drug phenomenon as part of a larger criminal web. Substance trafficking is inseparable from **human trafficking, money laundering, arms trafficking, child exploitation**, and organ trafficking. In this sense, the economic system that places the “money god” at the center ends up being a terrorist system that discards the wonder of creation: man and woman.

5.6 | The Anthropological Crisis: The “Throwaway Culture” and the Existential Void

The meaning of the Pope’s mentions always seeks the root of the problem, linking addiction to a model of civilization that excludes the weakest.

- **Chemical Slavery and Incipient Suicide:** He defines dependence as a “**chemical slavery**” that strips the human being of their greatest

good: freedom. For many young people, substance use is a “vain hope” of numbing themselves in the face of the weariness of existing and the lack of meaning, something Francis goes so far as to call an “**incipient suicide**”.

- **The Root in Exclusion (The “NEETs”):** The Pope identifies that young people who “**neither study nor work**” are the main target of the swindlers of death. The lack of horizons, of dignified work, and of adequate education creates the “breeding ground” for young people to be used as “**cannon fodder**” by armed gangs and drug traffickers.
- **“Spiritual Orphanhood” and the Virtual World:** Francis points out that at the root of many addictions lies the experience of “**spiritual orphanhood**” resulting from broken homes and a society that has become “motherless.” Added to this is the danger of the “**dark web**” and digital spaces that, under a false promise of connection, end up virtualizing the young person, uprooting them from concrete reality and plunging them into a profound loneliness.
- **Sports and Efficiency:** Even in areas such as sports, the Pope denounces that the use of doping substances is a symptom of a culture obsessed with success at any price and **productivity that does not accept failure**.

5.7 | The Ethics of Care: An integral paradigm in the face of the throwaway culture

In the face of the anthropological crisis described in the previous section, characterized by the *throwaway culture* and the existential void that pushes so many young people of our neighborhoods toward the margins of exclusion and addictions, the Magisterium of Pope Francis offers a fundamental theological and pastoral antidote. In programmatic documents such as the encyclical *Laudato Si* (on Integral Ecology) and the apostolic exhortation *Amoris Laetitia* (on love in the family), a transversal paradigm emerges forcefully: the *Ethics of Care* (or care seen as ethics).

This approach is not presented as a mere assistentialist strategy or a technical emergency response to the socio-health crisis. It is an ontological, axiological, and epistemological reality that proposes a principle of balance and personal, communal, and planetary sustainability. Care, assumed from the Samaritan faith, determines a profound *way of being, doing, and dwelling* in the world, transforming the institutional perspective of our pastoral responses.

The Ethics of Care unfolds with a broad reach that encompasses four constitutive and interconnected dimensions:

1. **Self-care (Personal dimension of the worker):** The process of accompanying and remaining alongside realities of high complexity, pain, and territorial vulnerability demands that pastoral teams, professionals, and volunteers themselves adopt permanent practices of discernment, mutual support, healthy boundaries, and integral health care. It is not sustainable over time to care for the broken brother or sister if the caregiver chronically neglects their own psychophysical and spiritual reality, falling into burnout or depersonalization.
2. **Care for the Other (Relational and Samaritan dimension):** It is grounded in proximity and in the face-to-face encounter with the vulnerable person, recognizing their inalienable dignity as a child of God, beyond the compulsion of their addictive behavior. This care translates into unconditional welcome and active listening, designing personalized itineraries oriented toward the re-education of the personality, the reordering of fundamental values, and the subsequent family and social reintegration. In less compulsive cases, an outpatient treatment approach is prioritized.
3. **Care for the Community (Neighborhood fabric dimension):** The human being heals in clusters and in community. Therefore, care ceases to be an isolated technical intervention to become incarnate in the creation of protective community environments. Strengthening neighborhood support networks, rebuilding solidarity bonds, and structuring the neighborhood center under the mystique of an “extended family” or “home” is indispensable for offering permanent emotional support against social exposure. In Latin American culture, faith and the relationship with God operate here as a *Central and identity-forming Protective Factor*.
4. **Care for the Common Home (Eco-glocal dimension):** In full harmony with integral ecology, the personal suffering of those who suffer from addiction is intimately linked to the degradation of their micro-environment. A prophetic pastoral ministry assumes that the transformation, cleaning, and dignification of community spaces and the local habitat is a constitutive part of the healing process. Respect for the physical environment and the local natural surroundings heals relationships and restores the sense of belonging to those who have been discarded.

By assuming the Ethics of Care as the guiding thread of the current Ecclesial Magisterium, the Church not only denounces the structures of sin of drug trafficking and disposal, but announces a three-dimensional methodological proposal (personal, communal, and planetary). This paradigm acts as the

great criterion of discernment that unifies the gaze of faith upon the territory before weighing the historical coincidences and differences in the institutional treatment of the phenomenon.

5.8 | The differences

John Paul II	Francis
Conceptual framework for understanding the problem	
Situates the problem primarily in an individual anthropological and spiritual dimension. Defines addiction as a “pathology of the spirit” born from an existential void and from the lack of moral values in a secularized society. The young person turns to drugs to flee from a reality that offers no meaning.	Although he recognizes the inner void, he frames the phenomenon within a systemic crisis called the throwaway culture. For him, drugs are the result of a system that excludes the weakest (especially young people who neither study nor work) and turns them into disposable material.
Drug Trafficking	
Defines trafficking as an “infamous trade” and emphasizes the duty of governments to resolutely confront the “traffickers of death” through repression and criminal legislation.	Describes drug trafficking as a “war that has been accepted and poorly fought.” His analysis is more political: he denounces that the narco prospers thanks to the complicity of political, judicial, and financial power, creating a parallel structure that corrodes democracy.
The image of the ecclesial response	
Proposes a “pedagogy of hope” based on the evangelical school. His biblical icon is the road to Emmaus, where the pastoral agent walks with the disoriented person to help them interpret their history in the light of the truth of Christ.	Uses a language of physical and emotional proximity, symbolized in the embrace and the Church as a field hospital. He calls Christians to “touch the suffering flesh of Christ” in the addict, privileging “listening therapy” and artisanal accompaniment over technical prescriptions.
Social causes	

Continues on the next page...

John Paul II (cont.)	Francis (cont.)
Places the family as the main bastion of prevention and healing. The drug crisis is explained, to a large extent, by the family's inability to transmit basic moral values.	Without neglecting the family, he places a greater emphasis on the "rehabilitation of politics." He maintains that in order to say "no" to drugs, politics must say "yes" to education, sports, and dignified work for young people, combating the "spiritual orphanhood" generated by a dehumanized economic system.

5.9 | Coincidences

Despite the differences in style and historical context, the magisterium of **John Paul II**—expressed in the manual *Church: Drugs and Drug Addiction*—and that of **Francis** coincide in fundamental certainties that define the Church's position on this problem. Both pontiffs present a vision that integrates moral condemnation, social denunciation, and pastoral commitment under the following axes of systematization:

5.9.1 Drug Trafficking as a "Culture of Death"

Both Popes coincide in identifying drug trafficking not as a simple economic crime, but as a structure of sin that feeds a "culture of death." They coincide in calling the traffickers "merchants of death," denouncing that they profit from the destruction of their brothers and sisters and from the pain of families. Likewise, they point out that the substance market is inseparable from other global crimes such as arms trafficking, money laundering, and human trafficking.

5.9.2 The rejection of liberalization and prudence regarding substitute drugs

There is a firm coincidence in the rejection of the liberalization of substance use as a strategy for solving the problem of addictions. Both pontiffs agree that "drugs cannot be defeated with drugs," qualifying legalization as a dead end that generates moral confusion by inducing the belief that what is legal is automatically acceptable. John Paul II's formula is particularly clear in questioning even the distinction between soft and hard drugs, considering it a mechanism that minimizes real risks.

However, it is necessary to distinguish precisely between two planes that must not be confused. The first is the moral principle: the use of drugs as a threat to freedom and the dignity of the person, and drug trafficking as a structure of sin. On this plane, the continuity between both pontiffs is clear and unequivocal. The second is the plane of concrete pastoral and health strategies: the devices, tools, and approaches that are deployed in the territory to accompany the person in their actual situation. On this plane, the complexity of territorial realities demands a situated discernment that cannot be resolved with a single formula.

John Paul II himself admitted the use of substitute drugs as a strictly medical and temporary step oriented toward abstinence. And the pastoral magisterium of Francis, by proposing the Church as a “field hospital” that heals wounds without requiring prior merits, has opened a space of discernment where fidelity to the moral principle is articulated with the operational flexibility that the reality of the territory demands. This discernment is developed in greater depth in chapter 10 of this manual, where the relationship between abstentionism and harm reduction is addressed in light of the ethics of care as an integrating criterion.

5.9.3 The addicted person as a victim of a “New Slavery”

For both, addiction represents the loss of the greatest human endowment: freedom. They define dependence as a “new form of slavery” (chemical and spiritual) that disfigures the dignity of the person created in the image of God. They reject the view of the addict as a “thing” or “broken piece of junk,” insisting that the focus should not be on the substances, but on the person, whose story must be heard and healed.

5.9.4 The response: Prevention and “Therapy of Love”

The systematization of their proposals points to a comprehensive education that offers a sense of life.

- **The Pedagogy of “Yes”:** Both maintain that to combat demand, one must say “yes” to life, to education, to sports, and to dignified work.
- **Samaritan Church:** The mission of the Church is to be a mother who embraces the wounded by the roadside, offering a “therapy of love” that restores hope to those who live in a gray and meaningless world.

5.9.5 The Family as a pillar of salvation

Both agree that the family is the first line of defense and the priority place of prevention. They maintain that a stable home, based on affection and dialogue, provides the security necessary for young people not to seek escape in artificial paradises. They ask the ecclesial community not to leave alone the families who suffer the drama of having a child in a situation of dependence.

In conclusion, the central coincidence resides in that victory over drugs is possible only through the globalization of solidarity, rescuing the human being from the void and exclusion in order to reintegrate them into a community that recognizes and loves them.

5.10 | Leo XIV: The pastoral ministry of addictions as a liberating struggle

Robert Francis Prevost, elected Supreme Pontiff on May 8, 2025, with the name Leo XIV, is a Pope formed in the Augustinian tradition and in the Latin American mission: for decades he was a missionary in Peru and bishop of Chiclayo. His pontificate is inscribed in the continuity of the Magisterium that, from the preferential option for the poor and the theology of the people, has been articulating an increasingly integral ecclesial response to the phenomena of exclusion and dependence. The Augustinian spirituality brings to this tradition a specific grammar of desire: the understanding of the human heart as an irreducible search that only in God finds rest, and that illuminates in a particular way the experience of addiction.

The first great magisterial gesture of Leo XIV on this topic took place on June 26, 2025—International Day against Drug Abuse and Illicit Trafficking—when the Pope received in the San Damaso Courtyard of the Vatican hundreds of people who had experienced firsthand the drama of dependence. In that speech, Leo XIV starts from an anthropological conviction that structures his entire pastoral ministry: the dignity of the human being never disappears, but “*sometimes it only shines when it is almost totally lost.*” This paradox is not a consoling piety; it is the theological grammar of the God who goes out to meet us: “*The risen Jesus keeps coming and bringing his breath. He often does so through people who pass through our closed doors and who, despite everything that may have happened, see the dignity that we have forgotten or that has been denied to us.*”

Leo XIV, Speech,
June 26, 2025

Leo XIV points with prophetic clarity to the displacement of the problem from

the individual toward the structure: “*It is easier to fight its victims. All too often, in the name of security, war has been and is being waged against the poor, filling prisons with those who are nothing more than the last link in a chain of death. Those who hold the chain in their hands, on the other hand, gain influence and impunity.*” The pastoral consequence is direct: “*Our cities must not be freed from the marginalized, but from marginalization; they must not be cleaned of the desperate, but of desperation.*” This is not a utopian ideal, but the logic of the Gospel applied to the concrete politics of accompaniment: the pastoral ministry of addictions does not clean the streets, it turns them into places of encounter and of life.

Consistent with his Augustinian identity, Leo XIV connects the thirst for substances with the deepest structure of human desire. He cites Psalm 63—“the abyss that inhabits us” (Ps 63:7)—and recalls the confession of Augustine: “We seek peace and joy, we are thirsty for them. And many deceptions can disappoint us and even imprison us in this search.” This spiritual reading of addiction does not replace the social or psychological diagnosis: it presupposes and integrates them into a broader horizon of meaning, of which the act of “seeking” is already, in itself, an opening to transcendence. Here the intuition that the manual defends as one of its central theses reappears: addiction is also a failed search for what only God can give.

Leo XIV, Speech,
June 26, 2025
citing Saint
Augustine

The apostolic exhortation *Dilexi te* (October 4, 2025), the first major document of the pontificate, deepens this logic by applying it to those who accompany. Leo XIV affirms that “*the poorest are not mere objects of compassion, but teachers of the Gospel. It is not a matter of bringing God to them, but of finding him among them.*” This inversion is fundamental for the pastoral ministry of addictions: the pastoral agent does not bring salvation to the territory; they discover it there. The brother or sister in a situation of dependence is not the recipient of a mission, but a privileged interlocutor in whom Christ makes himself present in a particular way. Whoever forgets this turns pastoral ministry into technical assistance and loses its soul.

Leo XIV,
Dilexi te
No. 79 (2025)

The encyclical *Magnifica Humanitas* (May 25, 2026), the first encyclical of his pontificate, also opens a question that this manual cannot avoid: artificial intelligence and digital platforms as new vectors of dependence. Leo XIV, who explicitly inscribes his reflection in the tradition inaugurated by the *Rerum Novarum* of his namesake Leo XIII in the face of the Industrial Revolution, warns that the algorithmic logics of social networks and digital environments operate with a grammar of compulsivity that shares structure with classic addictions: the search for immediate recognition, the inability to bear the void, the capture of attention in the service of commercial interests alien to the good

of the person. The digital territory is, also, a pastoral territory.

More than a new chapter, the pontificate of Leo XIV represents, for the Latin American Church, a confirmation from the center of what base communities already practice: that the pastoral ministry of addictions is inseparable from the struggle for justice, that incarnate accompaniment cannot be reduced to a technical device, and that the dignity of those who have been discarded is, precisely, the place where God has something decisive to say to us.

What the territory asks of us

We have traversed reality. We have looked at it from the neighborhood, from the family, from the school, from the prison, from the street. We have seen children who begin to use substances at the age of nine because no one is watching them. We have seen women who hide their substance use out of fear of losing their children. We have seen young people who find in drug trafficking the only visible path of social advancement. We have seen ecclesial communities that do not know how to approach the issue, and health systems that expel those who most need to be received. We have also listened to the Magisterium, which reminds us that behind every addiction there is a person wounded in their dignity, a thirst for meaning that found no channel, a cry that society preferred not to hear.

Everything we have seen leaves us with questions that do not answer themselves. What is addiction really, and how can we understand it without reducing it to a sin or to a biological disease? What makes one person more vulnerable than another? How do we accompany without abandoning, without enabling, without imposing? From what criteria do we discern when mercy demands unconditional presence and when it demands structure and limits? What does the Church have to offer that no other actor offers?

Those questions are what give shape to the Judge. We do not start from theories to apply to reality, but from reality to build understanding. That is the epistemology this manual has chosen: ascending, incarnate, synodal. From the territory to reflection. From the wound to the question. From the question to discernment.

PART III

Judge

Discernment

This part of *Judge* constitutes the theoretical heart of this manual and is built entirely around the questions that arise in the heart and daily practice of the pastoral agent. After having received the reality of our peoples in the previous stage, we now enter a process of illumination where we seek to understand the nature of the problem in all its dimensions in order to guide our response.

An Ascending Epistemology: From the Territory to the Technical

Unlike traditional approaches that develop theories from scientific knowledge, this manual commits to an **ascending epistemology**. This means that our knowledge does not arise from abstractions, but from direct contact with the territory and from the questions that emerge in the encounter with the wounds of our communities.

For this reason, the order of the chapters follows a path of deepening that imitates the pastoral encounter:

1. We begin with **the social being**, analyzing the neighborhood and the bonds, which is where we first receive wounded life.
2. We then delve into the depth of the person through the **human spirit** and the **psyche**, seeking the root of existential emptiness and trauma.
3. We conclude with the biological understanding of **the substances and the organism**, understanding that the drug is not the center of the problem, but rather the final and visible symptom of much deeper fractures.

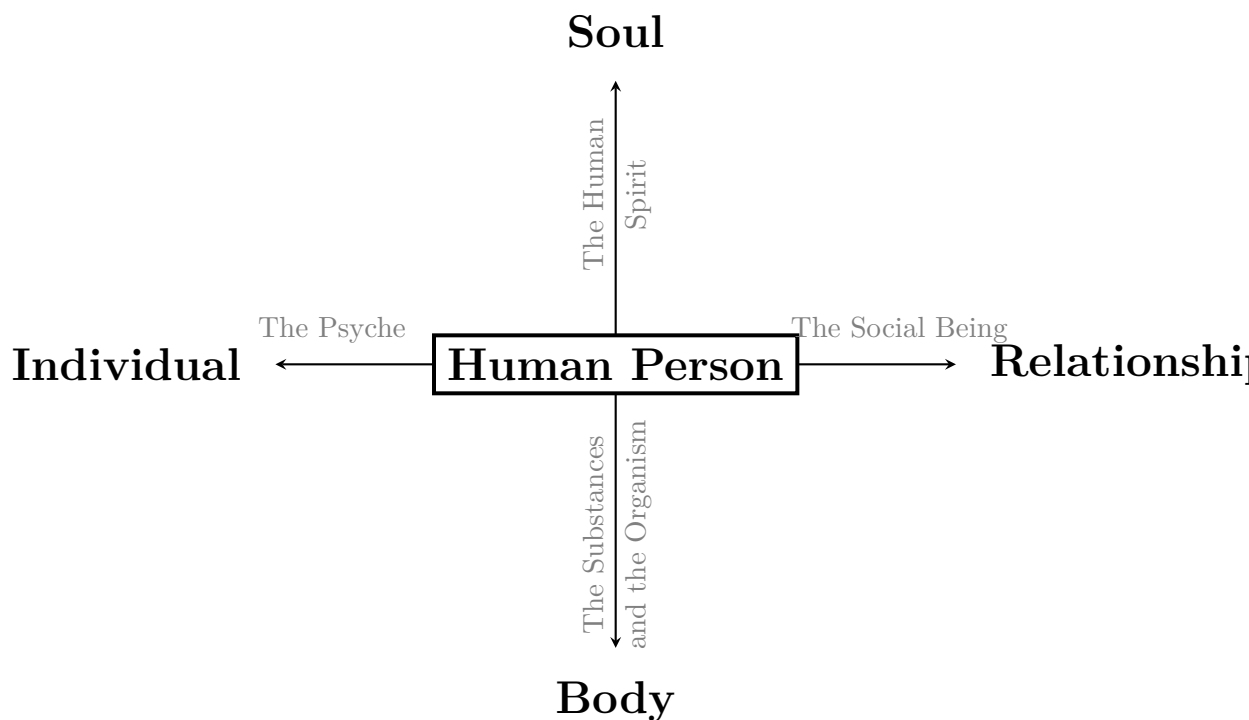
The Criteria of Integrity: Unity and Relationship

To avoid any reductionism that fragments the subject, the discernment of these dimensions is organized under two great constitutive tensions of the human being:

- **The unity of the person (the spiritual and the material):** We understand that the person is an indivisible unity of soul and body. We cannot discern the biological damage of the substance without considering the ontological dignity of the spirit that inhabits it. The human being is an *incarnate spirit* where what happens in the body has a correlate in one's openness to the divine and vice versa.

- **The tension between individuality and relationship:** The human being is constitutively relational; there is no person without relationship. Discernment obliges us to look not only at the individual and their will, but at the relational and social fabric that sustains or expels them. Integral health is only possible when the subject recovers the capacity to be-with-others in a community that recognizes them by name.

For this reason, we wish to propose a **graphic diagram** that will allow us to locate ourselves on the map of discernment. On the vertical axis one can observe the tension *body — soul (spirit)*, and on the horizontal axis the tension *individual — relationship*. As can be seen, each of these poles gives rise to a dimension. Thus, the chapters we present in this part of the manual dedicated to *Judge* correspond to these essential dimensions of the human person.



This diagram will also allow us to locate the various proposals developed in the part on *Act*. Some of them will have the spiritual component more developed, others the psychological, the biological, or the social. What is certain is that the fact of developing one component more does not imply the negation of the others. Here, then, a warning is raised: when a practical proposal develops one component but denies any other, what it is denying is the correct understanding of the human person. And that is indeed a problem! Let us then begin this path of discernment.

Very Brief Glossary

To navigate with clarity the path of this **ascending epistemology** that the manual proposes, it is necessary to establish a common language from the beginning of our discernment. Although our priority is listening to the wounds of the community and the reconstruction of the person's dignity, the reality of the neighborhoods obliges us to use certain technical terms that come from the health sciences and neurobiology.

The objective of this brief glossary is not to exhaust the scientific depth of the concepts, but to provide operative definitions that allow us to name with precision what we observe in the chapters The Social Being, The Human Spirit, and The Psyche.

By presenting these terms here, we reaffirm our central thesis: the substance is not the center of the problem, but rather an element that appears in the final symptom of other much deeper fractures. For this reason, we invite the reader to use these conceptual tools as a support for pastoral judgment, knowing that the *technical anatomy* and the biological detail of each one will be deepened in Chapter 9: The Substances and the Organism, thus closing our journey, which goes from the territory to the neurosciences.

A note on the language of the manual. The reader will notice that throughout these pages different terms are used to refer to the same reality: addiction, substance use disorder (SUD), problematic use, dependence, toxomania, chemical slavery, pathology of the spirit. This variation is not an oversight but a deliberate decision. Each term comes from a different framework of understanding — clinical, pastoral, magisterial, social — and is used in the context that corresponds to it. When the manual speaks from neurobiology, it uses the language of science; when it speaks from the Magisterium, it uses the language of the pontiffs; when it speaks from the territory, it uses the language of the pastoral agents. This terminological plurality is coherent with the biopsychosocial-spiritual model that vertebrates the document: if the person is an indivisible unity viewed from four dimensions, the language that names them cannot be one-dimensional. What remains constant beneath all these terms is the conviction that we are facing a real suffering of a real person whose dignity is prior to any diagnosis, and that the way in which we name them conditions the way in which we accompany them.

1. PAS (Psychoactive Substances)

These are chemical components that, when introduced into the organism, have the capacity to cross the blood-brain barrier and alter the functioning

of the Central Nervous System (CNS), modifying mood, perception, and behavior.

2. SUD (Substance Use Disorder)

This is the clinical term for referring to addiction. It is defined as a chronic and recurrent brain condition that alters the circuits of will and control.

3. Reward System and Dopamine

This is the biological system responsible for processing pleasure and learning. Dopamine is the chemical messenger that is released massively upon use, *hijacking* the subject's will and prioritizing the substance over vital needs.

Cf. art. 9.3.1 (Judge,
The Substances
and the Organism,
Pharmacodynam-
ics..., Art. 1...)

4. Dual Pathology

This is the coexistence of a mental disorder (such as depression, psychosis, or bipolar disorder) with a substance use disorder.

5. Half-Life and Detoxification

The half-life is the time the body takes to eliminate half of the original dose of a substance. It is the biological chronometer that determines how long an intoxication lasts and how much real time a total organic cleanse requires.

6. Neuroplasticity

This is the brain's capacity to physically change its structure based on stimuli. It is what allows the brain to *learn* dependence, but it is also the basis of biological hope for recovery.

7. Zinberg's Triad (Subject - Substance - Context)

This is the model that explains that the experience of use does not depend solely on the drug, but on the interaction between the person (biography, emotional state), the chemistry of the substance, and the environment (culture, neighborhood).

Each of these concepts will be deepened in Chapter 9: The Substances and the Organism, where we will analyze the final symptom of this journey.

CHAPTER 6

The Social Being

This chapter addresses the communitarian dimension of the person, starting from the anthropological premise that the human being is constitutively relational and cannot be understood or fulfilled in isolation. In contrast with individualistic approaches that reduce the phenomenon to the mere will of the subject, here a paradigm shift toward the communitarian is proposed as the key to integrally embracing the person and their environment.

The concepts of territorial closeness, presence, and bond are deepened, rescuing the importance of recognizing the other by name in order to break with the dehumanization of welfare systems. Likewise, the theoretical foundation of the community family and community child-rearing is developed, recognizing that the organized community must constitute itself as the support network that offers a safe place where biographical ties are broken or absent.

A central axis of this dimension is the need to arrive first, which implies understanding promotional spaces —such as play, sports, and art— as fundamental preventive tools that generate strengths in the construction of the social being. Finally, the text invites us to overcome the fragmentation of institutional responses through horizontal networking, positioning the community as a subject with the capacity for transformation to restore dignity to its members most made vulnerable by the use of psychoactive substances (PAS). Later, in the chapter titled **The Substances and the Organism**, we will provide a technical definition of this name.

6.1 | The Community and the Territory. Closeness and New Realities

This section delves into the territorial community, understood not only as a physical space, but as a system of networks of persons who share life and organize themselves under an ethic of solidarity and belonging. The fundamental transition from physical closeness to significant presence is analyzed, where shared time transforms proximity into a profound bond that recognizes the dignity of the other by calling them by name, breaking the anonymity of fragmented welfare systems.

Within this framework, the territory is positioned as the stage where the organized community must take the initiative and go out to encounter the brothers and sisters most made vulnerable by the use of psychoactive substances (PAS), acting as an agent of integral health where traditional institutions tend to fail. Finally, the text invites us to address the new realities of the 21st century, such as the challenge of citizenship in the digital territory, warning about the importance of avoiding the romanticization of the neighborhood. This allows us to identify with honesty the violence, the way in which drug trafficking parasitizes the neighborhood economy by hijacking public spaces through terror, and the exclusions that still persist in the social fabric.

6.1.1 Article 1: On the Distinction between Physical Closeness and Significant Presence

■ Statement of the topic

Community accompaniment in territories marked by the use of psychoactive substances (PAS) demands a conceptual distinction between simple spatial proximity and the depth of the personal encounter. It is analyzed how the factor of time and the intention of the pastoral agent transform physical contact into an event of healing and recognition of dignity.

■ Central question

What is the fundamental difference between physical closeness and significant presence in the context of community accompaniment?

■ Existing positions or objections

- One might think that no real difference exists, since in order to be present it is an indispensable requirement to be physically close, with presence being a simple synonym for geographic closeness.
- On the other hand, it is argued that presence depends on the technical frequency of encounters, suggesting that whoever conducts more visits or specific activities would have a greater presence than someone who resides in the territory without a determined agenda of care.

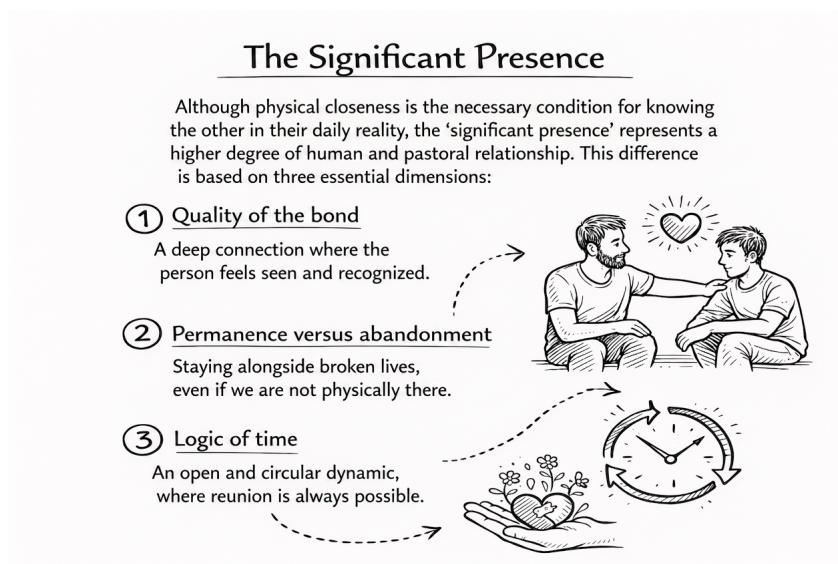


Figure 6.1: Significant presence

■ Foundation or criterion of discernment

Time qualifies closeness and transforms it into a significant presence. This dimension constitutes a much deeper closeness, of an emotional and psychological character, that transcends the mere accidental coincidence in a given physical space.

■ Thesis and argumentative development

Although physical closeness is the necessary condition for knowing the other in their daily reality, significant presence represents a superior degree of human and pastoral relationship. This difference is grounded in three essential dimensions:

1. First, the quality of the bond, where physical closeness can be superficial, while presence is a deep connection that allows the person to feel truly seen and recognized.
2. Second, permanence versus abandonment, understanding that presence is the consequence of remaining alongside the most broken lives, even when the companion is not physically there.
3. Third, the logic of time, which abandons institutional rigidity to adopt a territorial and circular dynamic, where the encounter does not end with a technical result but rather remains always open to re-encounter.

■ Response to the objections

1. Regarding the first objection, while physical closeness facilitates initial contact, for it to be transformed into significant presence it must be mediated by the absence of judgment and permanence in love.
2. As for the second objection, presence is not measured by the quantity of technical hours, but by the capacity to humanize the journey of the brother or sister, allowing their story to gain meaning through a non-specific thread that sustains their life.

6.1.2 Article 2: On the Bond (Calling by Name) versus the Dehumanization of the System

*Jn 10:3 — The
gatekeeper opens
it for him, and
the sheep hear his
voice; he calls his
own sheep by name*

■ Statement of the topic

The act of calling by name constitutes the fundamental gesture for the restoration of ontological dignity in contexts of social vulnerability. It is analyzed how the personal and affective bond acts as an antidote against the tendency of institutional systems to fragment the person, reducing them to a number, a clinical diagnosis, or an administrative category.

■ Central question

Does the bond, expressed in the act of calling by name, effectively break the dehumanizing dynamic of welfare systems?

■ Existing positions or objections

- It could be argued that the use of a first name is a superficial formality that does not alter the technical efficacy of a medical or psychological treatment. Under this view, what truly heals is the application of standardized scientific protocols, with affective closeness being a secondary element.
- Another objection holds that systems must prioritize anonymity and impartiality to guarantee equity, avoiding personalisms that could compromise the objectivity necessary for managing resources.
- Finally, it is affirmed that in situations of high complexity due to the use of psychoactive substances (PAS), the focus must be exclusively on the pathology, considering the subjectivity of the name as something accessory in the face of the urgency of clinical detoxification.

■ Foundation or criterion of discernment

Christian anthropology teaches that the person is never a number nor an anonymous being, but a brother or sister with an ontological dignity that remains intact even when their life is profoundly wounded. The act of calling by name recognizes the totality of the being and their transcendent vocation, affirming that the value of each individual is infinite and sacred.

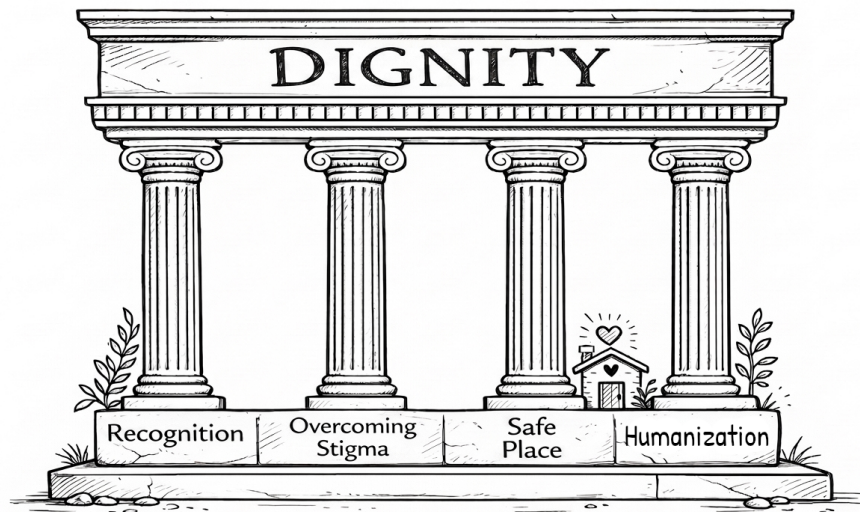


Figure 6.2: The bond against dehumanization

■ Thesis and argumentative development

The bond is the first step to rebuilding the damaged social tie. While the system tends toward administrative fragmentation that dissects the individual into case files or criminal records, the bond recovers the unity of the person through four dimensions:

1. First, the recognition of infinite dignity, where intrinsic value does not depend on the capacity for recovery nor on moral standing.
2. Second, the overcoming of stigma, replacing pejorative labels with the real identity of the subject, which allows the person to recognize themselves in their strengths.
3. Third, the construction of a safe place, where the trust generated by the name allows those who have lived in abandonment to feel once again called to exist for others.
4. Fourth, the humanization of the journey, understanding that accompaniment does not seek only therapeutic results, but a loving attention that respects the artisanal and unique character of each life process.

■ Response to the objections

1. Regarding the first objection, while technique is necessary, the bond is the indispensable support that allows any professional tool to be effective; without love there is no true healing or education.
2. As for the second, true equity is not born of bureaucratic anonymity, but of the mercy that takes charge of the particular complexity of each brother or sister to guarantee their real access to rights.
3. Finally, in response to the third objection, addiction must be understood as a symptom of an internal fracture and not as the essence of the person; reducing the human being to their illness is to incur in a materialist reductionism that ignores their integral unity and their capacity to be the protagonist of their own story.

6.1.3 Article 3: On the Need to Avoid the Romanticization of the Neighborhood

■ Statement of the topic

Accompaniment in the territories demands an honest gaze that recognizes both the healing power of community bonds and the dynamics of oppression and social sin present within them. The importance of avoiding an idealized vision of the neighborhood is analyzed in order to identify and transform the structural violence that affects persons with problematic use.

■ Central question

Is it vital to avoid the romanticization of the neighborhood in the pastoral practice of accompaniment and prevention?

Existing positions or objections

- One might think that the neighborhood must always be seen as a sanctuary of solidarity and popular wisdom, and that pointing out its dark sides would be a lack of respect toward the culture of the poorest.
- On the other hand, it is argued that focusing on internal violence only reinforces the media stigma that already weighs upon popular sectors, and therefore the theoretical gaze should highlight only the positive aspects to counteract the narratives of death.

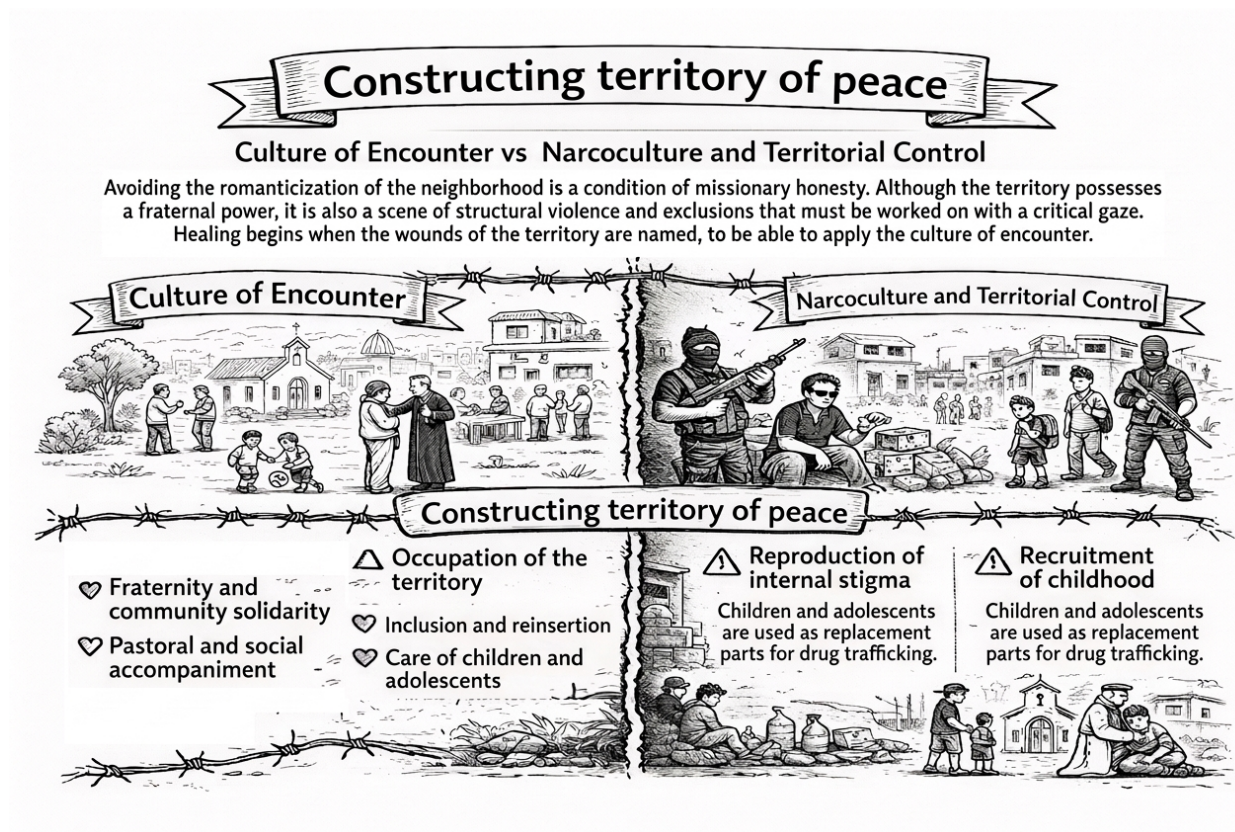


Figure 6.3: The neighborhood must not be romanticized

Foundation or criterion of discernment

Avoiding romanticization is a condition of missionary honesty. While the territory possesses a fraternal power, it is also the stage of structural violence and exclusions that must be addressed with a critical gaze. Healing begins

when the wounds of the territory are named so that the foundation of integral accompaniment can be applied.

■ Thesis and argumentative development

The urgency of maintaining a realistic view of the territory is grounded in four theoretical dimensions:

1. First, the occupation of the territory by evil, recognizing that drug trafficking is not an external agent, but an entity that parasitizes the neighborhood economy, hijacks public spaces, and uses terror to extinguish forms of community organization.
2. Second, the reproduction of internal stigma, where the community itself can segregate the most broken brothers and sisters, persons living on the street, or the travesti-trans population, treating them as waste.
3. Third, the recruitment of children, where the system of organized crime uses children and adolescents as replacement pieces in the sale of psychoactive substances (PAS), generating a new form of slavery.
4. Fourth, the identity of the Church as a field hospital, which demands the recognition that the battlefield is painful and complex, requiring a presence that does not ignore hunger, the lack of rights, or helplessness.

Amoris Laetitia
No. 291

■ Response to the objections

1. Regarding the first objection, although popular wisdom is an inalienable value, discernment allows us to distinguish between the culture of the people and narco-culture, which profits from poverty and destroys the democratic fabric of the community.
2. As for the second objection, the objective is not to feed stigma, but to exercise a prophetic function that identifies real violence so that the organized community can demand the fulfillment of fundamental rights and build alternatives to life that are not a mere cosmetic cover over social reality.

6.1.4 Article 4: On the Digital Territory as a New Social Challenge

■ Statement of the topic

The concept of territory has transcended traditional geographic limits to encompass the virtual environment, where a large part of contemporary social life takes place. This new scenario should not be understood simply as a recreational or communication tool, but as a space where digital citizenship is exercised and subjectivity is shaped, impacting in a real way the psychic and socioemotional dimensions of the person.

■ Central question

Does the so-called digital territory constitute a new scenario of risk and a fundamental challenge for the community approach to addictions?

■ Existing positions or objections

- One might think that the digital does not qualify as territory since it lacks physical proximity and concrete geography, belonging solely to the realm of private life.
- Likewise, it is argued that social networks are neutral tools whose risks are exaggerated by an alarmist perspective.
- Finally, it is maintained that the real problem resides solely in chemical substances, considering that the use of screens and video games is a harmless activity that does not generate biological damages comparable to the use of psychoactive substances (PAS).

■ Foundation or criterion of discernment

Cf. Digital Addictions (ch. 8) and Behavioral Addictions (ch. 9)

Existence and bonds are played out today to a large extent on the networks. This digital territory is the stage where loneliness and new forms of slavery grow, operating on the same reward centers as chemical substances. Recognizing digital citizenship implies understanding that the virtual has a concrete impact on the real and on the social fabric.

■ Thesis and argumentative development

The digital territory represents a displacement of the frontier of pastoral and social intervention. This challenge is grounded in five theoretical axes:

1. First, the delocalization of the bond and the development of subjectivity in the virtual world. Virtual hyperconnection, paradoxically, tends to deepen loneliness and unravel the social fabric. Prolonged transit through digital spaces normalizes logics of consumption and individualism that affect identity, the perception of the collective, and the capacity to sustain meaningful in-person encounters.
2. Second, the mechanisms of behavioral addiction, characterized by constant dopamine discharges through an incessant flow of notifications—which can reach hundreds daily—altering the brain circuits of pleasure and the capacity for waiting.
3. Third, the phenomenon of digital stress and FOMO (fear of missing out), which generates a constant search for approval and a hyperconnection that feeds persistent anxiety for peer validation and fragments attention, hindering the development of deep reflective processes.
4. Fourth, the emergence of new digital addictions, such as video games, pornography, and online gambling, which especially affect minors and constitute forms of behavioral addiction with neurobiological mechanisms analogous to those of chemical substances.
5. Fifth, the impact on the socioemotional dimension and bonds of care, where unregulated exposure to screens—which according to international studies can exceed eight hours daily in adolescents—replaces restorative silence and in-person encounter, weakening the function of the family as a safe harbor and generating an emotional disconnection that makes problems invisible to parents until the deterioration is severe.

Cf. art. 9.3.1 (Judge, The Substances and the Organism, Pharmacodynamics..., Art. 1...)

■ Response to the objections

1. Regarding the first objection, the digital is a territory because it is the place where the subject dwells, spends a large part of their time, and constructs their sense of belonging and identity.
2. As for the second objection, technology loses its neutrality when it becomes a space of dehumanization, manipulation, or digital addictions such as online gambling and pornography.
3. Finally, in response to the third objection, science demonstrates that behavioral addictions share neurobiological mechanisms with substance use disorders (SUD), altering the reward circuits and generating withdrawal symptoms such as irritability and mental obsession.

6.2 | The Family. Structures, Community Family, and Influences

This section addresses the family as the vital cell of society and the first experience of community, where the human being discovers their dignity and vocation to love. Inspired by the vision of the family as a polyhedron of realities, the concept of community family is deepened, understood as the support network that offers protection and belonging where biographical bonds—that is, the family ties of origin—are found to be fragilized. In harmony with the magisterium of Pope Francis in *Amoris Laetitia*, it is recognized that the family is not a problem, but an opportunity for social integration and the construction of a safe place against the phenomenon of the use of psychoactive substances (PAS).

The macroeconomic and social influences that condition the capacities of child-rearing are analyzed, recognizing the need for early intervention that allows arriving before suffering advances. Under the paradigm of community child-rearing, this section theoretically grounds the co-responsibility of the entire social fabric in the care of children and adolescents, promoting a mystique of hospitality that transforms the home into a domestic Church capable of healing orphanhood and rebuilding hope in the heart of the people.

6.2.1 Article 1: On the Nature and Vocation of the Family as an Opportunity

■ Statement of the topic

The family is frequently analyzed from the perspective of its crises, difficulties, or functional failures. However, before being a set of problems to solve, the family must be understood in its fundamental reality as a community of life and love that constitutes the foundation of society. Its vocation as a polyhedron of relationships that reflects the dignity of the human being is analyzed.

■ Central question

Should the family be considered primarily as a source of social conflicts or as an anthropological opportunity for integration and integral development?

■ Existing positions or objections

- One might think that the family is today an outdated institution, whose rigidity is often the cause of the psychic and social malaise of its members. Under this view, the family would be a precinct of tensions and intolerance that hinders individual autonomy.
- On the other hand, it is argued that, given the diversity of current models, the term family has lost its univocal meaning, becoming a precarious place of passage where bonds are abandoned to the fickleness of desires.

■ Foundation or criterion of discernment

The family is not a problem; it is primarily an opportunity. As an image of the Trinity, it is a communion of persons where fruitful love becomes a living sculpture capable of manifesting the creative capacity and the sense of transcendence of the human being.

■ Thesis and argumentative development

The family is the first and originary cell of the social dimension of the person. Its essential value is grounded in three theoretical pillars:

1. First, the family as a school of humanity, where the individual discovers that their identity is built in the relationship with another who recognizes and loves them gratuitously.
2. Second, the identity of the domestic Church, where the vital space is transformed into a place of shared presence, prayer, and blessing that sustains daily life.
3. Third, the value of the stable bond, which offers a definitive horizon against the culture of the provisional, allowing the person to project their future with security and confidence.

The family, even in its fragility, possesses the strength to love and teach to love, being the natural environment where life is safeguarded in all its stages.

■ Response to the objections

1. Regarding the first objection, while wounded families exist, the solution is not the weakening of the family bond but its renewal through a pedagogy of tenderness that heals violence and authoritarianism.
2. As for the second objection, true freedom does not consist in individualistic isolation, but in the capacity to give oneself generously in a common project that transcends the whims of sensibility to reach the maturity of love.

6.2.2 Article 2: On the Family as a School of Fraternity and Antidote against Individualism

■ Statement of the topic

In a social context characterized by exasperated individualism and the throw-away culture, the family is positioned as the primordial space where fraternity is introduced into the world. It is analyzed how the opening of the family toward the community constitutes a fundamental axis of prevention against the extreme loneliness and existential emptiness that often precede the use of psychoactive substances (PAS).

■ Central question

Is the family a closed precinct that must protect itself from society or an active subject of social transformation and political charity?

■ Existing positions or objections

- It could be argued that the mission of the family ends at the limits of its own home, having to concentrate all its energies on the well-being of its biological members to avoid distractions from its primary duties.

- Likewise, it is maintained that families made vulnerable by poverty already carry enough weight to demand of them a function of welcome or social commitment with others, which could weaken their own internal stability.

■ Foundation or criterion of discernment

Fraternity in the family radiates as a promise upon all of society. Social and ecclesial thought proposes that the family must not think of itself as a precinct meant to protect itself from society, but rather it must go out of itself in solidarity-seeking, becoming a nexus of integration between the public and the private to make the world domestic.

■ Thesis and argumentative development

The family possesses an intrinsic social mission that acts as an agent of collective healing and prevention of risk behaviors. This function unfolds in four theoretical dimensions:

1. First, the overcoming of narcissism, where coexistence teaches one not to be the center of the world and to value the common good.
2. Second, the mystique of hospitality, which allows the family to open its doors to those who are alone and to the most broken brothers and sisters, integrating them into its daily dynamic.
3. Third, the exercise of social charity, where affection is transformed into a commitment to justice and the defense of the fragile, working alongside the organized community.
4. Fourth, the prevention of spiritual orphanhood, offering a safe harbor of active listening that neutralizes profound loneliness.

By living fraternity, the family ceases to be a mere object of assistance to become a subject with the capacity to transform unjust social structures.

■ Response to the objections

1. Regarding the first objection, a family love that encloses itself exclusively within itself risks becoming sick; the true health of the family bond is found in its capacity for openness and gratuitous self-giving.
2. As for the second, even the most wounded family is capable of generating life if it feels part of a people; mutual solidarity among families is what allows homes not to succumb to exclusion, finding in the community network the protection that bureaucratic systems tend to deny.

6.2.3 Article 3: On the Mystique of Hospitality as a Bridge toward the Communitarian

■ Statement of the topic

Hospitality should not be understood as a simple norm of social courtesy, but as a fundamental mystique that defines the identity of the Christian family. It is analyzed how the gesture of going out of oneself and opening the home to wounded life constitutes the necessary bridge to transform the territorial network into a true community family, capable of sheltering those who have been discarded by the system.

Heb 13:2 — *Do not forget hospitality; for by it some have unknowingly entertained angels*

■ Central question

Is the mystique of hospitality the necessary foundation for the existence of a community family in the approach to addictions?

■ Existing positions or objections

- It could be argued that hospitality is a private virtue that has no impact on strategies of social or health intervention against the use of psychoactive substances (PAS). Under this view, opening the home would be an unnecessary risk for the security and intimacy of the nuclear family.

- Likewise, it is maintained that community institutions should be based on technical admission protocols and not on a mystique of gratuitous welcome, which would be disorganized and inefficient in the face of the complexity of the problem.

■ Foundation or criterion of discernment

The magisterium of *Amoris Laetitia* teaches that when the family welcomes and goes out toward others, especially toward the poor and abandoned, it becomes a symbol, testimony, and participation in the motherhood of the Church. Hospitality is the means by which the family fulfills God's plan to make the world domestic and to break the first circle of deadly selfishness.

■ Thesis and argumentative development

The mystique of hospitality is grounded as the integrating axis of accompaniment through three essential dimensions:

1. First, the testimony of ecclesial motherhood, where the family that opens its doors manifests a love that places no conditions and that is capable of receiving even the brothers and sisters most disastrous in their behaviors.
2. Second, the humanization of the territory, since hospitality transforms the public space into a place of neighborliness and care, neutralizing the extreme loneliness that often precedes addiction.
3. Third, the recognition of the face of Christ, where gratuitous welcome allows the sacred dignity of the broken brother or sister to be valued, seeing them as an end in themselves and not as an object of assistance.

In this way, hospitality ceases to be an isolated act to become the force that binds neighbors and institutions together into a single family of families.

■ Response to the objections

1. Regarding the first objection, hospitality has a real impact on public health, since it generates the sense of belonging indispensable for any recovery process to be sustainable.

2. As for the second objection, a mystique of hospitality does not exclude order or prudence, but rather transcends them; true efficiency in contexts of vulnerability is not born from bureaucratic coldness, but from a love that knows how to receive life as it comes in order to integrate it into a healing social fabric.

6.2.4 Article 4: On the Proposal of the Term Community Family

■ Statement of the topic

The incorporation of the concept of community family is proposed as a fundamental category for the approach to addictions in contexts of social exclusion. This term seeks to broaden the perspective on support systems, recognizing that the organized community assumes functions of care and protection that transcend traditional biological bonds, especially where primary ties have been violated.

Mk 3:33–35 — *Who is my mother and who are my brothers?... whoever does the will of God is my brother, my sister, and my mother*

■ Central question

Is it appropriate for the manual to propose the term community family instead of limiting itself exclusively to traditional family structures?

■ Existing positions or objections

- One might think that the term family should be reserved solely for bonds of kinship by consanguinity, marriage, or adoption, as defined by the classical social sciences. Under this view, expanding the concept to the communitarian could dilute the specific responsibility of the progenitors.
- On the other hand, it is argued that external support networks, such as parishes or clubs, should simply be called institutions, since they would lack the stability and affective intimacy proper to the biographical home.

■ Foundation or criterion of discernment

Cf. art. 8.5.3
(foster families)

The organized community must constitute itself as the alternative support network that offers a safe place where biographical ties are broken or absent. This integral response is grounded in the mystique of permanence in love and in the identity of the Church as a family of families that leaves no one orphaned.

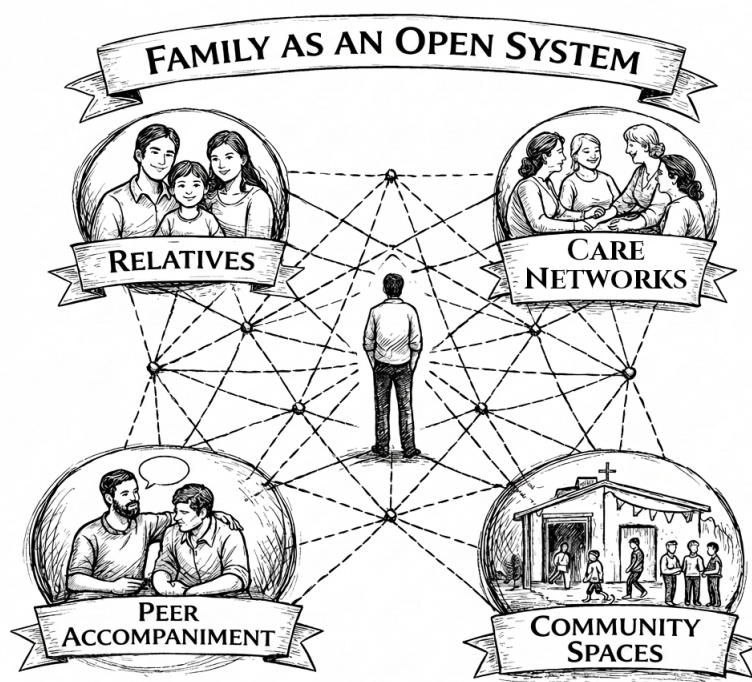


Figure 6.4: Community family

■ Thesis and argumentative development

The proposal of the term community family responds to a necessary paradigm shift grounded in four theoretical axes:

1. First, the response to functional orphanhood, where the community does not merely assist, but offers maternal protection in the face of the rupture of primary bonds.
2. Second, the integration of territorial actors, forming a network that unites the fragments that the administrative system tends to separate, acting as a solidary body.

3. Third, the construction of a safe place, a space of protection inspired by biblical shelter where the person can be and to which they can always return.
4. Fourth, the adoption of shared child-rearing, where all members of the social fabric feel co-responsible for the development and protection of the lives of the brothers and sisters most made vulnerable by the use of psychoactive substances (PAS).
5. Fifth, the need for protocols of care and protection. The community family is not a spontaneous space that is constituted by the mere desire to help; it requires a responsible organization that includes clear criteria for the protection of children and adolescents who participate in it. Territorial experience teaches that the community is not always a safe space: drug trafficking, abuse, and violence also inhabit the bonds of closeness. For this reason, every proposal of community family must include guidelines for the selection and accompaniment of adult referents, mechanisms of listening and reporting accessible to minors, and an articulation with the legal frameworks for the protection of childhood in force in each country. The mystique of hospitality does not replace institutional responsibility; it embodies and humanizes it.

■ Response to the objections

1. Regarding the first objection, the concept does not seek to annul parental responsibility, but to act as a support that strengthens them in contexts of extreme stress, preventing children from being left at the mercy of criminal networks. It is fundamental to distinguish between complementing the family—which is desirable and is the objective of this concept—and replacing it—which, when necessary, requires formal legal and institutional frameworks such as guardianship, tutorship, or adoption—. The community family operates in the first register: it accompanies, sustains, and strengthens, but does not replace parental responsibility nor the functions that the legal system reserves for institutions of protection.
2. As for the second objection, calling these spaces institutions reflects a merely functional bond; by calling them family, the emphasis is placed on identity, knowledge by name, and the mystique of the shared table, transforming technical assistance into a truly fraternal encounter.

6.2.5 Article 5: On the Conditioning of Macro Influences on Child-Rearing Capacities

■ Statement of the topic

The family does not constitute a watertight compartment, but rather is an open system that forms part of a broader social framework that conditions it significantly. It is analyzed how macroeconomic, political, and cultural factors exert external pressure that can either facilitate or, on the contrary, undermine healthy human development and the caregiving capacities of family referents.

■ Central question

In what way do macro-level influences condition and affect child-rearing capacities in families?

■ Existing positions or objections

- One might think that child-rearing is a purely individual and private responsibility, where success or failure in the education of children depends exclusively on the will and personal skills of the parents, without the socioeconomic environment being a determining factor.
- On the other hand, it is often said that maternal or paternal love is sufficient to overcome any adversity, suggesting that even in contexts of extreme poverty or exclusion, caregiving capacities should not be diminished if a strong affective bond exists.

■ Foundation or criterion of discernment

The magisterium of Pope Francis in *Amoris Laetitia* teaches that it is necessary to denounce with frankness the cultural, social, and economic conditionings that prevent an authentic family life. The family is a good from which society cannot do without, and therefore, the State and the organized community have the responsibility to guarantee the conditions necessary for homes to fulfill their mission of caring for and protecting life.

■ Thesis and argumentative development

Macro influences impact family dynamics through four fundamental theoretical mechanisms:

1. First, the deprivation of basic resources, where extreme poverty limits access to health and nutrition, generating additional burdens that hinder the motor and cognitive development of children and adolescents.
2. Second, the chronic stress of the caregiver caused by job instability, excessively long work hours, and the lack of essential services, which exhausts the psychic resources of adults and reduces their emotional availability to attend to the needs of their children.
3. Third, discrimination and social exclusion, which increase the physiological stress response in parents, weakening their affective warmth and pushing young people toward risk behaviors as an escape mechanism in the face of anguish.
4. Fourth, the presence of organized crime and drug trafficking in the territory, which fragment homes and force the family to live under a logic of survival that annuls spontaneous child-rearing processes.

In the face of this scenario, the need for early intervention through community promotional spaces that act as buffers against these external pressures is grounded.

■ Response to the objections

1. Regarding the first objection, while individual responsibility exists, the real exercise of freedom and the capacity to educate require minimum conditions of social, legal, and economic order; without a facilitating environment, child-rearing ceases to be an act of freedom to become a reactive struggle for subsistence.
2. As for the second objection, love is the axis of the home, but prolonged stress acts as a developmental disruptor that can silence the affective response of the caregiver. For this reason, community child-rearing is presented as the necessary support network to sustain parents who find themselves overwhelmed by structural injustices.

6.2.6 Article 6: On the Impact of Discrimination and Social Exclusion on the Risk of Youth Substance Use

■ Statement of the topic

Vulnerability to the use of psychoactive substances (PAS) cannot be explained solely by individual or biological factors. There is a close relationship between the dynamics of social exclusion and the processes of stigmatization that act as powerful macro-environmental forces, disrupting the healthy development of young people and pushing them toward risk behaviors as a mechanism of response to a hostile environment.

■ Central question

In what way do discrimination and social exclusion increase the probability that young people will resort to the use of psychoactive substances?

■ Existing positions or objections

- It could be maintained that substance use is a strictly individual decision based on free will, and therefore social discrimination would not be a cause but a pretext for evading personal responsibility.
- Another position argues that the most determining factors are purely genetic, representing the greatest part of vulnerability, which would place social exclusion as a secondary factor compared to the organic predisposition of the individual.

■ Foundation or criterion of discernment

Many young people fall into the networks of substance use because they feel invisible and have ceased to exist for others due to a throwaway culture and abandonment. The Magisterium teaches that liberation from injustices is what truly promotes freedom and human dignity, since there is no full freedom where social conditions suffocate hope.

■ Thesis and argumentative development

Discrimination and social exclusion operate as triggers of youth vulnerability through three fundamental theoretical mechanisms:

1. First, the deterioration of mental health through chronic stress, where the perception of being rejected by the system increases the physiological response of anguish, with the substance functioning as a self-therapeutic attempt to alleviate a life perceived as intolerable.
2. Second, the weakening of the care network, since when families suffer exclusion, caregivers manifest levels of exhaustion that affect their child-rearing roles, leaving young people without the safe harbor necessary to resist the pressures of the environment.
3. Third, invisibility and the lack of meaning, where exclusion generates a culture in which the young person feels they have nothing to contribute; lacking roots and a horizon of educational or employment opportunities, the immediacy of substance use fills the existential void caused by social uprooting.

■ Response to the objections

1. Regarding the first objection, while free will is a human constitutive, its real exercise requires minimum conditions of social justice; without these, freedom is obscured by conditionings that need to be healed through community integration.
2. As for the second objection, although genetics is a factor to consider, science recognizes that risk is the result of a synergistic interaction between biology and the environment; an affectionate environment and an inclusive community can protect even those who possess greater biological vulnerability, while exclusion can cause any individual to cross the threshold toward dependence.

6.2.7 Article 7: On the Principles for a Family-Based Preventive Intervention

■ Statement of the topic

The prevention of the use of psychoactive substances (PAS) in the family setting must overcome the welfare-based and merely informational model to become a process of empowerment and capacity strengthening. The theoretical and methodological criteria that allow the family to constitute itself as an effective protective factor through the development of caregiving skills and the consolidation of healthy bonds are analyzed.

■ Central question

What are the fundamental principles that should govern an effective preventive intervention in the family setting?

■ Existing positions or objections

- One might think that family prevention should be purely informational, under the premise that if parents know the biological and legal effects of substances and transmit them to their children, this will suffice to prevent use.
- On the other hand, it is argued that interventions should focus exclusively on young people, since the family belongs to the private sphere and institutions should not interfere in the internal dynamics of child-rearing or in the autonomy of the home.

■ Foundation or criterion of discernment

The Magisterium teaches that the family is the deepest agent of socialization and the first place where the proper use of freedom is learned. The most successful interventions are those that enable caregivers to develop and practice new skills with their children, recognizing that integral education is a primary right of parents that the community must accompany in a subsidiary manner.

■ Thesis and argumentative development

A family-based preventive intervention is grounded in six guiding principles:

1. First, the assessment of needs and risk, adapting the program to the specific reality of the community, distinguishing whether universal, selective, or indicated prevention is required.
2. Second, the adequacy to the stage of the life cycle and dosing, ensuring that activities are appropriate for the age of the children and have the necessary duration to automatize new caregiving behaviors.
3. Third, interactive methodology, avoiding the lecture format to foster role-playing and active participation, understanding that social learning occurs through guided practice.
4. Fourth, the development of sensitivity and structure, teaching parents to combine affection and empathy with the establishment of clear rules and supervision.
5. Fifth, the link with school and organized community, reviving the educational alliance so that caregivers become involved in the institutional spaces of the child or adolescent, thereby strengthening their network of belonging.

■ Response to the objections

1. Regarding the first objection, science and pastoral experience demonstrate that the mere delivery of information does not modify behaviors; the real preventive factor is the modeling of healthy habits in an environment of affective warmth.
2. As for the second objection, although the family is an intimate nucleus, it is not a watertight compartment; in the face of contexts of poverty or exclusion that generate chronic stress, community intervention is indispensable to sustain the protective function of parents under the logic of shared child-rearing.

6.2.8 Article 8: On the Paradigm of Community Child-Rearing

■ Statement of the topic

Child-rearing has traditionally been understood as a task confined exclusively to the sphere of family and biological intimacy. However, in the face of the unraveling of the social fabric caused by drug trafficking and exclusion, the need for a paradigm shift toward community child-rearing arises. It is analyzed how the organized community must assume a shared responsibility to protect and empower the lives of children and adolescents, especially when primary bonds are found to be fragilized.

■ Central question

Is community child-rearing a legitimate and necessary model to guarantee integral development and the prevention of risk behaviors in contexts of vulnerability?

■ Existing positions or objections

- One might think that child-rearing is a non-delegable and private responsibility, and therefore the intervention of other neighborhood actors would be an intrusion into family autonomy. Under this view, success or failure in a child's education depends exclusively on the progenitors, disconnecting the social environment from any ethical commitment.
- On the other hand, it is argued that community spaces such as clubs or parishes should limit themselves to providing specific services (sports or catechesis) without getting involved in the affective and subjective maturation processes of childhood.
- Finally, it is warned that involving community actors in child-rearing processes could expose children and adolescents to risky situations if those actors do not have adequate training or supervision, considering that the contexts of vulnerability where this proposal is deployed are also scenarios where networks of abuse and exploitation operate.

■ Foundation or criterion of discernment

Social magisterium and the vision of the Church as a family of families teach that the human being is constitutively relational. *Amoris Laetitia* proposes that the family should not isolate itself, but rather be a nexus of integration between the public and the private. The organized community must constitute itself as the support network that offers protection and belonging where the primary network is nonexistent, grounding itself in the principle of social co-responsibility for the life of the brother or sister.

■ Thesis and argumentative development

Community child-rearing is grounded as a strategy of collective healing and protection deployed in four dimensions:

1. First, early and promotional intervention, understanding that play, sports, and art are not merely recreation, but fundamental preventive tools that generate strengths in the construction of the social being before substance use advances.
2. Second, the construction of a safe place, where the territory offers care spaces that neutralize the offerings of street corners and the street, allowing childhood to recover its right to joy.
3. Third, the function of community affective referents, who offer a secure attachment and a pedagogy of tenderness that repairs functional orphanhood.
4. Fourth, the culture of encounter against individualism, where child-rearing ceases to be a solitary process to become a dynamic of a people that cares for its most fragile members, guaranteeing access to fundamental rights that the system tends to ignore.

■ Response to the objections

1. Regarding the first objection, community child-rearing does not seek to annul parental authority, but to act as a subsidiary support that

strengthens them in situations of extreme stress or exclusion, preventing the child from being left at the mercy of organized crime.

2. As for the second objection, separating technique from affection is to incur in a dehumanizing fragmentation; community spaces are only truly educational when they succeed in providing maternal care to the life of the brother or sister, transforming functional assistance into a stable and healing bond of belonging.
3. As for the third objection, the warning is legitimate and the manual assumes it seriously. Community child-rearing does not consist of delegating the care of minors to any available adult in the territory. It demands the construction of protective environments with explicit criteria: careful selection and training of adult referents, the presence of more than one adult in every space of accompaniment of minors, channels of listening and reporting accessible to children, articulation with the child protection agencies of each country, and an institutional culture that does not tolerate or cover up any form of mistreatment or abuse. The Church has painfully learned that closeness and affection, when not accompanied by clear protocols and transparency, can become the setting for the worst of damages. The community child-rearing that this manual proposes assumes that lesson as a constitutive part of its design, not as a subsequent addition.

6.3 | Work and Money

This section proposes to discern the operative dimension of the human being as an intrinsic component of their health and ontological dignity. Work is not analyzed here as a simple datum of economic subsistence, but as the vertebrating axis that allows the brother or sister to reconstruct their identity, order their time, and participate actively in the creative work of God. Likewise, it seeks to illuminate the relationship with money and material resources, understanding them as a sign of realism and a thermometer of the maturity achieved in the face of the dynamic of compulsion. Through this pastoral judgment, we will seek to integrate labor therapy, the learning of trades, and paid employment under the criterion of a structured mercy that promotes the autonomy and protagonism of the subject within their people.

6.3.1 Article 1: Work as Participation in Creation

■ Statement of the topic

Contemporary culture tends to reduce human labor to a mere commodity or to a simple instrument for the production of wealth. In the accompaniment of our brothers and sisters, it is vital to rescue the profound meaning of daily work. It is not only a matter of what man produces, but also of what work does with man. We must discern whether labor activity is an accidental element or whether it is a sacred dimension that allows the subject to unfold their vocation and perfect their nature in dialogue with the Creator.

Gen 2:15 — *The Lord God took the man and placed him in the garden of Eden to cultivate it and care for it*

■ Central question

Does work constitute an essential dimension of human identity that allows persons to participate in the creative work of God and restore their wounded dignity?

■ Existing positions or objections

- It seems that work is merely a necessary burden for biological survival or a consequence of the world's disorder that possesses no intrinsic spiritual or therapeutic value.
- It seems that, in persons with addiction problems, work is an unattainable objective or a prize that should only be granted at the end of the journey, considering it alien to the initial stages of healing.

- It seems that operative or technical labor is inferior to the spiritual life, suggesting that true recovery is played out only on the plane of faith or psychology, leaving the dimension of doing on a secondary plane.

■ Foundation or criterion of discernment

Our Christian anthropology and social magisterium teach that the human being, created in the image of God, is called to be a collaborator in the divine work through the cultivation and care of creation. Work is the vertebrating axis that grants meaning to daily life. In working, the human being not only transforms things, but realizes themselves as a capable and creative subject.

■ Thesis and argumentative development

We respond that work is an intrinsic component of integral health and a motor of operative identity for the following reasons:

- Mirror of identity: Through their work, the human being recognizes themselves as someone who has something to give. Labor allows one to objectify one's own talents and reconstruct a subjectivity fragmented by the depersonalization that substance use generates.
- Orderer of time and desire: Work structures the daily rhythm, combating the blocks of empty time that tend to be triggers of compulsion. It educates the will toward concrete goals and allows one to transition from immediate gratification to the satisfaction of shared effort.
- Protagonism in the people: In working, the individual leaves their isolation and integrates into the community, passing from being an object of assistance to being an active subject who contributes to the well-being of their family and their neighborhood.

■ Response to the objections

1. To the first: Although work involves effort and fatigue, its essence is promotional and humanizing. It is the path by which man perfects creation and finds a purpose that transcends mere survival.
2. To the second: Work, in the form of labor therapy, is a medicine from the very beginning of the process. It is not a prize for success, but a pedagogical tool that helps recover self-esteem and the habits necessary for life.

3. To the third: There is no real division between the spiritual and the operative. In the proximity of the daily task, the person finds a concrete path of healing where faith becomes flesh and the spirit is strengthened through discipline and service.

6.3.2 Article 2: The 3Ts (Land, Shelter, and Work)

■ Statement of the topic

The dignity of the human being cannot be sustained in a vacuum; it requires basic material conditions that allow the unfolding of one's freedom and belonging to a people. Following the social magisterium of the Church, we identify three fundamental pillars for a dignified life: Land, Shelter, and Work. It is necessary to judge whether these elements are purely political demands or whether they constitute sacred dimensions of restorative justice, whose absence feeds the structural helplessness in which addictions take root.

Lk 4:18–19 — *The Spirit of the Lord is upon me... he has sent me to proclaim good news to the poor, to proclaim liberty to the captives*

■ Central question

Do Land, Shelter, and Work constitute an indissoluble triad of sacred rights whose guarantee is a necessary condition for an integral and sustainable recovery?

■ Existing positions or objections

1. It seems that the Church should focus solely on the spiritual dimension of the human person, leaving the demands of Land, Shelter, and Work to state agencies or to the political, social, and technical struggle.
2. It seems that, given the urgency of addiction, the only priority is abstinence, considering that the lack of housing or land ownership are secondary problems that will be resolved once the subject is *clean*.
3. It seems that proposing access to the 3Ts as part of treatment is a form of welfarism that fosters the brother's or sister's dependence instead of their autonomy and personal effort.

■ Foundation or criterion of discernment

The social thought of the Church teaches that human dignity is integral and that the goods of creation are destined for all. There is no true freedom without a material basis to sustain it. Land, Shelter, and Work are sacred rights because they allow the person to cease being a discarded wanderer and to become a citizen with roots, protection, and purpose. The helplessness produced by the lack of these dimensions is the breeding ground where narco-culture offers its false promises.

■ Thesis and argumentative development

We respond that the guarantee of the 3Ts is an imperative of justice and a motor of resilience for the following reasons:

- Land as belonging: Access to a territory and to an organized community allows the brother or sister to recover their sense of home. Land symbolizes the roots and the stability necessary to project a future that substance use tends to fragment into a perpetual present.
- Shelter as protection: Shelter is not only a physical structure, but the space of intimacy and security where the family bond is rebuilt. Without a safe place to rest and be received, the person remains in a state of biological alertness and chronic stress that triggers the desire to use.
- Work as sustenance: Work is the axis that allows Land and Shelter to become sustainable. It is the motor that restores the subject's place in the popular economy and their social protagonism, preventing them from falling once again into the drift of exclusion.

■ Response to the objections

1. To the first: A spirituality that ignores the suffering flesh and material needs of the brother or sister is a disincarnate faith. The ecclesial mission includes political charity, which seeks to transform the structures of sin that deny these fundamental rights.
2. To the second: Abstinence is fragile if it is not safeguarded by a dignified life. The 3Ts are not the prize at the end of the finish line, but the scaffolding of justice that allows the brother or sister to stand on their feet against the pressures of the environment and marginality.

3. To the third: Access to the 3Ts is not welfarism, but restitution of rights. It is not about “giving” passively, but about generating the conditions so that the brother or sister, through their own protagonism and the support of the community, can inhabit their land, care for their shelter, and dignify themselves in their work.

6.3.3 Article 3: Structured Mercy

■ Statement of the topic

In the accompaniment of persons with trajectories of substance use and exclusion, a tension frequently arises between unconditional welcome and the need for operative order. There is the risk of falling into a welfarism that, by avoiding demands, ends up abandoning the brother or sister in their own chaos. The task is to discern whether the implementation of norms, schedules, and work responsibilities is an act contrary to charity or whether, on the contrary, it constitutes a superior form of love that offers the subject the scaffolding necessary to reconstruct their will.

■ Central question

Is structured mercy a legitimate pastoral criterion that unites the tenderness of welcome with the firmness of the pedagogical rule as a necessary condition for the integral health of the brother or sister?

■ Existing positions or objections

1. It seems that mercy should always be unconditional and without limits, and therefore establishing rules or work structures would be a form of legalism that contradicts the gratuity of evangelical love.
2. It seems that rigid structures and the demand for tasks replicate the systems of control and punishment that have already expelled the brother or sister from other social spheres, deepening their feeling of rejection.
3. It seems that, in the face of the pain of the other, the only pastoral approach is total flexibility, considering that any type of structure is an unbearable burden for someone who is already sufficiently broken.

■ Foundation or criterion of discernment

True mercy is not a diffuse sentiment nor a permissiveness that leaves the other adrift. It is an operative charity that takes charge of the other's fragility by providing a safe and predictable environment. A mercy without structure is neglect; a structure without mercy is cruelty. The balance resides in a pedagogy that uses the firmness of the rule to protect the freedom that is still weak, offering a *field hospital* where both affection and order are necessary.

■ Thesis and argumentative development

We respond that structured mercy is an instrument of justice and healing for the following reasons:

- Relational security and containment: For those who come from the chaos of the street or from compulsion, the healthy limit functions as a protective embrace. The structure of work and community norms reduce anxiety by offering a setting where the brother or sister knows what is expected of them and what they can expect from the environment.
- Repair of the will: Addiction destructures the capacity to decide. Structured mercy proposes small daily goals that allow one to train the muscle of the will once again, transforming inertia into an intentionality oriented toward the good.
- The pedagogical value of the limit: The limit is not a punishment, but a boundary that defines the space of mutual respect. It teaches that one's own actions have consequences and that error is an opportunity for learning and forgiveness, not a reason for definitive expulsion.

■ Response to the objections

1. To the first: The gratuity of God is not disorder. Structured mercy makes transparent a love that wants the brother or sister to grow and be perfected. The limit is the expression of a God who cares for us by preventing us from destroying ourselves.
2. To the second: Unlike punitive systems, pastoral structure is born from the bond and from proximity. It is not imposed from a distant authority, but is lived in community, where the one who accompanies submits to the same rule and rhythm of life as the one who is accompanied. The limit is set thinking of the good of the other, and out of love.

3. To the third: Total flexibility often becomes indifference. Proposing a structure is a sign of hope: it is telling the brother or sister that we believe in their capacity to respond, to be responsible, and to be the protagonist of their own process of new life.

6.3.4 Article 4: The Gradual Meaning of Work in Recovery

■ Statement of the topic

One of the most recurrent tensions in accompaniment settings is the incorporation of work activity. There is the fear that work represents an excessive stress that could trigger a relapse or that, on the contrary, prolonged inactivity fosters the destructuring of the subject. We must discern whether the demand to work is appropriate for someone who is healing their bonds and their will, avoiding falling into simplifications that ignore the complexity of the life of the person in recovery.

■ Central question

Should persons going through a recovery process perform work activities?

■ Existing positions or objections

1. It seems that they should not work, since the stress inherent to the labor market and the pressure for productivity are triggers of anxiety that put the recently achieved abstinence at risk.
2. It seems that work should be a prize granted only at the end of the journey, once the person has demonstrated absolute maturity, considering that before that it would be a distraction from the therapeutic and spiritual process.
3. It seems that any occupation is valid as long as it keeps the person busy, suggesting that the nature of the task does not matter as long as it serves to combat the blocks of empty time that substance use leaves behind.

■ Foundation or criterion of discernment

We respond that in order to answer this question adequately it is imperative to specify that, in the realm of addiction pastoral care, work is not a univocal concept. To speak of work implies referring to three distinct and progressive dimensions that must be applied according to the maturity of the subject: labor

therapy as the medicine of habit, the learning of trades as the reconstruction of operative identity, and paid employment as a milestone of justice and social autonomy.

■ Thesis and argumentative development

It is affirmed that the person in recovery must work, provided that the activity is artisanally adjusted to the stage that their heart and mind are going through, under the following criteria:

- Work that organizes (Labor Therapy): In the initial phases, the goal is not productivity but the reorganization of the interior life. The daily tasks of the community function as a pedagogical instrument to recover rhythms, discipline, and a sense of service. It is the passage from the chaos of substance use to the order of the shared.
- Work that trains (Learning a Trade): Once the initial crisis is overcome, the brother or sister needs to rediscover their talents. This formative stage seeks for the subject to acquire technical competencies and social skills. Learning a trade restores hope and allows the brother or sister to project a possible future outside the circuit of exclusion.
- Work that integrates (Paid Employment): Finally, real labor insertion is the sign of full recovery. The salary is the motor that allows economic and family independence. Paid employment verifies that the brother or sister has ceased being an object of assistance to become a citizen who is the protagonist of their own people.

■ Response to the objections

1. To the first: The risk of relapse is mitigated through gradualness. Labor therapy does not seek the demands of the market, but emotional containment in a protected environment. It is a structure that cares for the freedom of the brother or sister while it grows stronger.
2. To the second: Work is not the final goal, but a constitutive dimension of health from the beginning. Postponing the operative until the end deprives the brother or sister of an essential motor of identity. Labor inclusion must be a transversal axis that accompanies the entire journey of healing.

3. To the third: Not any occupation heals. Work must have a pedagogical meaning and respect the dignity of the person. An activity devoid of purpose does not contribute to the reconstruction of the being, while a task performed with community mystique restores wounded self-esteem.

6.3.5 Article 5: Money as a Sign of Realism and Maturity

■ Statement of the topic

In accompaniment processes, the relationship of persons with money tends to be a topic of high sensitivity. There is a tendency to consider material resources as an absolute risk factor that must be avoided to prevent relapses, or as an element alien to spiritual and therapeutic life. However, omitting the economic dimension of the subject can lead to a disincarnate recovery that does not prepare the brother or sister for the demands of the real world. We must discern whether the management of material resources is an obstacle to healing or whether it constitutes a necessary pedagogical tool to measure maturity in the face of compulsion.

■ Central question

Should the management of money be integrated into the recovery process as a sign of realism and a thermometer of maturity in the face of the dynamic of impulsivity?

■ Existing positions or objections

1. It seems that persons in recovery should not handle money, since having cash acts as an immediate trigger of the desire for use (craving) and exponentially increases the probability of a relapse.
2. It seems that addiction pastoral care should focus exclusively on the values of the spirit and mental health, considering that concern for money contaminates the nature of the process and diverts the brother or sister from their true inner healing.
3. It seems that the management of resources should only be permitted in the final stage of institutional discharge, assuming that any prior contact with money is an imprudence that puts the achievements attained in treatment at risk.

■ Foundation or criterion of discernment

Anthropological realism teaches that the human being is a biopsychosocial and spiritual unity that lives in a world conditioned by material needs. Authentic freedom does not consist in fleeing from reality, but in the capacity to inhabit it with responsibility. The management of money, under a scheme of accompaniment, allows the verification of the passage from the compulsive pattern (immediate gratification) to the planning pattern (vital projection). Without this exercise in realism, the recovered autonomy runs the risk of being an illusion that breaks at the first contact with the market.

■ Thesis and argumentative development

We respond that the integration of money management is indispensable for integral and sustainable health for the following reasons:

- Money as a thermometer of maturity: The capacity to conserve and administer resources without yielding to the impulse to use is the objective verification that the biological and spiritual *brake* has begun to function. It is the terrain where the will is trained to distinguish between momentary desire and real need.
- Financial re-education and planning: Those who come from exclusion or from the street tend to live in a perpetual present where the resource is instantly exhausted. Using money in a pedagogical way —especially the first paycheck— teaches the brother or sister to plan, to save for their family, and to care for their common home, restoring their identity as a responsible administrator.
- Overcoming material orphanhood: Access to and management of money break the logic of institutional dependence. Managing one's own resources restores dignity to the subject, allowing them to pass from being a passive recipient of aid to being a protagonist who contributes to the sustenance of their home and their organized community.

■ Response to the objections

1. To the first: Risk is not eliminated by prohibition, but managed through pedagogy. The accompanied management of money in safe environments allows the brother or sister to learn to live with the stimulus without being governed by it, strengthening their self-efficacy before total insertion.

2. To the second: There is no division between faith and flesh. A healthy spirituality is one that helps man be free in the midst of his circumstances. Money, ordered toward the good of the family and service, ceases to be a motor of slavery to become a means of justice.
3. To the third: Postponing contact with money until the end generates a reality shock that tends to be devastating. Gradual and tutored exposure is the necessary scaffolding for the brother or sister to gain security and demystify the fascination that substance use has projected onto material resources.

6.4 | Overcoming Fragmentation and Integrality of Accompaniment

This section addresses the fundamental challenge of overcoming fragmentation in the approach to problematic use, analyzing both its epistemological and administrative dimensions. It examines how excessive specialization of knowledge and bureaucratic compartmentalization of institutions tend to dehumanize the person, reducing them to a set of isolated problems that the system fails to integrate. In the face of this scenario, non-specific accompaniment is proposed as the integrating force and the connecting thread that weaves together the responses of health, justice, and the social.

The text theoretically grounds the centrality of the person as a transversal axis that demands a change of logic: moving from institutional self-sufficiency to horizontal networking. Under this integral perspective, the role of the organized community is highlighted as the environment capable of housing the complexity of the subject, providing a safe harbor and a bond of belonging that transcends technical assistance. Finally, the importance of promoting integration processes that recognize the ontological dignity of each brother and sister is analyzed, ensuring that access to fundamental rights is not obstructed by the rigidity of fragmented administrative systems.

6.4.1 Article 1: On Epistemological and Administrative Fragmentation

■ Statement of the topic

The approach to addictions faces the obstacle of fragmentation, a phenomenon that operates both in the construction of knowledge and in the organization of institutional responses. This division disarticulates the unity of the person, hindering an intervention that responds to the real complexity of those who are going through problematic use of psychoactive substances (PAS).

■ Central question

What does epistemological and administrative fragmentation consist of and in what way does it affect dignity and accessibility in integral accompaniment?

■ Existing positions or objections

- It could be argued that the specialization of knowledge is strictly beneficial, since depth in areas such as medicine, psychology, or law guarantees higher quality technical care.
- Likewise, it is maintained that the division of functions in the State is the most efficient way to manage public resources, avoiding disorder through portfolios with specific budgets and competencies. Under this view, fragmentation would not be a problem, but a requirement of technical and administrative modernity.

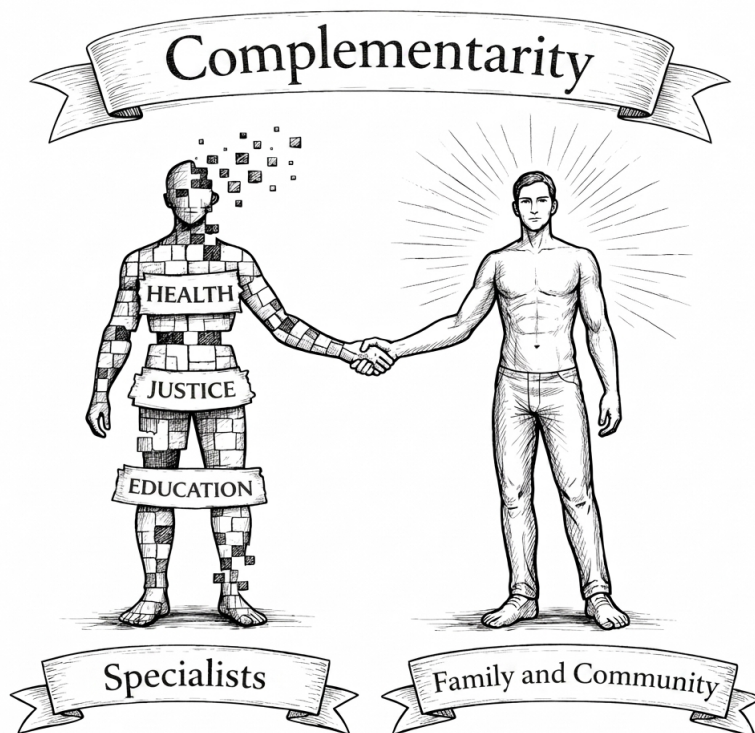


Figure 6.5: Fragmentation and the integral perspective

■ Foundation or criterion of discernment

Integral thought and social magisterium teach that the whole is greater than the sum of its parts. A fragmented response is insufficient for addressing complex problems, since hyperspecialization and bureaucracy tend to ignore the ontological unity of the person. Technique must always be subordinated to a holistic perspective, capable of recognizing the totality of the other's life.

■ Thesis and argumentative development

Fragmentation acts as a double obstacle that dehumanizes care:

1. First, epistemological fragmentation dissects the human being through a magnifying glass effect; science specializes so much in one part (biological, psychic, or social) that it loses sight of the personal history, the loneliness, and the territorial bonds of the subject.
2. Second, administrative fragmentation translates this division into watertight institutional boxes. Governments organize themselves into compartments with limited competencies that fail to articulate, so that the requirements of one institution can become impediments for another. This reality generates a crisis of accessibility where the most vulnerable persons are excluded, unable to navigate by themselves an institutional framework that perceives them as a set of isolated procedures and not as a life that cries out to be integrated.

■ Response to the objections

1. Regarding the first objection, while specialization allows depth, in the paradigm of complexity the interaction between the dimensions of the person produces realities that cannot be understood by studying each piece separately.
2. As for the second objection, administrative efficiency is lost when the response is ineffective for the subject; true efficiency is born from a network that, overcoming self-sufficiency, manages to unify the fragments of response to humanize the journey of each brother or sister.

6.4.2 Article 2: On the Action of Non-Specific Accompaniment against Fragmentation

■ Statement of the topic

In the face of the dehumanization produced by the division of the person into isolated technical areas, the need for an integrating figure arises. Non-specific accompaniment is analyzed as the connecting thread that traverses the various instances of care, restoring unity to the life of the brother or sister and ensuring that the system does not expel them.

■ Central question

Is non-specific accompaniment the effective means to overcome administrative and epistemological fragmentation in the approach to addictions?

■ Existing positions or objections

- One might think that accompaniment should always be specific and technical in order to be professional. Under this view, if a person has a health problem, they need exclusively a doctor, and if they have a legal problem, a lawyer; therefore, a non-specific companion would lack the necessary tools to solve concrete problems.
- On the other hand, it is argued that fragmentation is a problem of state management that must be resolved through bureaucratic reforms and budget unification, and not through community action based on affective bonds.

■ Foundation or criterion of discernment

Accompaniment is defined as the humanization of the journey. While the specialist has an incisive but partial gaze, the community companion possesses a holistic and integral gaze, similar to that of a mother who knows the totality of her child's life and is capable of uniting what the system separates.



Figure 6.6: The non-specific accompaniment of the community

■ Thesis and argumentative development

Non-specific accompaniment acts as the integrating force of the recovery process through three fundamental functions:

1. First, the humanization of the journey, allowing the subject to overcome the fear and the lack of meaning in the face of institutions that tend to be cold and expulsive.
2. Second, the transversality of the process, since, unlike the technical approach that is circumstantial and punctual, non-specific accompaniment walks hand in hand with the person in all their stages, whether on the street, in the hospital, or in the courthouse.
3. Third, the weaving of the fragments, where the companion acts as the support that unites the responses of health, identity, and justice, guaranteeing real accessibility to the fundamental rights that administrative division tends to obstruct. This non-specific presence is what allows the

attempts at change of a person to be transformed into a life story with meaning.

■ Response to the objections

1. Regarding the first objection, non-specific accompaniment does not seek to replace technical knowledge, but to complement it; its function is to ensure that the person can sustain the medical treatment or legal process through emotional support and constant presence.
2. As for the second objection, although the State is the guarantor of rights, it lacks the capacity to generate communities of care and bonds of belonging; only the organized community can offer the safe place and the persistence in love indispensable for integral healing.

6.4.3 Article 3: Horizontality and the Centrality of the Person in Networking

■ Statement of the topic

Networking is often hindered by hierarchical visions or approaches centered solely on the substance. The need to structure accompaniment networks horizontally is analyzed, placing the singularity of the person as the transversal axis that unifies all institutional and community interventions.

■ Central question

Why must networking in the approach to addictions be structured horizontally and place the person as the central axis of all action?

■ Existing positions or objections

- One might think that networking must be strictly hierarchical and pyramidal, where State institutions or medical specialists issue directives to communities to ensure administrative control of resources.

- Likewise, it is often said that the initial approach should be centered exclusively on the elimination of the symptom (abstinence), leaving the approach to subjectivity and personal history for a stage after biological recovery.

■ Foundation or criterion of discernment

To act as a network, the construction must be horizontal, valuing what each sector can contribute. The displacement of the focus must always go from the substance use to the person, recognizing that the human being is an integral unity —biopsychosocial and spiritual— and that the network must respond to that totality for healing to be sustainable.

■ Thesis and argumentative development

Horizontality and the centrality of the person are grounded in four theoretical dimensions:

1. First, the overcoming of institutional self-sufficiency, recognizing that no one has all the answers and that the complementarity of knowledge (NGO, parish, hospital, club) truly benefits the subject.
2. Second, the valuing of all contributions, where the network allows the sum of wills to result in a greater good than the simple addition of the parts, planning strategies in terms of processes and not of isolated events.
3. Third, respect for singularity and timing, which obliges the network to adopt an artisanal perspective that adapts to the sacred story of each brother or sister, avoiding the imposition of rigid recipes or standards of success.
4. Fourth, the promotion of protagonism, where the network does not assist a passive object, but empowers a responsible subject, integrating peer companions and the community as political actors of social transformation.

■ Response to the objections

1. Regarding the first objection, although technique is necessary, the State and institutions cannot by themselves generate bonds of belonging; horizontality protects the autonomy of the community and prevents territorial knowledge from being absorbed by a bureaucratic logic.
2. As for the second objection, an approach centered solely on the substance is a reductionism that ignores the complexity of the person; placing the subject at the center from the beginning humanizes the journey and ensures that the institutional network does not treat them as an administrative case that bounces between offices.

6.5 | Methodology of Tenderness and Community Roles

This section delves into the methodology of tenderness as the central axis of the community approach, integrating the pedagogy of three languages proposed by Pope Francis: the head for understanding the complexity of the phenomenon, the heart for the affectivity that reads pain in the eyes, and the hands for the touch and embrace that tear down the walls of stigma. Fundamental roles born from the territory are described, such as the *madrazas*—women referents of the community who assume a maternal role of care and protection where primary bonds are broken—and the peer companions, experts by experience who, having traversed the same pain, become positive leaders capable of guiding others from empathy and the authority of testimony.

Through the paradigm of community child-rearing, this approach proposes a friendship with time that rejects standardized recipes and commits to artisanal processes based on reciprocity, rootedness, and the conviction that human bonds are the definitive motor for the restoration of dignity. Under this perspective, the importance of arriving first through early intervention is emphasized, empowering promotional spaces such as play, art, and sports. These settings are understood as a gymnasium for the definition of the social being, fundamental for generating subjective strengths before substance use advances. Finally, the methodology of tenderness recognizes that the ontological dignity of the person remains intact even in the darkest depths of addiction, and it is the task of the organized community to remove the obstacles that block the unfolding of the spirit.

6.5.1 Article 1: The Application of the Three Languages in the Methodology of Tenderness

■ Statement of the topic

The community approach to addictions requires a pedagogy that transcends the mere transmission of technical or moral information. The proposal of Pope Francis on the integration of the three languages—the head, the heart, and the hands—is analyzed as the fundamental structure of a methodology of tenderness that allows a real and transformative encounter with wounded life.

■ Central question

In what way should the languages of the head, the heart, and the hands be integrated and applied in the integral accompaniment of persons with problematic use?

■ Existing positions or objections

- One might think that the approach should be strictly technical and intellectual, focusing exclusively on the scientific and theoretical knowledge of the phenomenon to guarantee the efficacy of the treatment (only the head).
- Likewise, it is often maintained that physical or affective gestures, such as the embrace or close contact (the hands), are secondary or unprofessional in a mental health setting, and that moral instruction or pharmacological intervention should be prioritized.

■ Foundation or criterion of discernment

Christian anthropology and the magisterium of Francis teach that the person is an indivisible unity. The methodology of tenderness is not sentimentalism, but a way of making transparent the love of God who goes out to encounter the totality of the human being, recognizing that there is no true healing without a closeness that involves thought, affection, and concrete action.

■ Thesis and argumentative development

The application of the three languages constitutes an integral pedagogy that humanizes the recovery process and overcomes social stigma through three interconnected dimensions:

1. First, the language of the head, which implies the development of creative strategies for understanding the complexity of psychoactive substances (PAS), translating knowledge into tools and skills accessible to those being accompanied.

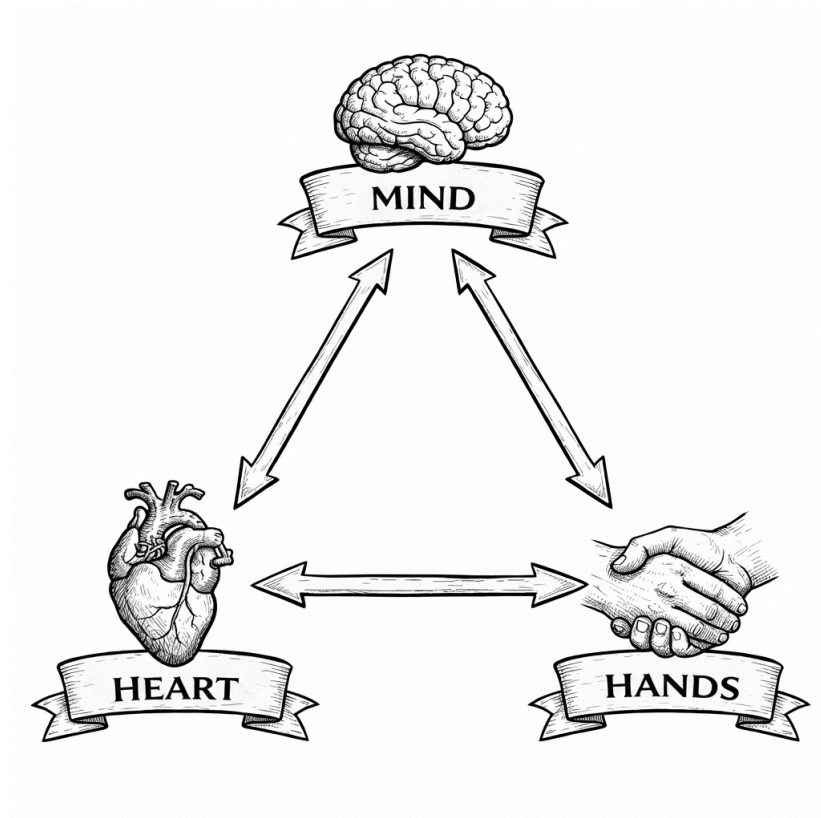


Figure 6.7: Methodology of tenderness

2. Second, the language of the heart, referring to affectivity and emotional proximity; it consists of the capacity to read pain in the eyes and smile of the brother or sister, providing them with the assurance that they are valued for their ontological dignity above their problem.
3. Third, the language of the hands, which represents the body and the touch indispensable for tearing down the walls of indifference. Gestures such as shaking hands or embracing restore dignity to the suffering body of Christ in the people and transform the territory into a place of shelter.

The conjunction of these elements allows one to recognize the radical singularity of each brother or sister and accompany their life as it comes.

■ Response to the objections

1. Regarding the first objection, although technique is necessary, an approach that uses only the head is insufficient for those who suffer from orphanhood

and extreme loneliness; true pastoral wisdom demands that the mind engage with feeling and doing in order to heal integrally.

2. As for the second objection, the language of the hands is not a distraction from treatment, but a gesture of inclusion and respect that often possesses a therapeutic impact superior to discourses, offering immediate security to those who have lived years of discard and social rejection.

6.5.2 Article 2: Friendship with Time as the Axis of Recovery

■ Statement of the topic

Friendship with time is analyzed as a fundamental virtue and strategic axis of the community approach. Unlike institutional logics that demand immediate results, this approach recognizes that the healing of lives traversed by the use of psychoactive substances (PAS) requires slow, circular processes that are respectful of the sacred story of each person.

■ Central question

Why is friendship with time considered the fundamental axis and principal virtue of recovery in the community model?

■ Existing positions or objections

- One might think that time is a scarce resource and that, given the urgency of overdoses and the violence of drug trafficking in the territories, recovery should be immediate and efficient, since waiting too long could be interpreted as negligence or lack of professionalism in treatment.
- On the other hand, it is often maintained that recovery time should be dictated strictly by scientific and administrative protocols —such as the duration of a scholarship or fixed periods of internment— considering that if there are no results in that time, the process is a failure.

■ Foundation or criterion of discernment

The magisterium of Pope Francis teaches that time is superior to space, which implies that it is a priority to initiate processes of human maturation rather than attempting to dominate spaces of control. “Time prevails over everything” and the Church and the community must be friends of time, moving away from a “franchise” logic to embrace slow and deep vital processes.

■ Thesis and argumentative development

Friendship with time is the axis of community recovery because it recognizes that the healing of a broken life is not a technical event, but an existential process that cannot be forced. This thesis is grounded in five theoretical dimensions:

1. First, the overcoming of franchise logic, understanding that the construction of bonds cannot be standardized and requires permanence to generate the necessary trust.
2. Second, the distinction between biographical time and institutional time, where community accompaniment must last as long as life needs, without the expiration dates typical of administrative systems.
3. Third, respect for the artisanal process, where one walks alongside the person respecting their comings and goings, understanding that forcing change generates resistance.
4. Fourth, making history through listening, where the caring and prolonged presence functions as a repository of memory that gives meaning to the brother’s or sister’s journey.
5. Fifth, the counterpoint to the immediacy of substance use, offering a slow pace that teaches one to manage frustration and waiting, reconstructing the capacity to project a future in the face of the magical satisfaction of the instant that addiction proposes.

■ Response to the objections

1. Regarding the first objection, the urgency of the crisis is addressed with constant presence and not with hasty solutions; time is not a delay, but the stage where mercy becomes flesh for sustainable healing.
2. As for the second objection, successes in the territory are not measured by medical discharges within rigid deadlines, but by the strengthening of ontological dignity and reintegration into a family or community; a process that seems slow to the State may be the only real miracle capable of turning a story of death toward a life with meaning.

6.5.3 Article 3: The Paradigm of “Arriving First” and the Power of Promotional Spaces

■ Statement of the topic

Lk 19:5 — *Zacchaeus, come down immediately, for today I must stay at your house*

Historically, the approach to problematic use has maintained a strong welfare bias, centering the perspective and resources on accompaniment processes when suffering and addiction have already advanced. “Arriving first” is not a naivety about the omnipresence of substances in the consumer society: it is the strategic decision to prioritize formative presence over reactive presence, to be in the life of the person before the crisis installs accompaniment as the only possible mode. In the face of this reactive approach, the need arises to consolidate the paradigm of early intervention, grounded in the capacity of the organized community to generate scenarios that contribute to forging strengths in the subjective and collective construction of childhood and adolescence.

■ Central question

What is the strategic value of “arriving first” through promotional spaces within the framework of a methodology of tenderness and integral prevention?

■ Existing positions or objections

- One might think that activities such as play, sports, or art are merely recreational, accessory, or secondary resources, lacking real preventive value in the face of the power of psychoactive substances (PAS). Under this view, it is often said that pastoral energy and State budgets should

be reserved exclusively for instances of crisis, detoxification, or street outreach.

- Likewise, there is the position that prevention should be strictly informational or technical, centered on warning about the biological damages of the drug, and not on the integral development of the social being.

■ Foundation or criterion of discernment

The magisterium of Pope Francis and Christian anthropology teach that the identity of the young person is forged in the encounter with the other. The methodology of tenderness proposes that promotional spaces are a “gymnasium for the definition of the social being.” These settings allow the culture of encounter to be sown, building formative instances that give rise to guiding decision-making and strengthening the will to say “no” in the face of the offer of substance use.

■ Thesis and argumentative development

Early intervention constitutes the transformative axis of the community model and is grounded in four essential pillars:

1. First, the creation of scenarios of strength, where the child or adolescent develops healthy bonds and a solid subjectivity before facing the pressure of peers or the offer of the market.
2. Second, sports and art as formative tools, where habits of self-care, perseverance, and co-responsibility are incorporated, allowing the young person to recognize themselves as the protagonist of their own story in the face of existential emptiness.
3. Third, the disputing of the territory, where the organized community occupies public spaces —such as the playing field or the cultural center— to offer options of belonging that neutralize the recruitment of street corners and organized crime.
4. Fourth, educational integrality, which understands the processes as a complementary continuum between the formal (school), the non-formal (clubs and parishes), and the permanent (family), ensuring a network of protection that responds to the desires and searches of childhood.

■ Response to the objections

1. Regarding the first objection, waiting for addiction to manifest before intervening is a form of social abandonment; true healing begins by ensuring the right to development and joy.
2. As for the second objection, the State has the responsibility to invest in sustained and sustainable preventive programs, since technical information alone does not modify behaviors if a social fabric that provides meaning and hope does not exist. Promotional spaces are not accessories, but the place where the obstacles that block the unfolding of the spirit are removed, protecting the ontological dignity of each child and young person.

6.5.4 Article 4: Community Memory as a Tool of Healing and Empowerment

■ Statement of the topic

In contexts of exclusion, the lives of persons tend to be fragmented into isolated attempts at recovery that fail to consolidate into a coherent story. Community memory is not merely a record of past events, but a tool of subjective and collective restoration that allows those fragments to be woven together to transform them into a true life story with meaning.

■ Central question

Is community memory a relevant factor and an effective tool for the therapeutic and recovery process of persons in situations of substance use?

■ Existing positions or objections

- It is often said that the memory of the past is detrimental to recovery, since remembering wounds, abandonments, and violence suffered would only deepen the pain and paralysis of the subject.

- On the other hand, one might think that the process should focus exclusively on the individual and their immediate future, dismissing the history of the neighborhood or the territory as an anecdotal element that does not influence the deep healing of the person.

■ **Foundation or criterion of discernment**

From territorial experience we affirm that “memory is therapeutic”. Recovering the shared history of the neighborhood constitutes a path of hope for families, since it allows one to recognize that the human being is a sacred being with roots, and that their identity is strengthened by feeling part of a people that walks united in the face of adversity.

■ **Thesis and argumentative development**

The therapeutic importance of memory is grounded in five essential dimensions:

1. First, the construction of identity and hope, where recovering neighborhood history allows families to recognize their roots in order to build a solid foundation that supports change.
2. Second, making history through listening, since for a subject to have history they need another who receives it; the attentive listening of the community allows sufferings to cease being disconnected events and become learning.
3. Third, the disputing of the narrative, where community memory rescues the testimony of life and resilience of those who were able to move forward, against the narrative of death and violence that the media often impose on popular sectors.
4. Fourth, rootedness, which draws the subject away from destruction and extreme individualism by integrating them into an “us” with continuity in time.
5. Fifth, political value and empowerment, since sustained memory is what allows communities to remain firm in crises, functioning as an axis of political charity and social justice.

■ Response to the objections

1. Regarding the first objection, remembering does not seek stagnation in pain, but rather to name the wound so that it ceases to be an unconscious motor of substance use and becomes a scar integrated into a story of resurrection.
2. As for the second objection, no person heals in solitude; community accompaniment shelters the individual in order to transform the social fabric as a whole, recognizing that there are no healthy persons outside of a community that also learns to repair its bonds.

6.5.5 Article 5: The Roles of the Weavers of Care and Peer Accompaniment as Pillars of the Community

■ Statement of the topic

Within the methodology of tenderness, territorial figures emerge whose function transcends traditional technical or professional assistance. The importance of the women referents of the community who assume maternal shelter functions and of the peer companions as motors of a community mechanism capable of repairing bonds and restoring hope in contexts of high vulnerability is analyzed.

■ Central question

Do these roles of care and accompaniment constitute fundamental and specialized elements to ensure the efficacy of the community approach to addictions?

■ Existing positions or objections

- One might think that the work of the women referents in the territory is simply a task of domestic volunteerism or kitchen assistance, lacking a pedagogical or professional therapeutic framework. Under this view, it is often said that any person with good will could perform the task without the need for a specific role definition.

- Likewise, one might think that peer accompaniment is redundant or even risky compared to professional teams, since a person in recovery would not have the technical authority necessary to guide the lives of others.

■ Foundation or criterion of discernment

Christian anthropology and the methodology of tenderness teach that the healing of a sacred being requires languages that speak to the heart and to the hands. These figures are pillars that give mystique to the community family, grounding themselves in the legitimacy granted by testimony and the capacity to provide maternal care to wounded life, functions that the State or pure technique cannot always cover by themselves.

■ Thesis and argumentative development

The roles of territorial care configure the nodal mechanism of the community through two vital functions that remove the obstacles that block the spirit:

1. First, the peer companion is defined as the expert by experience: a person who, having traversed and overcome the same pain of addiction, the street, or prison, and finding themselves today in a stage of stability, places their life at the service of guiding others. Their authority is not born from an academic degree, but from having been healed and raised from the same situation in which the new members find themselves today, which allows them to act as a positive leader capable of speaking the language of the neighborhood.
2. Second, the community care referents are women of the territory who assume a maternal role of protection. Their function is that of weavers of care who repair functional orphanhood through loving attention in daily tasks, offering the embrace that many brothers and sisters never received in their violated childhood. Both figures are essential for recognizing the ontological dignity of each person and accompanying their life as it comes.

■ Response to the objections

1. Regarding the first objection, the role of the care referents transcends the domestic; it is a pedagogical and restorative function that provides the affective security indispensable for the subject to recognize themselves as valuable.
2. As for the second objection, the peer companion does not compete with the professional, but complements them by contributing a unique empathy and territorial reach. Their presence ensures that the person feels seen and accompanied in their radical singularity, transforming the coldness of the system into a true experience of the Church that goes forth.

6.6 | Social Inclusion, Sexual Differences, and Human Rights

This section addresses social inclusion as an imperative of justice, grounded in the recognition of persons with problematic use as full subjects of rights and not as mere objects of assistance. It delves into the feminization of poverty and the urgency of a gender perspective that understands the trajectories of women and of the travesti-trans population, recognizing that for this group, identity and exclusion form a single fabric of survival in the face of systemic violence.

Likewise, a model of solidarity economy and cooperativism is proposed that restores dignity through work, understanding it not as a final reward after recovery, but as an essential condition for the process to be sustainable and integral. Finally, the text invites the exercise of a political charity that transcends individual help to generate social processes of fraternity, demanding from the State the protection of human rights and the creation of safe environments that allow the most marginalized to unfold their capacities and recover their place in the people.

6.6.1 Article 1: Social Exclusion and Structural Poverty as a Wound of Society

■ Statement of the topic

The phenomenon of problematic use is not an isolated event, but rather constitutes one of the most painful expressions of social exclusion and structural inequality. Poverty is analyzed not only as the lack of material goods, but as a systematic violation of fundamental rights that tears apart the social fabric and erodes the notion of a people.

■ Central question

In what way do structural poverty and social exclusion condition the phenomenon of substance use and why does addressing them constitute an imperative of justice?

■ Existing positions or objections

- One might think that substance use is a merely individual or health problem that affects all social classes equally, diminishing the importance of the economic factor. Under this view, poverty would be an accidental circumstance and not a conditioning cause.
- Likewise, it is often said that overcoming poverty depends exclusively on the personal will to progress, dismissing the responsibility of the State in creating conditions for a dignified life.

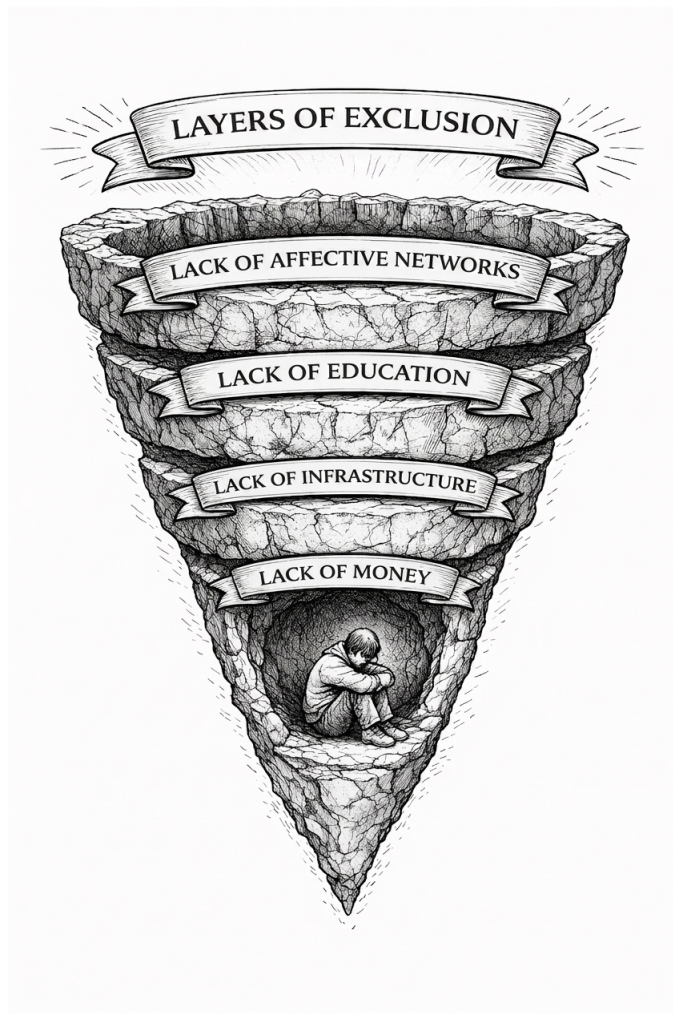


Figure 6.8: Poverty is not only an economic issue

■ Foundation or criterion of discernment

Cf. Greater biological vulnerability in poverty and chronic stress (ch. 9)

Christian anthropology teaches that the human being is a sacred being whose ontological dignity remains intact even in situations of social destitution. However, the throwaway culture denounced by Pope Francis acts as an “oil stain” that invades the most marginalized territories, depriving persons of their right to integral development. Liberation from structural injustices is the necessary condition for the person to recover their freedom and their protagonism.

■ Thesis and argumentative development

Structural poverty constitutes the scenario of greatest risk for the unfolding of addictions due to three critical dimensions:

1. First, the deprivation of basic resources, where the lack of land, shelter, and dignified work exhausts the psychic resources of families and generates chronic stress that pushes young people toward substance use as a self-therapeutic attempt in the face of an intolerable reality.
2. Second, invisibility and the lack of meaning, where social exclusion convinces the subject that they have nothing to contribute to society, plunging them into an existential void that drug trafficking exploits to offer a false belonging.
3. Third, structural violence and lack of protection, where the absence of the State in health, education, and security allows organized crime to parasitize the neighborhood economy and hijack public spaces. In the face of this, social inclusion is not a reward for recovery, but the indispensable foundation for removing the obstacles that block the unfolding of the spirit.

■ Response to the objections

1. Regarding the first objection, while substance use cuts across all social classes, exclusion removes the networks of protection and the opportunities for treatment, turning addiction into a death sentence for the poor.

2. As for the second objection, the real exercise of freedom requires minimum conditions of justice; therefore, it is the duty of the State to guarantee access to fundamental human rights, while it is the community's role to provide the fraternal embrace that restores the identity of the brother or sister as a subject of rights and not as an object of assistance.

6.6.2 Article 2: The Feminization of Poverty as a Reality of Multiple Exclusion

■ Statement of the topic

Structural poverty does not impact the social fabric in a neutral manner, but rather targets women with particular ferocity. This phenomenon, defined as the feminization of poverty, creates scenarios of extreme vulnerability where the lack of access to basic rights such as land, dignified work, and health pushes women into situations of extreme survival, such as prostitution or small-scale drug dealing.

■ Central question

What is understood by the feminization of poverty and how does it affect the subjectivity of women in situations of substance use?

■ Existing positions or objections

- One might think that poverty affects men and women equally in contexts of exclusion and that, therefore, material deprivations are universal for any person in a street situation.
- Likewise, it is often said that highlighting female poverty is a form of discrimination against men, who also suffer the scourge of addiction in contexts of misery.

■ Foundation or criterion of discernment

Christian anthropology recognizes that social sin and structural injustice strike with greater cruelty those who have fewer possibilities of defending their rights. Recognizing the feminization of poverty is an act of missionary honesty that allows the identification of the “double condemnation” that women suffer: the social stigma for their substance use and the judgment for not fulfilling the idealized role of perfect mother or household caregiver.

■ Thesis and argumentative development

The feminization of poverty is a reality of exclusion that manifests itself in three critical dimensions:

1. First, the lack of state protection, where the system does not tend to offer women the same infrastructure of shelter and rehabilitation as men.
2. Second, housing and economic precariousness, which exposes them to greater risks of becoming street-dwelling and violence, especially when they must raise their children alone.
3. Third, the invisibilization of their pain, where their trajectories of substance use tend to be silenced by social shame and pressure from the family environment. Liberating these injustices is the precondition for the person to recover their ontological dignity and their freedom. For this, the State must assume its responsibility in creating legislative and social conditions that guarantee the future of these women.

■ Response to the objections

1. Regarding the first objection, although poverty is general, women face unique access barriers and a multiple exclusion that leaves them in a situation of greater biological and social helplessness.
2. As for the second objection, pointing out this reality does not diminish the importance of the man’s pain, but rather seeks justice in the response; a model of mercy must be sensitive to differences so as not to apply a

desk-bound logic that ignores the specific wounds of the suffering body of the woman among the people.

6.6.3 Article 3: Differentiated Approaches and Specific Accompaniment for Women

■ Statement of the topic

Given the complexity of female trajectories in the use of psychoactive substances (PAS), it is insufficient to apply standardized treatment protocols. The imperative arises to consolidate differentiated approaches that address the specific needs of mental health, emotional security, and family bonds proper to women in order to remove the obstacles that block their spirit.

■ Central question

Why does accompaniment of women require a differentiated methodological approach and what are the fundamental pillars for the process to be sustainable?

■ Existing positions or objections

- One might think that treatment protocols should be uniform to guarantee scientific and technical equity, considering that a specific approach for women would be an unnecessary expenditure of resources or an administrative complication.
- Likewise, it is often said that care in mixed-gender centers is sufficient to address any addiction problem without gender distinction.

■ Foundation or criterion of discernment

A model centered on the person must recognize the radical singularity of each sacred story. Christian anthropology teaches that true equity does not consist in the equality of bureaucratic treatment, but in the justice of the artisanal response that takes charge of the totality of the person's life, adapting care to their particular wounds.

Cf. Spirituality in Women (ch. 7) and Vulnerability of Women in the Process of Change (ch. 8)

■ Thesis and argumentative development

The differentiated approach constitutes a tool of therapeutic justice grounded in five critical dimensions:

Cf. art. 9.4.3 (Judge, The Substances and the Organism, Differences according to..., The physiological response...)

1. First, biological vulnerability, recognizing that women develop severe medical consequences more rapidly than men (telescope effect).
2. Second, the centrality of trauma, since the great majority of female trajectories are marked by gender-based violence and abuse that require spaces of emotional safety.
3. Third, accompaniment in the face of family abandonment, since unlike men, women tend to face the process in absolute affective solitude.
4. Fourth, the protection of motherhood, eliminating the fear that the State will take away custody of children as a condition for receiving help.
5. Fifth, the role of the peer companion, defined as the expert by experience who, having traversed and overcome the same pain of addiction or exclusion, places her life at the service of guiding others from the authority that her own testimony of recovery grants her.

■ Response to the objections

1. Regarding the first objection, the specificity of the approach is not a technical luxury, but the guarantee that the process respects the inalienable dignity of each sister.
2. As for the second objection, mixed-gender centers often cannot guarantee the approach to complex trauma or the reproductive needs of women; therefore, the differentiated approach allows an intervention that does not ignore the specific wounds of the suffering body of the woman among the people.

6.6.4 Article 4: Differentiated Approaches and Specific Accompaniment for Men

■ Statement of the topic

Community accompaniment in popular neighborhoods encounters a reality of male substance use that is strongly traversed by territorial logics, street dynamics, and mandates of masculinity. Frequently, male substance use is experienced in a public and expressive manner, linked to the culture of the street corner, peer validation through risk, aggression, or insertion into circuits of criminality and violence. A Samaritan approach demands understanding these sociocultural specificities in order to offer tools that allow the dismantling of these mandates and propose specific healing itineraries.

■ Central question

Does the proposal of integral accompaniment require the implementation of a specific approach that addresses the territorial logics and sociocultural mandates of men in the neighborhood center?

■ Existing positions or objections

- **Objection 1:** It seems that addiction is a universal and neutral problem, and therefore the neighborhood center should apply the same criteria and accompaniment dynamics for all subjects, without distinction of their gender or cultural conditioning.
- **Objection 2:** It seems that focusing on a specific approach for men weakens the shared community life of the parish, promoting an unnecessary separation within the reception settings.

■ Foundation or criterion of discernment

Jesus walks with each one knowing their story and the weight of their culture. Healing the wounds of men in the neighborhood requires an incarnate gaze that does not ignore the codes of the street or the social pressures that sustain their substance use. Pastoral discernment urges us to provide a space where the man can lay down the weapons of omnipotence to recognize his own vulnerability and be embraced in his dignity.

■ Thesis and argumentative development

Specific accompaniment for men within the community model is deployed under the following pastoral and operative criteria:

1. **Dismantling the mandates of hegemonic masculinity:** In the territory, male substance use is often linked to the need to demonstrate strength, endurance, or control, hiding pain or frustration behind risk behaviors. The community process must foster safe spaces where the man learns to dismantle the demand of an omnipotent or violent masculinity, allowing himself to express suffering, fear, and weakness without feeling judged by his peers.
2. **The resignification of street corner culture and the territory:** The crew and the street corner often function as the only network of belonging in the face of exclusion. The neighborhood center should not demonize these spaces, but rather offer a surpassing alternative: transforming the logic of the gang or the risk circuit into a positive community belonging, redirecting the codes of street loyalty and fraternity toward common service, mutual care, and solidarity work in the neighborhood.
3. **Specific spaces of speech and elaboration:** While the richness of PLAPA lies in shared community life —where the table, the workshops, and prayer are shared— the approach to men requires specific instances (exclusive speech groups). In these intimate spaces of man to man, complex themes can be addressed such as absent or conflictive fatherhood, anger management, stories of violence or imprisonment, and the reconstruction of a responsible and affective life project.

■ Response to the objections

- **To the first:** Ignoring that male substance use is shaped by street culture prevents the deconstruction of the deep causes of their relapses and violent behaviors. A neutral approach fails to penetrate the armor of “toughness” with which the man defends himself in the neighborhood; a relational and incarnate interpretive key is needed for the process of reconfiguring values to be real.
- **To the second:** The specific space does not isolate the man from the community, but rather prepares him to inhabit it in a healthier way. Providing them with a space of their own to elaborate their specific pains strengthens their integration into shared common activities, allowing them to build relationships of true respect, fraternity, and complementarity with the women and families of the neighborhood center.

6.6.5 Article 5: Popular and Solidarity Economy as Motors of Identity and Dignity

■ Statement of the topic

The integral recovery of persons with problematic use requires overcoming the vision of work as a simple goal of economic reintegration. The need to integrate the dimension of popular and solidarity economy as essential components of the therapeutic process, capable of reconstructing habits and restoring the sense of social protagonism to the brother or sister made vulnerable in their own territory, is analyzed.

■ Central question

Should popular economy and dignified work be integrated as essential elements from the early stages of recovery, or do they constitute merely final objectives of social reintegration?

■ Existing positions or objections

- One might think that work is merely a means of economic survival and that what is relevant is that the person obtains income so as to stop being a social burden.
- Likewise, it is often said that employment should be the final reward after having achieved total abstinence, under the idea that the person does not yet possess the discipline necessary to fulfill a productive task.
- On the other hand, one might think that money management is a high-risk factor that triggers the desire to use, and therefore it should be avoided during treatment.

■ Foundation or criterion of discernment

Christian anthropology and the magisterium of Pope Francis teach that work is a fundamental part of human dignity that allows man to cultivate himself and sustain his family. Economic inclusion is not the prize at the end of the

road, but a condition of justice for recovery to be sustainable and dignified, allowing the subject to recognize themselves once again as a citizen with rights and responsibilities.

■ Thesis and argumentative development

The integration of popular economy into recovery proposes a paradigm shift that prioritizes being over doing through five fundamental axes:

1. First, work as a social tie, functioning as a bridge to reconstruct the bond with the community and transform the assisted into a productive subject.
2. Second, the promotion of cooperativism in popular sectors, driving enterprises that accommodate the community dynamic and the timing of the artisanal process.
3. Third, financial re-education, using money in a pedagogical way to transition toward a progressive autonomy and replace the immediacy of the street with planning.
4. Fourth, structured mercy, which implements an organized flexibility with clear but empathetic rules, understanding that work is a means for healing.
5. Fifth, the valuing of one's own talents, where social inclusion recognizes the tools that the subjects already possess to dispute the neighborhood economy from drug trafficking.

■ Response to the objections

1. Regarding the first objection, dignified work transcends survival; it is the path to achieving the freedom necessary to decide about one's own health and housing.
2. As for the second objection, the process must be circular, allowing the person to test themselves in productive tasks from stabilization stages in order to strengthen their identity.
3. Finally, in response to the third objection, the risk of money is mitigated with assisted and pedagogical control; administering the first paycheck in

an accompanied manner helps gain security and reinforces the family's confidence in the process. For this to be possible, the State must assume its responsibility in creating public policies that promote employment and cooperativism in the most marginalized neighborhoods.

6.6.6 Article 6: The Approach to Human Mobility and Interculturality

■ Statement of the topic

Mt 25:35 — *I was a stranger and you welcomed me*

Human mobility and interculturality are not phenomena external to the territory, but dimensions that profoundly modify the social fabric where community action takes place. The need to integrate the reality of the migrant brother or sister as an essential interpretive key for the integral accompaniment of problematic use is analyzed, recognizing that uprooting and the lack of a network tend to heighten social vulnerability.

■ Central question

In what way should the manual integrate human mobility and interculturality as fundamental dimensions of pastoral accompaniment?

■ Existing positions or objections

- One might think that migration is a strictly political or sociological topic that should not occupy a central place in an addiction manual, which should focus solely on mental health and recovery from psychoactive substances.
- It is often argued that accompaniment processes should be standardized for all inhabitants of a territory without distinguishing cultural origin, under the premise that addiction would affect human biology equally, regardless of the person's historical background.

■ Foundation or criterion of discernment

Pope Francis teaches that human mobility is a sign of the times that requires a specific pastoral care that respects the cultures and spiritual richness of each people. Christian anthropology affirms that every migrant possesses an inalienable dignity; therefore, the Church must act as a “field hospital” that welcomes the orphanhood and extreme vulnerability that the migratory process tends to generate, recognizing that there is no healing without rootedness.

■ Thesis and argumentative development

The approach to human mobility is grounded in five critical dimensions for social justice:

1. Recognition of ontological dignity: The social practice of considering migrants as second-class subjects must be denounced, which aggravates their invisibility and the risk of resorting to substance use as an escape in the face of contempt.
2. Impact on territorial configuration: Migration transforms neighborhoods; the organized community must enter into these new realities to integrate migrants into its circles of care, preventing isolation from pushing them toward drug trafficking networks.
3. Educational and leveling response: It is imperative to propose pedagogical reinforcement strategies for migrant children and adolescents who have had their schooling interrupted, offering them promotional spaces that generate belonging.
4. Accompaniment in incarceration: It is recognized that incarcerated migrants face greater loneliness due to the lack of a biographical network; therefore, accompaniment must be differentiated to prevent uprooting from leading to a relapse in substance use.
5. Inculturation of pastoral care: The proposed spirituality must adapt its language so that the migrant brother or sister discovers a God who walks with them in their own story, transforming the pain of the journey into a process of community resurrection.

■ Response to the objections

1. Regarding the first objection, although migration has political facets, its root is human; the vulnerability generated by the lack of land, shelter, and work is a direct conditioning factor of substance use that the evangelizing mission cannot ignore.
2. As for the second, although addiction has a biological basis, recovery is a relational process; ignoring the culture of the other is a form of administrative fragmentation that prevents generating the bond of trust necessary for the person to feel loved in their totality.

6.7 | The Companion and Political Advocacy

This section defines the role of the companion not only as an affective support, but as a subject of political advocacy capable of transforming the structures of exclusion. Inspired by the political charity proposed by Pope Francis, the Church is invited to move from the concrete pastoral response to the demand for humanizing public policies that guarantee the rights of the most vulnerable. The text emphasizes that, while the State is the guarantor of rights, it does not have the capacity to generate community by itself, and therefore it is imperative to defend territorial knowledge and the principle of subsidiarity to strengthen the networks of care without them being absorbed by state bureaucracy. Finally, a prophetic gaze is reclaimed that denounces social sin and structures of injustice, positioning peer companions as protagonistic actors in the dispute over meaning against models that prioritize the sanitization or repression of public space.

6.7.1 Article 1: The Exercise of Political Charity as an Ecclesial Mission

Mic 6:8 — *What does the Lord require of you? To act justly, to love mercy, and to walk humbly with your God*

■ Statement of the topic

The evangelizing mission in the face of problematic use does not exhaust its meaning in immediate assistance. The need for the Church to assume the exercise of political charity is analyzed, transitioning from individual help to the transformation of the social structures that generate exclusion and helplessness.

■ Central question

Should the Church enter into political charity as part of its mission in the approach to addictions?

■ Existing positions or objections

- One might think that the Church should limit its action exclusively to the spiritual and religious sphere, avoiding entering into matters of public policy so as not to distort its mission and become a non-governmental organization (NGO) of social assistance.

- It is argued that the responsibility of care and recovery is the exclusive competence of the State. Under this view, the Church should simply fill the gaps where public assistance does not reach, without questioning or influencing the structures of power.
- One might think that in territories dominated by narco-culture and violence, the exercise of political charity is dangerous and futile, due to the possible complicity of state structures with organized crime.

■ Foundation or criterion of discernment

Pope Francis teaches that charity is the heart of the spirit of politics and is manifested as a preferential love for the last. Christian anthropology affirms that faith is inseparable from the defense of human dignity; therefore, when the community unites to generate processes of fraternity and justice, it is exercising a form of charity that transcends the individual to become social.

■ Thesis and argumentative development

The Church exercises political charity as an irrevocable manifestation of its own essence through five strategic axes:

1. **Prophetic denunciation:** It consists of demystifying narco-politics and denouncing “sanitizing” policies that seek to clean public space by treating persons who use substances as waste or criminals, instead of recognizing their sacred dignity.
2. **Advocacy for the State as guarantor:** Demanding that the State assume its constitutional obligations in health, identity, and housing. The Church acts as the thread that articulates these fragmented responses so that they effectively reach the territory.
3. **Alliance for the common good:** Promoting an articulation between the university (research), the business sector (employment), and the organized community (territorial presence) to build public policies based on reality and not on desk-bound plans.
4. **Reoccupation of democratic spaces:** Encouraging the community to once again inhabit clubs, mutual aid societies, and neighborhood centers as an antidote against the individualism that drug trafficking exploits to occupy the territory.

5. **Defense of the right to care:** Promoting the autonomous and unavoidable right to care, to be cared for, and to self-care, especially for populations that the penal or health systems have made invisible.

■ Response to the objections

1. Regarding the first objection, the Church is not an NGO, but its social commitment is the incarnation of the mercy of Christ, who takes charge of the integrity of man in all his dimensions.
2. As for the second, although the State has the primary responsibility, it does not have the capacity to generate by itself bonds of belonging; the Church contributes territorial knowledge and the experience of family that administrative rigidity cannot offer.
3. In response to the third, precisely where the culture of death prevails is where the organized community must enter to dignify life. Political charity allows the transformation of fear into organization and offers a narrative of hope in the face of the dictatorship of drug trafficking.

Conclusion

The exercise of political charity allows the Church to be a prophetic voice in the public space, transforming the conditions of injustice into scenarios of freedom and protagonism for the most vulnerable brothers and sisters.

6.7.2 Article 2: The Fundamental Importance of Self-Care for the Pastoral Agent

Mk 6:31 — *Come
away by yourselves
to a deserted place
and rest a while*

■ Statement of the topic

Pastoral service in the field of addictions implies constant contact with pain, violence, and complex human realities that involve a high emotional cost. It is analyzed whether the strategy of self-care is an optional component or an indispensable condition to ensure the integral health of the agent and the quality of accompaniment.

■ Central question

Is the self-care strategy fundamental to guaranteeing the efficacy and continuity of the pastoral agent's work in the field of addictions?

■ Existing positions or objections

- One might think that the pastoral agent must give themselves totally to service without reserve, following the example of Christ's sacrifice, and that worrying about one's own personal well-being constitutes an act of selfishness or a lack of apostolic zeal in the face of the urgency of others' suffering.
- It is often said that spiritual support and the grace of God are sufficient to sustain the caregiver. Under this view, technical self-care strategies or human pauses would not be required, since the mission itself would provide the strength necessary not to falter.

■ Foundation or criterion of discernment

Rest is not optional, but a necessity ordained by Christ himself for those who are at the center of service. The Church, as a field hospital, must care for its own soldiers wounded by fatigue and pain, recognizing that the Holy Spirit also acts through human mediations and respect for biological limits.

Cf. art. 8.7.4 (clinical self-care)

■ Thesis and argumentative development

Self-care constitutes an ethical principle and a theological necessity for the sustainability of service, grounded in five dimensions:

1. **Guarantee of the quality of care:** The psychophysical state of the agent significantly conditions the help they provide; an exhausted caregiver loses the capacity for active listening and empathy, turning the mission into a rigid and defensive structure.
2. **Prevention of burnout:** The permanent accompaniment in contexts of vulnerability can lead to compassion fatigue. Self-care protects the mental health of the agent against the impact of secondary trauma.

3. **Sustainability of the mission:** Chronic exhaustion prevents the continuity of service. Managing one's own life and emotions is a condition for pastoral service to be lasting and not a spasmodic response.
4. **Recognition of human vulnerability:** The pastoral agent is not a superhero, but a vulnerable person who also needs tenderness and care. The pastor must allow themselves to be cared for and recognize that the periphery where they work is also a mirror of their own shortcomings.
5. **Theology of rest:** Following the magisterium of Pope Francis, rest is an integral part of the mission and a right that glorifies God. Knowing how to sit on the "bench of substitutes" allows others to take the relay and avoids the temptation of omnipotence.

■ Response to the objections

1. Regarding the first objection, rightly understood charity begins with one's own person; one cannot transmit the love of God if the agent's heart is parched from fatigue. Self-care allows the service to be an expression of solidarity and not an exhausting burden.
2. As for the second, although faith is the driving force, the human being is a unity of body and soul. Technical formation and the support of peer groups are necessary human mediations for the grace of God to bear fruit in a balanced life.

Conclusion

Self-care guarantees that the pastoral agent will remain a docile and healthy instrument of divine mercy, ensuring that accompaniment is always a human encounter of healing and not an exhausting bureaucratic routine.

6.7.3 Article 3: The Mandate to Take the Initiative and Go Out into the Streets in the Peripheries of Substance Use

Lk 14:21–23 — *Go out quickly into the streets and lanes of the city, and bring in the poor, the crippled, the blind, and the lame*

■ Statement of the topic

The identity of a community that accompanies problematic use is defined by its outward movement. The profound meaning of the mandates to “primerear” (take the initiative) and “callejear” (go out into the streets) is analyzed as gestures that break with ecclesial self-referentiality in order to seek wounded life in its everyday settings.

■ Central question

What does the mandate to take the initiative and go out into the streets within the human peripheries of substance use and exclusion imply for the Church?

■ Existing positions or objections

- One might think that the Church should wait in its temples for persons to seek help of their own will, and that going out insistently to look for them could be interpreted as an invasion of privacy or a lack of respect for individual freedom.
- One might think that going out into the streets and getting stained by the reality of the street puts holiness and institutional image at risk, suggesting that the community should remain centered on its rites so as to be an unalterable beacon of morality.

■ Foundation or criterion of discernment

Pope Francis affirms that he prefers a Church that is bruised, hurting, and dirty from going out into the streets, rather than a Church that is sick from being enclosed and from the comfort of its own securities. The evangelizing community must take the initiative, enter into human processes, and accompany life no matter how hard it may be, recognizing that God always takes the first step in love.



Figure 6.9: The method of the Church that goes forth

■ Thesis and argumentative development

The concepts of taking the initiative and going out into the streets define a pastoral attitude that transforms territorial presence in four dimensions:

1. **Taking the Initiative (Primerear):** It means not waiting for the excluded to come, but getting ahead and going out to encounter those who are far away. It is the response of one who feels loved first by God and wishes to bring that balm to the crossroads of the roads.
2. **Going Out into the Streets (Callejear):** It is the active disposition of seeking the life that suffers in the most hidden corners, such as street corners, plazas, and bridges. It implies entering into the daily life of others in order to shorten distances, assuming the reality of the other until having “the smell of the sheep.”
3. **Dwelling in the Periphery:** It is not a superficial tour, but rather stopping one’s step to look into the eyes and listen to the one who was left by the wayside. The Church recognizes itself as a “field hospital” that heals urgent wounds before asking about technicalities.
4. **Touching the Flesh of Christ:** It implies renouncing the shelters of security to enter into direct contact with the misery and pain of the

brother or sister. In doing so, life becomes marvelously complicated and the community lives the true experience of being a people.

■ Response to the objections

1. Regarding the first objection, taking the initiative is not invading, but offering an inexhaustible mercy to those who feel invisible to society. It is a gesture of proximity that seeks to restore hope to those whom the culture of abandonment has pushed to stop looking toward the future.
2. As for the second, the holiness of the Church is not protected in isolation, but is nourished in service. True spiritual worldliness is that which disguises itself as empty religious practices while ignoring the cry of the most broken brothers and sisters.

Conclusion

Taking the initiative and going out into the streets are the actions that allow the Church to be faithful to its mission, transforming social contempt into an encounter of dignity where each person is recognized as a sacred being.

CHAPTER 7

The Human Spirit

The spiritual dimension is the essential constitutive element of the human being that drives us to ask ourselves what we are in this world for and what life we want to choose for ourselves and for others. Far from being a religious appendix or a subjective feeling, the spirit is the essence of being where our deepest identity resides, as well as our relationship, granting us an absolute and inalienable dignity that no fall can erase.

When judging the problem of psychoactive substance (PAS) use from the perspective of faith, we recognize that substance use disorder causes a progressive disconnection from this inner reality, often becoming a “failed spiritual search” that attempts to anesthetize deep wounds of orphanhood and fill an “existential rift” that only the encounter with transcendence can satisfy.

Therefore, this manual invites us to look at the person as an integral unity of body and soul, rescuing the heart as the unifying and intimate center where reason and feeling are integrated and where the deepest identity resides. It is in this core of the personality where the demands for happiness, truth, and justice are forged—demands that PAS use fails to satisfy—opening the way to a process of deep reconnection and healing guided by the Spirit.

This chapter is composed of 9 sections:

1. Nature, definition, and foundations
2. The spiritual condition
3. Addiction as a spiritual phenomenon

4. The process of reconnection
5. The Christian path
6. The sacraments
7. Spiritual wisdom
8. Spirituality in women
9. The anchor of community

7.1 | Nature, Definition, and Foundations

This section establishes that spirituality is the essential constitutive element of human identity and the driving force that orients the person toward the meaning of their existence. It is grounded in the infinite ontological dignity of being created in the image of God, an indelible mark that the use of psychoactive substances cannot erase or eliminate. By recognizing that the human being is constitutively a search for meaning, the community organizes itself to awaken this latent dimension.

7.1.1 Article 1: Spirituality as the Essential Constitutive Element and Driving Force of Identity

Gen 2, 7 — *He
breathed into his
nostrils the breath of
life, and the man be-
came a living being*

■ Statement of the topic

When addressing substance use, it is common to focus on the biological or social damages. However, the need arises to discern whether the spiritual is an accidental response to distress or whether it constitutes the very core of the human being. We must judge whether the fundamental questions about the meaning of life represent the driving force that integrates affectivity and reason in the heart of the person.

■ Central question

In what way does the spiritual dimension define human identity and act as the force that moves the subject toward the search for meaning?

■ Existing positions or objections

- **Objection 1:** Neuroscience demonstrates that substance use alters reward circuits; therefore, motivation is purely chemical and not spiritual.
- **Objection 2:** Many subjects only seek God when they have “hit bottom,” suggesting that spirituality is an effect of pain and not a prior essence.
- **Objection 3:** If a person does not profess a religious faith, they would seem to lack this driving force, invalidating spirituality as a universal constitutive element.



Figure 7.1: Spirituality and identity

■ Foundation or criterion of discernment

It is established that the essence and existence of the human being are constitutively related to God. The human being is “capable of God” and possesses an absolute dignity that resides in their deepest identity. The heart is recognized as the unifying center where reason and feeling are integrated, being the core where the demands for happiness and truth are forged.

■ Thesis and argumentative development

We respond that spirituality is the driving axis of human identity for the following reasons:

- **Operative anthropological unity:** The spirit is the integrating principle that allows the subject to examine their own biology and make decisions about their history. Spirituality empowers the person not only to survive but to be the protagonist of their life through testimony.
- **Difference between potency and condition:** It is vital to distinguish between spiritual potency (inalienable essence) and spiritual condition (dynamic state of the relationship with God). Substance use does not create the spiritual need; rather, it is a failed search in the face of a prior existential rift.
- **Dynamism of the spirit:** Spirituality allows the human being to take distance from their immediate reality. This capacity for transcendence is what enables reconnection and commitment to life.

■ Response to the objections

Cf. art. 6 (Judge,
Very Brief Glossary)

- **To the first:** Spirituality uses neuroplasticity assisted by grace to reorient the will. The vital purpose acts as a superior stimulus capable of reorganizing the reward circuits that the substance had hijacked.
- **To the second:** The distress acts as an “existential alarm” that reveals the prior spiritual rift. Pain does not create spirituality; rather, it is the signal that the transcendence system demands its place after the anesthesia of substance use.
- **To the third:** One must distinguish between universal spirituality and institutional religion. Every human being exercises their spiritual force when choosing what orientation to give their life and when seeking truth in their bonds through fraternal dialogue.

7.1.2 Article 2: The Spiritual Dimension as a Search for Meaning and Vital Purpose

■ Statement of the topic

Given the multifactorial nature of substance use disorder, the need arises to ask ourselves about the meaning of existence. This search constitutes the axis upon which the identity and freedom of the human being to decide about their own life and their relationship with others are built.

■ Central question

How is the spiritual dimension defined as the search for purpose and the place that each person occupies in the world?

■ Existing positions or objections

- **Objection 1:** Questions about the life project belong to the field of psychology or ethics and not necessarily to a transcendent spiritual dimension.
- **Objection 2:** In persons with severe substance use, these questions lose relevance in the face of the urgency of immediate survival or the satisfaction of desire.

■ Foundation or criterion of discernment

It is affirmed that spirituality is the essence of being that moves a person to seek meaning. If this dimension is not developed, the totality of the person remains blocked, becoming a source of existential anguish. The search for meaning remains latent even in the most severe cases.

■ Thesis and argumentative development

We respond that the spiritual dimension is defined by these questions because they constitute the “what for” of existence:

- **Purpose of being:** The spiritual addresses the task of questioning the reason for being. It is the space where the subject decides what orientation to give their life through the active listening to their own desire for fullness.

- **Mending of the existential rift:** Addiction usually settles where questions have no answer. Authentic recovery implies a reconnection with the vital purpose that the substance attempted to supplant.

■ Response to the objections

- **To the first:** While psychology manages the operativity of psychic processes, spirituality grants the ultimate direction and the absolute end. The spirit is the one that asks for the meaning that the psyche alone cannot answer.
- **To the second:** Compulsive use is the “physical form” of a desperate spiritual question. The desire to eternalize the effect of the substance is the distorted manifestation of a thirst for the infinite that only reconnection with meaning can satisfy.

7.1.3 Article 3: The Foundation of Inalienable Ontological Dignity in the Image of God

Gen 1, 26-27 — *Let us make humankind in our image, according to our likeness... he created them in the image of God*

■ Statement of the topic

In accompaniment, we often encounter brothers whose lives seem to have lost all trace of humanity. Stigma tends to reduce the person to categories of “discard.” It is imperative to discern whether dignity is a moral construction that can be lost or whether it is a prior and unscathed datum that remains beneath the night of addiction.

■ Central question

In what way does being created in the image of God ground a dignity that cannot be eliminated by sin or by situations of substance use?

■ Existing positions or objections

- **Objection 1:** Dignity is associated with the exercise of reason. A person with severe cognitive deterioration seems to lose that which makes them specifically human.

- **Objection 2:** Sin and actions that harm the community degrade the person, causing them to lose their value before God.



Figure 7.2: Dignity, according to *Dignitas Infinita*

■ Foundation or criterion of discernment

It is established that an infinite dignity corresponds to each person beyond all circumstances. The fourfold distinction is introduced: ontological dignity (linked to being), moral dignity (exercise of freedom), social dignity (living conditions), and existential dignity (peace and hope). Ontological dignity is inalienable.

■ Thesis and argumentative development

We respond that ontological dignity is the primordial guarantee of integral health:

- **Primacy of being over act:** The subject subsists with all their dignity even if they cannot exercise their capacities. Pastoral judgment distinguishes between the “unworthy act” and the “worthy person.”
- **Redemption as confirmation:** Dignity is fully revealed in Christ, who assumes human existence, confirming the inestimable value of those whom the world qualifies as unworthy.

■ Response to the objections

- **To the first:** Dignity is not a functional performance of reason but an intrinsic attribute of being. Just as the sun exists even though clouds cover it, the divine mark in the brother remains intact beneath the darkening caused by the substance.
- **To the second:** Freedom against love can wound the divine likeness but can never erase the originating fact of being a beloved creature. This indestructible root is what allows the initiation of any fraternal dialogue of restoration.

7.1.4 Article 4: The Necessary Distinction between Spirituality and Religion

■ Statement of the topic

The challenge arises of addressing the spiritual dimension of persons who do not necessarily profess a faith. It is imperative to clarify whether spirituality is an exclusive patrimony of believers or whether it is a universal capacity that drives every subject to question their reason for being.

■ Central question

Is it necessary to distinguish between spirituality and religion to guarantee an inclusive and respectful process of reconnection?

■ Existing positions or objections

- **Objection 1:** Given that addiction is a spiritual illness and God is the one who heals, spirituality would be intrinsically a religious phenomenon.
- **Objection 2:** Unlinking both concepts could seem like an attempt to dilute the message of the Gospel and of Jesus Christ.

■ Foundation or criterion of discernment

It is affirmed that this foundational dimension must not be confused with belief in a specific divinity. Spirituality is not a privilege of the religious; every human being must choose what life to lead. The heart is the center where the deepest identity resides.

■ Thesis and argumentative development

We respond that it is indispensable to distinguish both planes for an effective pastoral ministry:

- **Universality versus Institutionalism:** Spirituality is the search for the “what for” of existence (potency). Religion proposes a language and a concrete path for living that relationship (condition).
- **Respect for freedom:** Recognizing universal spirituality avoids excluding those who do not seek help in traditional systems, allowing an encounter based on the reality of the other.
- **Distinction without separation:** While the distinction between spirituality and religion is analytically necessary to accompany every person without prior conditions, it should not be interpreted as a separation that validates a self-referential spirituality disconnected from the community. From the Christian perspective that animates this manual, the authentic spiritual search is not exhausted in the interiority of the subject: it constitutively tends toward the encounter with others and, ultimately, toward the communal and sacramental mediation where that search finds its fullness. The brother who arrives without faith is not excluded because of that; but the horizon of accompaniment includes the possibility that their search for meaning may lead them, in freedom and at their own pace, toward the encounter with Christ and with the ecclesial community. Universal spirituality is the door; communal and sacramental life is the house to which that door can open.

■ Response to the objections

- **To the first:** Spiritual healing begins by recovering the awareness of one’s own dignity, which is prior to any formal religious practice.

- **To the second:** The distinction does not dilute the proclamation of Jesus Christ but rather strengthens it by incarnating it in the concrete reality of the brother. Recognizing universal spirituality as a starting point allows the first proclamation to be not an imposition but a proposal that respects the time and history of the other. The pastoral agent knows that the thirst for meaning that dwells in every human being is, as the Christian tradition teaches, a thirst for God that does not yet recognize itself as such. Distinguishing spirituality from religion is not renouncing the proposal of the Gospel; it is discerning the moment and the manner of doing so, so that the proposal is received as what it is: good news and not a condition of access to care.

7.1.5 Article 5: The Distinction between Psychic Life and Openness to the Divine

■ Statement of the topic

In accompaniment, there is often a confusion that reduces the non-biological to a single psychic or spiritual category. It is vital to recover a functional distinction that allows understanding how the human being possesses dimensions that are affected in diverse ways by substance use disorder.

■ Central question

In what way does the distinction between psyche and spirit allow us to understand the integral unity of the person without falling into a duality of the soul?

■ Existing positions or objections

- **Objection 1:** In many therapeutic approaches, “psyche” and “spirit” are used as synonyms; therefore, there would be no need to distinguish them.
- **Objection 2:** If substance use alters the biological mechanisms of the brain, both the will and transcendence would be mere byproducts of brain chemistry.

■ Foundation or criterion of discernment

The Church teaches that the human being is a whole being: spirit, soul, and body. “Spirit” means that the human being is ordered to a supernatural end. Although we maintain the inseparable unity, the tripartite anthropology is a valuable tool for differentiating affectivity (soul) from transcendence (spirit).

■ Thesis and argumentative development

We respond that it is useful to recognize a trichotomy of dimensions within the unity of the person:

- **The place of emotions and transcendence:** This distinction allows identifying that in substance use disorder, while the psyche suffers from impulsivity, the spirit preserves the potency to seek meaning.
- **The spirit as openness:** The spirit is the deepest center of the soul that opens it to grace. It allows taking distance from emotional impulses to choose a superior good through testimony.

■ Response to the objections

- **To the first:** While psychology treats affective and behavioral processes (psyche), spirituality deals with the existential vocation and the relationship with the Absolute (spirit).
- **To the second:** Science explains the biological machinery, but reducing everything to the biological ignores the radical capacity to be the protagonist of one’s own history. What happens in the body has a correlate in the spirit and vice versa.

7.2 | The Spiritual Condition

This section analyzes the spiritual condition as the dynamic state of the relationship that the human being establishes with God and with others, always starting from their personal history of affectivity, their bonds, and their ethics. It explores how environments of lack of protection or affective orphanhood damage this condition, plunging the subject into an existential rift. At the same time, it proposes the heart as the unifying center where the freedom of the subject can be restored through communal encounter and the awakening of their innate spiritual potency.

7.2.1 Article 1: The Spiritual Condition and the Development of Potency through Bonds

■ Statement of the topic

In the pastoral ministry of accompaniment, we observe that trajectories of substance use tend to arise from histories of orphanhood and broken bonds. The need arises to discern whether the human spirit can develop as a purely autonomous force or whether it requires the mediation of others to remain healthy. We must judge whether the wounds of affectivity define the soil in which the relationship with God must germinate or whether they are accidental elements that do not condition the health of the soul.

■ Central question

To what extent does the health of the spiritual condition depend on the relational history and the mediation of the community?

■ Existing positions or objections

- **Objection 1:** Given that the relationship with God is constitutive of being, spiritual health should be independent of the contingencies of human bonds.
- **Objection 2:** If spirituality depended on bonds, those who have suffered abandonment would lose their capacity for transcendence, which contradicts the inalienability of the spirit.

- **Objection 3:** Spiritual potency should be able to be activated from the pure interiority of the subject without the need for external mediations that could prove to be failed.

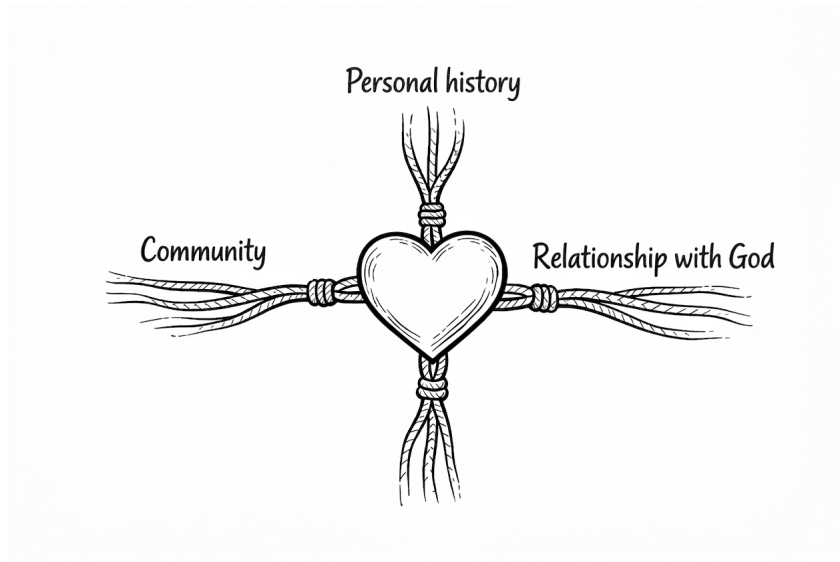


Figure 7.3: Spirituality and bonds

■ Foundation or criterion of discernment

It is established that there is no spirituality without others. The human being is constitutively relational, and others function as necessary mirrors for posing one's own response to the world. Love is recognized as the medicine that allows the restoration of being when primary bonds have been damaged, awakening the spiritual dimension through proximity and testimony.

■ Thesis and argumentative development

We respond that the healthy experience of spirituality is tied to the relational fabric for the following reasons:

- **Spirituality as a seed:** Human development is potential. Although the information for transcendence is innate, it requires generative bonds to unfold. If the environment is hostile, the spiritual dimension is wounded, generating the existential rift where substance use disorder takes hold.
- **Need for human mediation:** The heart is the center where bonds are processed. Without primary trust, the self cannot sustain itself to

open to transcendence. The community repairs through affection what orphanhood fractured.

- **Mending of the internal fracture:** Spiritual health manifests in the capacity to love. By offering an environment of active listening, the community allows the natural flow of spiritual life to flow again, removing the obstacles of trauma.

■ Response to the objections

- **To the first:** The human spirit does not operate in a vacuum but incarnated in relationship. Just as the brain needs stimuli to develop, spiritual potency requires bonds to be recognized and valued by the subject themselves as an operative reality in their life.
- **To the second:** Orphanhood does not eliminate the essence but does damage the condition or the state of health of the spirit. The subject remains worthy, but their capacity to experience that dignity is blocked by maladaptive memory networks that only fraternal dialogue can disarm.
- **To the third:** Community mediation does not create spirituality but acts as the facilitating environment that removes affective obstacles. The encounter with the brother is the sensible sign that allows the subject to believe in a God who previously seemed alien to them due to accumulated helplessness.

7.2.2 Article 2: The Impact of Orphanhood and the Lack of Home Love on Spiritual Development

Jn 14, 18 — *I will not leave you orphaned; I am coming to you*

■ Statement of the topic

When analyzing trajectories of substance use, it is observed that the onset is usually preceded by a feeling of family and social invisibility. It is imperative to judge whether the lack of a solid foundation of love in the home deeply wounds the subject's capacity to connect with their own transcendence or whether the spirit remains immune to the lack of protection in the environment.

■ Central question

How does having grown up in an environment of orphanhood and without support networks affect the development of the spiritual condition?

■ Existing positions or objections

- **Objection 1:** Free will allows the subject to choose their spiritual path independently of their prior relational history.
- **Objection 2:** Orphanhood can function as a motor of resilience that drives the subject to seek God with greater force when lacking human supports.

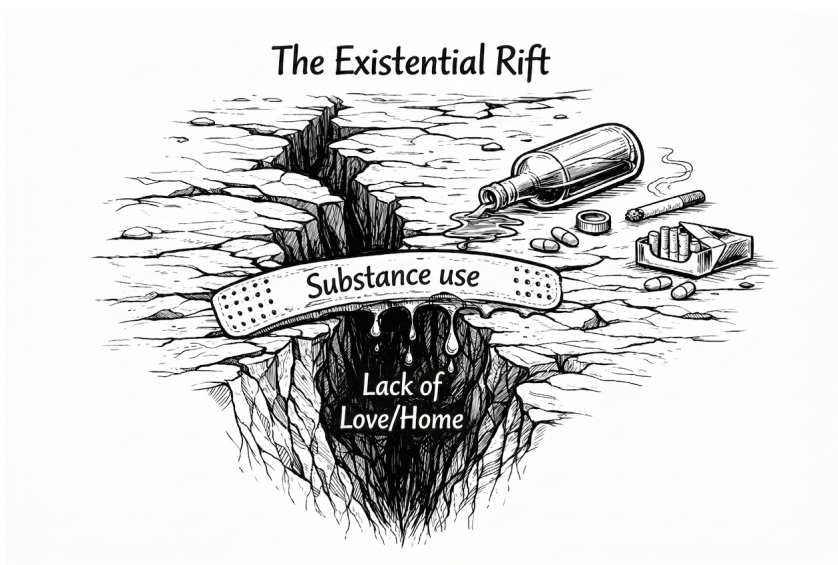


Figure 7.4: Orphanhood and addiction

■ Foundation or criterion of discernment

It is affirmed that orphanhood produces a disconnection from the horizon of life. If the spiritual dimension is not developed due to lack of support, something of the totality of the person remains blocked. The Church teaches that love is the medicine that allows the restoration of being in the face of the desolation of the throwaway culture.

■ Thesis and argumentative development

We respond that the environment of orphanhood gravely affects the spiritual condition of the subject through these points:

- **Fracture of the sense of belonging:** Those who do not find the shared table seek shelter in substance use, which attempts to falsely fill the void. This lack of roots makes it difficult to answer for whom it is worth spending one's life.
- **Obstruction of identity:** By not feeling loved by human references, it becomes difficult for the subject to recognize themselves as the image of God, since the human mirror where they should have seen themselves reflected was broken by neglect or mistreatment.

■ Response to the objections

- **To the first:** Freedom requires conditions of safety to be fully exercised. In contexts of abandonment, substance use appears as a survival strategy in the face of an unbearable world and not as a free and sovereign choice of the will.
- **To the second:** Although God acts in the darkness, healing requires that a community assume the role of the absent family. Resilience is not a solitary act but the fruit of being looked upon with love by others through active listening.

7.2.3 Article 3: The Place of the Heart in the Structure of the Human Spirit

■ Statement of the topic

It is not enough to define the spirit as an abstract capacity; it is necessary to identify the anthropological place where the human being processes their existence and integrates their faculties. In the biblical tradition and in recent Magisterium, this place is the heart, the core of the personality where reason and feeling converge. Understanding how this unifying center is wounded is key to understanding the devitalization that characterizes substance use disorder.

■ Central question

How is the heart integrated as the center of reason and feeling where the demands for fullness reside?

■ Existing positions or objections

- **Objection 1:** Neuroscience locates decision-making in the prefrontal cortex, leaving the heart as a mere literary metaphor without basis in real human functioning.
- **Objection 2:** In a person with severe substance use, the demands for truth seem to have disappeared, being replaced by biological impulsivity.

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

■ Foundation or criterion of discernment

The heart is the unifying center of the person, the place where each one makes their synthesis and where the source of their choices is found. The human being is an integral unity with a center that gives orientation to life and where the capacity to be capable of God resides.

■ Thesis and argumentative development

We respond that the heart constitutes the center of the structure of the spirit:

- **Seat of the original demands:** The heart is an impulse toward the infinite. These demands act as the compass of the spirit that allows evaluating whether life has meaning or is a directionless existence.
- **Point of union between intelligence and affect:** It is where the subject feels the truth and reasons their affects, allowing an integral gaze that overcomes fragmentation through fraternal dialogue.

■ Response to the objections

- **To the first:** Although functions are localized in brain areas, the heart represents the center of existential gravity. Faith understands cognitive processes as the activity of an incarnate spirit that integrates the totality of being, something that the description of neurons alone cannot exhaust.

- **To the second:** The demands for happiness do not die but are anesthetized. The recovery process helps the brother to listen to their own heart again through active listening, progressively displacing the voice of chemical compulsion.

7.2.4 Article 4: The Role of Freedom in the Relationship with God

Gal 5, 1 — *For freedom Christ has set us free. Stand firm, therefore, and do not submit again to a yoke of slavery*

■ Statement of the topic

A tension arises between the dignity of the person and the reality of addiction, often described as a chemical slavery. It is imperative to discern whether the brother preserves the radical capacity to choose God in the midst of their dependence or whether freedom is a mere illusion in the face of the power of psychoactive substances.

■ Central question

What role does freedom play in the subject's capacity to open themselves to the relationship with God in a context of problematic use?

■ Existing positions or objections

- **Objection 1:** Compulsive use alters the capacity for judgment in such a way that the person loses real dominion over their acts, leaving their freedom annulled by physiology.
- **Objection 2:** Structural poverty conditions life in such a way that people cease to have real possibilities of choosing, erasing any transcendent search.

■ Foundation or criterion of discernment

Cf. The paradox of the captive will (ch. 9, biological dimension)

God has created the human being endowing them with dominion over their acts. Although freedom is frequently obscured by social or chemical conditioning, it is never destroyed at its ultimate root. The relationship with God is constitutive and can never be eliminated from the essential structure of being.

■ Thesis and argumentative development

We respond that freedom is the postulate that allows the human being to respond to divine love:

- **Freedom that needs to be freed:** In substance use disorder, freedom is weakened but not dead. The encounter with grace offers a force that the will alone does not possess to overcome the existential rift.
- **The protagonism of the subject:** Reconnection is not an imposition but a voluntary act where the subject decides to place their life in the care of a Higher Power, recovering the helm of their existence through testimony.

■ Response to the objections

- **To the first:** The spirit preserves the radical capacity to ask for help, which is the first act of recovered freedom. Integral treatment uses neuroplasticity assisted by grace to form new bonds that strengthen the will against the impulse.
- **To the second:** Social conditions affect the exercise of freedom but do not annul the capacity to opt for hope. Even in misery, the human being is an active subject capable of initiating a fraternal dialogue that transforms their internal and external reality.

Cf. art. 6 (Judge,
Very Brief Glossary)

7.3 | Addiction as a Spiritual Phenomenon

This section recognizes that substance use disorder often functions as a self-therapeutic attempt to anesthetize an existence that has become intolerable due to trauma and the lack of a horizon of meaning. Substance use settles in a fracture of the deep identity, causing a progressive disconnection of the subject from their essence and from transcendence. Addiction manifests as an errant path that seeks to fill with immediate gratification a void of belonging that can only be filled through the encounter with divine love in community.

7.3.1 Article 1: The Nature of Problematic Use as a Fracture of Transcendence

■ Statement of the topic

Historically, substance use has been judged as a “vice” or a “weakness of character,” a view that usually leads to stigma and blame. However, experience reveals that substance use touches the deepest fibers of identity. It is imperative to discern whether we are facing a simple error of the will or a crisis of the spirit that cries out for an answer to the ultimate meaning of life.

■ Central question

In what way should problematic use be judged: as a moral failing or as a fracture in the connection with transcendence?

■ Existing positions or objections

- **Objection 1:** The use of substances outside of prescription constitutes a grave fault that places the problem strictly in the terrain of morality and sin.
- **Objection 2:** Given that the onset of substance use originates from a voluntary decision, the subject is the sole person responsible for their trajectory, which reinforces the idea of moral degradation by choice.

■ Foundation or criterion of discernment

It is established that behind any dependence there is a void of meaning. The Church, by acting as a refuge, maintains that the dignity of the brother remains intact even when their capacity to act freely is clouded. Pastoral judgment prioritizes the integrity of the person, recognizing that the disorder is a symptom of a prior spiritual fracture.

■ Thesis and argumentative development

We respond that substance use disorder, in addition to its biological and psychological dimensions analyzed in the corresponding chapters, involves a fracture of transcendence that constitutes its deepest and least visible wound. This spiritual dimension does not replace the others but rather pervades them: the void of meaning does not operate in parallel to the neurobiological damage or the psychic trauma, but inhabits them from within, configuring the existential ground upon which those damages settle and sustain themselves. For the following reasons:

- **Anesthesia of helplessness:** Substance use functions as an attempt to conceal wounds of abuse that the subject cannot process. It is not a search for evil but an escape from a reality perceived as a constant threat.
- **False absolute:** The substance appears as a promise of immediate well-being that seeks to replace true transcendence. The “magic instant” of substance use attempts to fill the space that corresponds to the relationship with God and with brothers and sisters.

■ Response to the objections

- **To the first:** Although disordered acts exist, the approach must prioritize the healing of the spiritual wound. The moral failing is secondary to the interior desolation; treating the brother with mercy is what allows the initiation of a restorative fraternal dialogue.
- **To the second:** Although the onset may be operational, the progression toward dependence strips the subject of their real autonomy. The judgment must focus on the loss of freedom caused by chemical slavery, offering an accompaniment that humanizes the journey through testimony.

7.3.2 Article 2: Addiction as a Failed Spiritual Search and an Anesthetic Attempt at Repair

Jer 2, 13 — *My people have committed two evils: they have forsaken me, the fountain of living water, and dug out cisterns for themselves, cracked cisterns that can hold no water*

■ Statement of the topic

Behind every addiction resides a deep desolation. The need arises to discern whether compulsive use is, at its root, a desperate attempt by the person to reconnect with the transcendent through a mistaken means that, instead of liberating, ends up anesthetizing the identity and fracturing the bonds.

■ Central question

Is it possible to understand addiction as a failed spiritual search and a self-therapeutic attempt to repair wounds of affectivity?

■ Existing positions or objections

- **Objection 1:** Neuroscience defines addiction as a condition of the reward circuits; therefore, it is a physiological process and not a search for meaning.
- **Objection 2:** Attributing substance use to a spiritual “self-therapy” could weaken individual responsibility in the face of the damage done to the community.

■ Foundation or criterion of discernment

Cf. art. 9.4.3 (reward system and wanting)

It is affirmed that the human being possesses an internal structure that demands meaning. Addiction represents a missed encounter with that purpose, where the subject attempts to quench a thirst for the infinite with material answers. Love is recognized as the medicine that allows the restoration of being in the face of this failed attempt at repair.

■ Thesis and argumentative development

We respond that addiction is an erroneous response to a legitimate spiritual need:

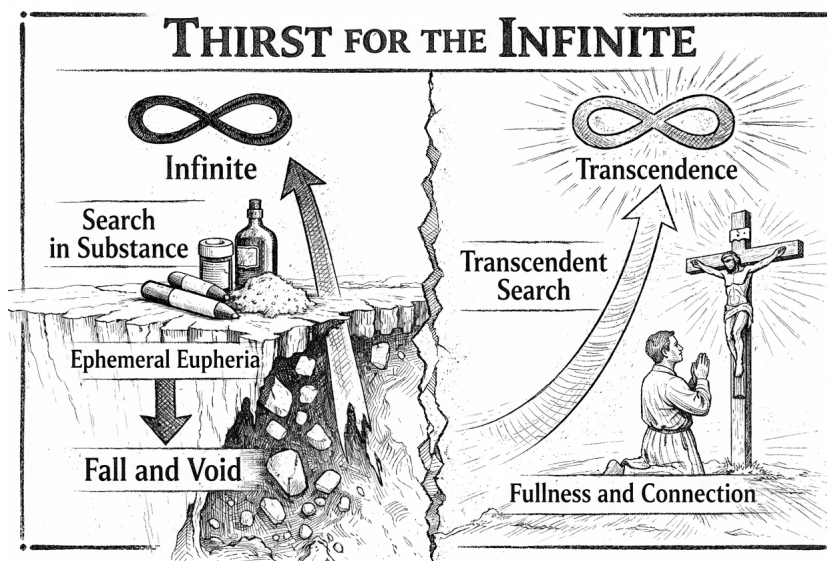


Figure 7.5: The failed search

- **Mending of orphanhood:** The substance presents itself as the only possibility to endure in contexts of extreme vulnerability, attempting to mechanically compensate for what only human bonds and testimony can heal.
- **Misdirected thirst for the infinite:** Instead of elevating the person, the drug encloses them in a cycle of loneliness. Recovery consists of removing the obstacles that block the desire to live so that reconnection may flow.

■ Response to the objections

- **To the first:** Science explains the machinery of damage, but spirituality explains the deep cause. Brain damage explains why it is difficult to stop, but the internal fracture explains why the need to accelerate toward substance use as a flight from pain was felt.
- **To the second:** Understanding the anesthetic component does not remove responsibility but rather situates it within a framework of justice and mercy. The objective is that the brother, through active listening, recognize their wound so as to be able to choose a life project where substance use is no longer necessary.

7.3.3 Article 3: The Disconnection from Inner Reality and from God in Substance Use Disorder

■ Statement of the topic

Substance use disorder is not limited to an organic impairment but reaches the capacity to love and the openness to the divine. It is necessary to clarify whether this pathology constitutes a real fracture in the bond with one's own interiority or whether it is simply a maladaptive behavior without impact on the core of being.

■ Central question

In what way does substance use disorder cause a progressive disconnection from inner reality and from God?

■ Existing positions or objections

- **Objection 1:** Many users maintain social functionality, which would suggest that substance use does not necessarily interrupt their inner life or their perception of reality.
- **Objection 2:** If the relationship with God is indelible, there cannot be a real “disconnection,” since the human being always remains open to the divine by nature.

■ Foundation or criterion of discernment

It is recognized that the spirit is the dimension that recovers most slowly, for it is the axis of the renewal of the soul. The disorder causes a progressive missed encounter with spiritual truth, plunging the brother into a cycle of desolation that distorts all their human relationships.

■ Thesis and argumentative development

We respond that substance use disorder fractures the unity of the person:

- **Loss of attunement:** The distancing from one's own essence does not occur suddenly but increases with the severity of substance use, generating a void that the individual attempts to fill with more substance, aggravating the devitalization.
- **Alteration of security:** Traumatic experiences lead the subject to perceive the world as a threat. The substance acts as a veil that separates them from their unifying center and from the God who manifests in serenity.

■ Response to the objections

- **To the first:** External functionality can conceal a deep deterioration. The lack of spiritual connection manifests as a progressive incapacity to love selflessly or to find a purpose that transcends the social mask.
- **To the second:** It is vital to distinguish between potency (the indelible mark of God) and condition (the dynamic state of the relationship). Substance use can cloud or darken the awareness of the divine presence without erasing it; therefore, recovery requires active listening that helps to remove that veil.

7.3.4 Article 4: The Settlement of Addiction in the Void of Meaning and Social Lack of Protection

■ Statement of the topic

The human being possesses original demands for happiness; however, in contexts of extreme exclusion, an internal fracture occurs. It is imperative to understand whether addiction is the cause of this void or whether it is a failed response provoked by the lack of protection from the family and social environment.

Eccl 1, 2.14 — *Vanity of vanities, all is vanity... I have seen all the works that are done under the sun; and indeed, all is vanity and chasing after wind*

■ Central question

In what way does addiction settle in the void of meaning generated by social lack of protection and lack of belonging?

■ Existing positions or objections

- **Objection 1:** Attributing the problem to external factors of lack of protection could blur individual responsibility, reducing the subject to a passive victim of their historical context.
- **Objection 2:** Curiosity or peer pressure are operational decisions that suggest the disorder arises from the will and not necessarily from a lack of prior social roots.

■ Foundation or criterion of discernment

It is established that dignity remains intact, but the spiritual state is wounded when the community fails to be a safe harbor. Integral healing requires addressing both the fragility of the individual and the injustice of the structures that generate social discard.

■ Thesis and argumentative development

We respond that addiction compensates for deep deficiencies of protection:

- **Reactive development:** When the environment does not provide secure attachment, a defensive personality is generated that seeks relief in immediate gratification, settling in the rift that society failed to cover.
- **Social invisibility:** In contexts of vulnerability, the drug falsely fills the need for purpose. The disorder is the compulsive search for an experience to escape a present without hope or support networks.

■ Response to the objections

- **To the first:** Recognizing the internal fracture does not remove responsibility but rather situates it within a framework of justice. The objective is that the community remove the obstacles of abandonment so that the brother can recover the protagonism of their life through fraternal dialogue.
- **To the second:** In contexts of high vulnerability, what begins as curiosity transforms into a survival strategy. The lack of strong social foundations means the subject has nothing to hold onto to brake the impulse, requiring the anchor of a community that offers testimony and safety.

7.3.5 Article 5: Consumerism as the “Gospel of Well-being” and Driver of Spiritual Disconnection

■ Statement of the topic

Consumerism has erected itself as a belief system that promises immediate happiness, competing directly with the search for meaning. It is necessary to judge whether this promise is a real solution or whether it is the driver that deepens the person’s disconnection from their interiority and from the transcendent.

■ Central question

To what extent does consumerism act as a gospel of well-being that offers magic solutions that aggravate spiritual disconnection?

■ Existing positions or objections

- **Objection 1:** The pursuit of well-being is a natural inclination toward pleasure; therefore, the consumption of goods and sensations is biologically adaptive and not a cause of spiritual disconnection.
- **Objection 2:** Addiction problems are neurobiological illnesses that do not depend on cultural or ideological factors such as consumerism.

■ Foundation or criterion of discernment

The spiritual judgment recognizes that true fullness cannot be bought. The reduction of hope to material possession generates a devitalization of the spirit, reinforcing dependence through the offer of a “magic instant” that never quenches the deep thirst for the infinite.

■ Thesis and argumentative development

We respond that consumerism is an ideology that aggravates the internal fracture:

- **Magic solution:** Immediate satisfaction is proposed as the supreme value, turning the substance into a false absolute that supplants true transcendence and the effort of personal growth.
- **Corrosion of the social fabric:** By prioritizing “having” over “being,” the subject remains isolated in their consumption, losing the network of belonging that is the fundamental anchor of recovery and health.

■ Response to the objections

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

- **To the first:** Authentic well-being is not just the release of dopamine but integral fulfillment in community. Consumerism confuses momentary desire with the need for meaning, which sooner or later manifests as desolation.
- **To the second:** Although addiction alters the brain, cultural factors determine whether a person turns to substances to anesthetize a life that the market system has made intolerable. The health process requires a fraternal dialogue that helps to distinguish the value of being from the logic of having.

7.4 | The Process of Reconnection

The process of reconnection is defined as a natural and spontaneous flow that manifests in the encounter with God and with the community within the framework of a responsible love. Starting from the premise that substance use disorder generates a progressive missed encounter or disconnection from the inner spiritual reality, the work of recovery does not consist of forcing behavioral change through imposition but of removing the obstacles that block this flow. Through the spiritual path and discernment, the aim is for the subject to heal their relational history in order to recover their highest functions. Ultimately, reconnection allows the person to move from a state of desolation to a renewed trust in the future, recognizing themselves once again as a valuable, unique, and unrepeatable being.

7.4.1 Article 1: The Spontaneity of Spiritual Reconnection in the Encounter with God and Brothers and Sisters

■ Statement of the topic

Faced with the problem of substance use, it is often considered that recovery is exclusively the result of a titanic effort of the will or of a complex psychological technique. However, the perspective of the Church maintains that the spiritual dimension possesses its own dynamism that tends toward health. It is necessary to discern whether the reconnection with the meaning of life is an artificial construction or a natural flow that springs forth when the fundamental bonds with the creator and the community are reestablished.

Lk 15, 17 — *Then he came to himself and said: 'How many of my father's hired workers have bread enough to spare, while here I am dying of hunger?'*

■ Central question

Why is it affirmed that spiritual reconnection occurs spontaneously in the encounter with God and brothers and sisters?

■ Existing positions or objections

- **Objection 1:** Behavioral change requires a high and constant motivation that demands a conscious and voluntary effort; therefore, it could not be a spontaneous process.

- **Objection 2:** Substance use generates such a deep disconnection that an imposing external intervention would be required to repair the person's vision.

■ Foundation or criterion of discernment

It is established that the encounter with transcendence within a framework of responsible love allows the force of reconnection to operate through a natural flow. The human spirit possesses an intrinsic inclination toward well-being and truth; therefore, it is not necessary to fabricate spirituality but rather to manifest it through welcome and relational safety.

■ Thesis and argumentative development

We respond that spiritual reconnection is spontaneous because it responds to the relational nature of the human being:

- **Relational essence of being:** The person is fulfilled in the bond. When a genuine encounter occurs, the spirit recognizes its natural environment and reconnection flows without the need for technical artifices, supported by the testimony of others.
- **Surrender to a Higher Power:** Reconnection is activated when the person accepts their fragility. In that act of trust, the encounter with grace activates a deep healing that transcends pure voluntaristic effort.

■ Response to the objections

- **To the first:** Although motivation fluctuates, the community acts as an external motor of hope that sustains the subject. Spontaneity does not mean the absence of effort but rather that the impulse for that effort is born from a recovered internal desire and not from external pressure.
- **To the second:** The spiritual spark is not ignited by imposition but when the person feels valued in their identity. The recognition of one's own value, mediated by active listening, is what naturally reverses the disconnection caused by the substance.

7.4.2 Article 2: The Obstacles to Spiritual Reconnection and Their Removal through Discernment

■ Statement of the topic

Although the spirit possesses a dynamism toward health, we observe that this flow often seems halted by the weight of desolation. For recovery to be effective, it is not enough to propose external goals; it is necessary to discern what elements act as an internal barrier. Understanding these impediments allows the community to act to clear the channel of the inner life and facilitate the brother's reconnection with their vital purpose.

■ Central question

What are the obstacles that block the natural flow of spiritual reconnection and in what way can they be removed through discernment?

■ Existing positions or objections

- **Objection 1:** Given that the relationship with the transcendent is an inalienable constitutive element, nothing on the psychological or social plane should be able to obstruct a gift of divine origin.
- **Objection 2:** Discernment is a complex rational function that requires cognitive integrity that substance use usually damages, preventing the subject from actively participating.

■ Foundation or criterion of discernment

The work of restoration consists of identifying the factors that block the dynamism of the spirit. It is recognized that the spiritual dimension can be affected by extreme affective deprivation. The pastoral criterion seeks to generate the relational conditions necessary for the potency of being to manifest itself again after removing the obstacles of abandonment.

■ Thesis and argumentative development

We respond that the experience of transcendence is conditioned by obstacles that require a pedagogy of proximity:

- **Main obstacles:** Lack of protection generates a void of meaning that the subject attempts to cover with substances. Social stigma feeds a feeling of unworthiness, causing an internal fracture that blocks the desire for improvement.
- **Removal through the spiritual path:** The culture of encounter offers safety, while sacramental life helps to break the cycle of guilt, allowing the person to feel valued once again.

■ Response to the objections

- **To the first:** Ontological dignity remains intact, but the awareness of that dignity is clouded by pain. Removing obstacles does not create the spiritual light but rather lifts the veil of desolation so that this light may illuminate the concrete life of the subject.
- **To the second:** Discernment in the Church is not a solitary intellectual exercise but an art of shared accompaniment. The community lends its capacity to judge and to hope to the brother through fraternal dialogue, sustaining them until they recover their autonomy.

7.4.3 Article 3: The Spiritual Awakening as a Spark of New and Worthy Life

Eph 5, 14 — *Sleeper,
awake! Rise from
the dead, and Christ
will shine on you*

■ Statement of the topic

In accompaniment, a state of devitalization is often observed where the subject seems to have lost their internal motor. We must discern whether transformation is born from a mere effort of the will or whether there exists a spark that is ignited upon recovering the awareness of one's own value. Understanding this awakening allows the community to act as the environment that facilitates this new light guiding the brother's steps toward a life with purpose.

■ Central question

In what way does the spiritual awakening act as the spark that ignites the desire for a new and worthy life in the brother who suffers?

■ Existing positions or objections

- **Objection 1:** The change in addictive behavior is explained exclusively by brain neuroplasticity; therefore, appealing to a spiritual awakening is unnecessary for science.
- **Objection 2:** The will of persons with substance use disorder is profoundly damaged; therefore, an internal spark would be insufficient to overcome the compulsion.

Cf. art. 6 (Judge, Very Brief Glossary)

■ Foundation or criterion of discernment

It is established that when a person manages to reconnect with their meaning and their history, an internal movement occurs that opens paths of hope. This awakening is an affective experience where the subject recognizes themselves as a sacred being. Faith acts as the energy that transforms the perception of a hostile world into a space of possibility.

■ Thesis and argumentative development

We respond that the spiritual awakening is the fundamental spark for new life through these processes:

- **Recognition of essential value:** The spark is ignited when the person discovers that their identity is not defined by their errors. Upon recognizing themselves as a bearer of a divine mark, the brother ceases to see themselves as a social discard.
- **Activation of resilience in community:** This ignition occurs upon feeling welcomed. The atmosphere of unconditional affection breaks the cycle of fear, allowing the internal fracture to begin healing through the testimony of others.

■ Response to the objections

- **To the first:** Science describes the biological machinery, but spirituality is what grants the meaning and the “what for” necessary for that machinery to be set in motion toward an end that transcends mere physical survival.
- **To the second:** Although the will is weakened, the spiritual awakening depends on the help received. The affective bond and active listening repair the will, offering a force that the subject alone could not initially generate.

7.4.4 Article 4: The Recovery of Autonomy and the Responsible Management of the Life Project

■ Statement of the topic

In accompaniment, a strong institutional dependence is often observed. Autonomy arises as the highest level of independence and informed decision-making of which the subject is capable. It is imperative to judge how this potency translates into a responsible management that allows the brother to transition from being an assisted person to being an active citizen and protagonist in their community.

■ Central question

In what way does the recovery of autonomy allow the subject to become independent from institutional dependence through the responsible management of their life?

■ Existing positions or objections

- **Objection 1:** Cognitive and willpower deterioration would prevent these persons from taking the reins of their life without constant and permanent institutional supervision.
- **Objection 2:** Upon leaving the protected environment, the lack of a rigid external structure inevitably leads to the failure of the process due to exposure to the market.

■ Foundation or criterion of discernment

Recovery is a self-directed process where the person is the main agent. The success of the spiritual process is the development of the maximum potential of the individual to lead an autonomous life. The community must not replace the brother's will but strengthen their capacity for self-direction toward their final destiny.

■ Thesis and argumentative development

We respond that autonomy allows institutional independence through a process of progressive maturation:

- **Material management as a tool:** Financial reeducation and resource management allow replacing the impulsive pattern with planning. This facilitates access to housing and self-sustainability outside the institution.
- **Protagonism in the life project:** The subject ceases to be a spectator. This spiritual empowerment implies that the person assumes the responsibility for their well-being, participating in a fraternal dialogue with their social environment.

■ Response to the objections

- **To the first:** Although sequelae may exist, neuroplasticity and peer accompaniment allow learning new repertoires of personal management. Autonomy is progressive and is trained in the daily practice of caring for one's own life. Cf. art. 6 (Judge, Very Brief Glossary)
- **To the second:** Independence does not mean absolute isolation. The model contemplates that the person maintain bonds of belonging and networks of active listening with their community of origin, which prevents relapses through the safety of not being alone.

7.5 | The Christian Path

The Christian path is presented as a proposal of healing and freedom that transcends the purely clinical, centering its axis on the personal encounter with Jesus Christ. This journey is grounded in a Church going forth that acts as a refuge willing to receive life as it comes. Far from being a set of rigid norms, it proposes an incarnate spirituality where the community transforms itself into a family that accompanies pain without judging. Through mercy and the living experience of the Word, the process seeks to remove the obstacles of the soul so that the person recovers their capacity to love and to transcend, igniting the spark of a life project with meaning.

7.5.1 Article 1: The Proclamation of Faith in Relation to the Technical-Professional Approach

■ Statement of the topic

The tension often arises between trust in the transforming power of the Christian message and the need to resort to the tools of medicine or psychology. It is fundamental to discern whether the proclamation of God's love invalidates clinical work or whether both dimensions must be articulated in a unity of meaning for the integral restoration of the person who suffers from substance use disorder.

■ Central question

In what way is the proclamation of faith articulated with the technical-professional approach in the process of integral health?

■ Existing positions or objections

- **Objection 1:** If love is the supreme medicine, the proclamation of faith should be sufficient on its own, making technical or pharmacological intervention unnecessary.
- **Objection 2:** Given that addiction is a condition of the spirit, a technical solution is superficial, while faith would reach the very root of the problem.

■ Foundation or criterion of discernment

The Church avoids the temptation of a spiritualism that ignores physical and psychic realities. The intervention is an integral process where the biological and the spiritual are necessary ingredients but insufficient if applied in isolation. Health is the unfolding of the maximum potential of the person, which demands a harmonious collaboration between the wisdom of faith and the knowledge of science.

■ Thesis and argumentative development

We respond that there is no superiority in terms of exclusion but rather a necessary complementarity:

- **Faith as the foundation of meaning:** Faith grants the “what for” of recovery. It returns to the subject their deep identity, allowing them to move from desolation to hope.
- **The technical approach as mediation:** Science provides the means to treat the damaged biological machinery. To ignore biology would be a failure of pastoral responsibility; professional intervention stabilizes the brother so that their spirit recovers the capacity to decide.

■ Response to the objections

- **To the first:** God’s love also manifests through the gift of science. God frequently heals through human mediations; to reject the technical approach would be to dismiss the tools that providence makes available for the care of life.
- **To the second:** Although addiction affects the core of being, it is incarnated in the nervous system. The care of physical health disposes the spirit to receive the message of hope through the formation of new bonds in a fraternal dialogue.

7.5.2 Article 2: The Importance of the First Proclamation in the Spiritual Awakening of the Brother

■ Statement of the topic

In accompaniment, biological stabilization is often prioritized. However, the question arises about the efficacy of a spiritual message in subjects who have lost the sense of their own worth. It is fundamental to discern whether the message that God loves the human being unconditionally is a central piece in the health process or a secondary element.

■ Central question

What importance does the first proclamation have for awakening a spiritual dimension wounded by problematic use?

■ Existing positions or objections

- **Objection 1:** The disorder alters executive functions; therefore, a spiritual message would not have the capacity to repair neurological damage or to halt the biological impulse.
- **Objection 2:** In persons with difficulties in accepting limits, a message of unconditional love and lack of judgment could foster behavioral irresponsibility.

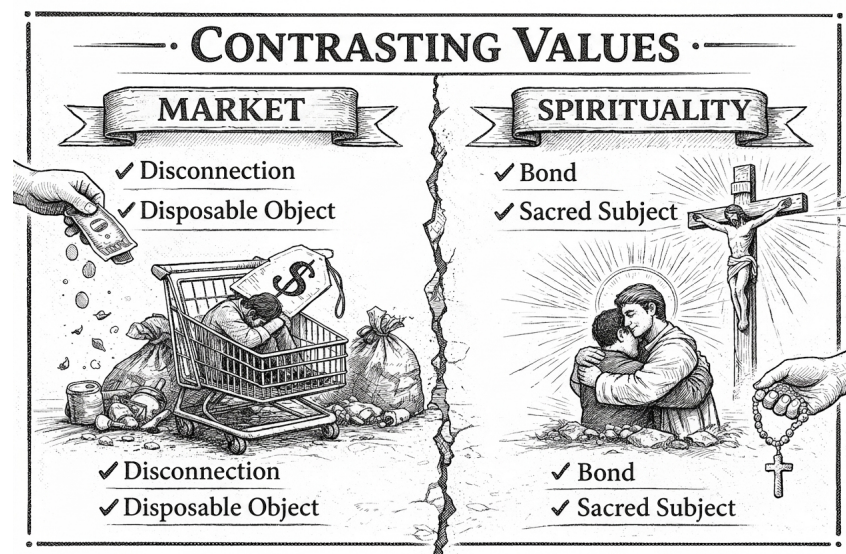


Figure 7.6: The values of spirituality

■ Foundation or criterion of discernment

The central message of faith acts as the spark that ignites the desire for a new life. It is not an abstract doctrine but an encounter that rescues the person from their devitalization. By restoring to the subject the awareness that their life is sacred, faith becomes the energy necessary to be the protagonist of their own history.

■ Thesis and argumentative development

- **Healing of the internal fracture:** Unconditional love responds to deep orphanhood. By knowing themselves loved beyond their behavior, the subject ceases to see themselves as a discard and recognizes themselves as a son or daughter.
- **Breaking the cycle of guilt:** The proclamation that God does not judge is vital for disarming self-contempt. The experience of forgiveness allows separating essential value from past errors.

■ Response to the objections

- **To the first:** While science repairs the machinery, spirituality grants the transcendent motivation to sustain that process. The vital purpose uses neuroplasticity to strengthen commitment to medical treatment.
- **To the second:** Mercy makes responsibility possible. Only those who feel themselves truly worthy are capable of assuming the management of their own life and freely adhering to the limits necessary for their well-being through active listening.

Cf. art. 6 (Judge,
Very Brief Glossary)

7.5.3 Article 3: The Personal Encounter with Christ as a Path of Resurrection

■ Statement of the topic

In pastoral ministry, pain is not a dead end but the place where fragility encounters grace. We must discern whether the encounter with Christ constitutes a true transformation that restores life to what seemed lost, opening a path of hope in the face of the desolation of substance use.

■ Central question

In what way does the personal encounter with Christ transform pain into a path of resurrection?

■ Existing positions or objections

- **Objection 1:** Pain is anchored in objective biological damage; a spiritual encounter cannot by itself reverse the physiology of the brain.
- **Objection 2:** Speaking of resurrection seems like a lyrical exaggeration in the face of life trajectories marked by relapse, hospitalization, or prison.

■ Foundation or criterion of discernment

Love is the supreme medicine. To love someone in Christ is to offer them a real possibility of new life. The resurrection is a present force that allows what was dead through substance use to bloom again through trust and the communal bond.

■ Thesis and argumentative development

- **Revelation of the sacred identity:** By seeing themselves through the eyes of Christ, the person ceases to be a number and recognizes themselves as a valuable being. This is the necessary spark to begin the reconstruction.
- **Christ as the physician who takes on the wound:** Jesus touches the suffering flesh and involves his life in the desolation of the brother. By identifying with the crucified one, the suffering person understands that their fragility is the point of encounter with a superior force.

■ Response to the objections

- **To the first:** The resurrection provides the “what for” of living that medicine alone cannot give, motivating the subject to commit to their integral health and to exercise their recovered freedom through testimony.
- **To the second:** Resurrection in this context is not measured by the absence of falls but by the capacity to stand up. It is the triumph of hope that affirms that, even at the limit, the human being preserves the potency to begin anew.

7.5.4 Article 4: The Value of Testimony and Active Listening in Generating Trust

■ Statement of the topic

In the accompaniment of persons marked by stigma, social rejection usually fractures the capacity to trust. The community must discern whether the use of the word possesses the potency necessary to heal this damaged bond or whether only standardized technical interventions are required.

■ Central question

In what way do testimony and active listening generate the trust necessary for recovery in those who have lived under the weight of rejection?

■ Existing positions or objections

- **Objection 1:** The approach must be primarily scientific; accounts of personal experiences lack the rigor to modify a biological condition.
- **Objection 2:** Listening is a subjective method that does not resolve the basic material needs, which are the true urgency of the brother.

■ Foundation or criterion of discernment

Cf. Active listening and the inner work of the companion (ch. 8)

Active listening is the first medicine in the restoration of the soul. The objective is to create an atmosphere of hospitality where the person expresses themselves freely. Testimony does not seek to impose a doctrine but to offer a reflection of hope that invites the other to pose their own vital response.

■ Thesis and argumentative development

- **The peer companion as a reference:** The testimony of one who has already traversed suffering generates a unique legitimacy. The brother trusts because the other knows the reality of the territory; their life is the proof that it is possible to rise.
- **Listening that dignifies:** Paying attention to the heart of the other, believing that their word is valuable, disarms the defensive attitude. The subject lowers their armor and begins to recognize their own intrinsic value.
- **Enabling the personal history:** Fraternal dialogue allows pain to be transformed into a coherent narrative and this into a life project. The person ceases to be a number and becomes a subject with their own name.

■ Response to the objections

- **To the first:** While science treats the physical machinery, testimony is what grants the reason to live. Technique repairs, but the shared word is what humanizes the journey and allows health to be integral.
- **To the second:** Active listening is the affective bond that allows the subject to recover trust in order to accept institutional help. Without this bridge of humanity, it is common for the brother to reject services because they feel instrumentalized.

7.5.5 Article 5: The Lectio Divina as a Path of Confrontation and Spiritual Healing

■ Statement of the topic

The question arises whether the reading of sacred texts is an intellectual exercise or whether it possesses the potency to interpellate the subject's biography. We must discern how the word of God allows the brother to reconstruct their identity in the face of the void of meaning left by substance use.

■ Central question

In what way does the Lectio Divina allow the word of God to confront and heal the life history of each person?

■ Existing positions or objections

- **Objection 1:** The disorder often generates cognitive deterioration that hinders the attention processes necessary for a meditative reading.
- **Objection 2:** Many persons in substance use suffer an internal fracture that makes religious language feel foreign to them or generates rejection due to prior experiences of guilt.



Figure 7.7: The prayerful reading of the Word of God

■ Foundation or criterion of discernment

Prayerful reading, grounded in reality, allows questioning one's own actions in the face of the model of Jesus. The word is not a cold norm but a presence that confronts daily living. What is sought is not erudition but an affective encounter where truth manifests in simplicity.

■ Thesis and argumentative development

- **Confrontation with a loving truth:** The word displaces the lies of substance use. Being a truth mediated by mercy, the brother feels invited to recognize their dignity and not to be condemned.
- **Reprocessing of memory:** Prayerful reading allows the resignification of painful memories. By illuminating the story with the gospel, the person discovers that their life is sacred and that the last word belongs to hope.

■ Response to the objections

- **To the first:** Understanding is not an intellectual achievement but an experience of the heart. The community practice uses fraternal dialogue as a mediator so that the brother feels welcomed and safe in the group.
- **To the second:** The word must be presented from a pedagogy of proximity. When the subject feels loved unconditionally, resistance diminishes, allowing the word to heal the damaged self-image through active listening.

7.5.6 Article 6: The Need for an Incarnate and Relational Spirituality Verified in Service

■ Statement of the topic

There exists the temptation to consider recovery as a strictly private phenomenon. It is fundamental to discern whether spirituality can sustain itself in isolation or whether it requires verification in the bond with others and in concrete service to be authentic.

■ Central question

Why is it fundamental that spirituality be verified in relational service and not in an isolated intimism?

■ Existing positions or objections

- **Objection 1:** Spirituality is the intimate relationship between the soul and the creator; the process should occur exclusively in the consciousness and will of the subject.
- **Objection 2:** Service to the neighbor is perceived as an external assistance activity that does not impact the deep rehabilitation of the spiritual dimension.

■ Foundation or criterion of discernment

The human being is constitutively relational. Spirituality is not an abstract refuge but an incarnate dimension. True spiritual health is recognized when the person leaves their egocentrism to encounter the suffering reality of their brothers and sisters.

■ Thesis and argumentative development

- **Healing through the bond:** Given that addiction is a missed encounter, the response is communion. Isolation is reversed through integration in a community that offers affection. The exchange of experiences allows pain to be transformed into shared history.
- **The principle of the wounded healer:** Maturity is verified in the transition from being an assisted person to being a server. By caring for another, the subject discovers that their history of pain has a salvific value, activating a resilience that restores the taste for living.

■ Response to the objections

- **To the first:** A faith disconnected from the brother runs the risk of becoming a mysticism that does not sustain life in the face of crises. The human being only discovers themselves fully in the encounter with the other through active listening.
- **To the second:** Service is the place where the authenticity of the spiritual awakening is verified. Fraternal dialogue and commitment to the neighbor provide the solid foundation for recovery to be lasting and full of testimony.

7.6 | The Sacraments

The sacraments are understood as vital encounters with divine mercy that sustain and transform the journey of integral health. In the logic of a community that acts as a refuge, sacramental life is offered as the channel of grace necessary to restore the unity of the person. The Eucharist and Reconciliation are not goals for those who have achieved perfection but means of healing so that the brother may heal their internal fractures and reorder their desires toward a life project with purpose.

7.6.1 Article 1: The Sacraments as a Remedy for the Wounded and Not as a Prize for the Perfect

■ Statement of the topic

In pastoral ministry, the question often arises whether a person going through the instability of relapses can access sacramental life. Some sectors demand impeccable behavior as a prior requirement, disqualifying the subject due to their moral fragility. It is imperative to judge whether the sacraments are instruments of healing for the wounded brother or prizes for a perfect minority.

Lk 5, 31 — *Those who are well have no need of a physician, but those who are sick. I have come to call not the righteous but sinners*

■ Central question

Should the sacraments be a prize for the perfect or a remedy for those who suffer the wounds of substance use?

■ Existing positions or objections

- **Objection 1:** Access to the sacraments requires a coherent state of grace; the disorder linked to substance use seems to be at odds with the holiness of these rites.
- **Objection 2:** Confession requires a firm purpose of amendment which, in a will biologically damaged by dependence, seems difficult to validate due to relapse.

■ Foundation or criterion of discernment

Amoris Laetitia N.291

It is established that the sacraments are acts of mercy destined for the restoration of the human being. Grace is the divine assistance that allows the person to rise. The Church acts as a field hospital that does not demand prior moral merits but offers spiritual nourishment as a right that springs from the need of the suffering person.

■ Thesis and argumentative development

- **Primacy of Grace over the will:** Deep healing is not only a human effort but an openness to the action of God. The sacraments act where the strength of the individual does not reach, purifying the heart and repairing the capacity to choose the good through testimony.
- **Breaking the cycle of self-contempt:** Addiction is usually marked by guilt. The sacraments separate the committed error from the sacred identity of the subject, restoring the peace necessary to sustain the health process.

■ Response to the objections

- **To the first:** The principal disposition for receiving grace is not perfection but the humility of recognizing one's own powerlessness. To deny the remedy to the sick is contrary to the mission of the Church; the sacrament is what grants the strength to begin order, not its final consequence.
- **To the second:** The purpose of amendment must be understood as a progressive path of integral health. God does not tire of forgiving; each sacramental encounter is a step in the spiritual reconnection that helps to unlearn the habit of death through fraternal dialogue.

7.6.2 Article 2: The Eucharist as Nourishment for the Weak in the Daily Struggle

Jn 6, 35.51 — *I am
the bread of life.
Whoever comes to
me will never be
hungry, and who-
ever believes in me
will never be thirsty*

■ Statement of the topic

Recovery is a journey marked by distress and compulsive desire. It is a matter of discerning whether the Eucharist possesses a real efficacy for providing the necessary strength in the battle for sobriety or whether it is merely a symbolic rite alien to the urgency of those suffering from substance use disorder.

■ Central question

In what way does the Eucharist act as nourishment for the weak that sustains the subject in their process of integral health?

■ Existing positions or objections

- **Objection 1:** The fight against addiction has a neurobiological basis; a spiritual element could not provide the physical “brake” that the brain has lost.
- **Objection 2:** Placing priority on sacramental nourishment could distract from the resolution of the urgent material needs (shelter and bread) of the brother.

■ Foundation or criterion of discernment

The Eucharist is a generous remedy for those who find themselves weakened. It represents the encounter with a living presence that restores the strength for perseverance, transforming suffering into a process of hope where divine love is the principal agent of restoration.

■ Thesis and argumentative development

- **Sustenance in the transit of pain:** In receiving communion, the person unites their fatigue to the self-giving of Christ. The experience of abstinence ceases to be a dead end and becomes a path of resurrection verified in testimony.

- **Restoration at the shared table:** Substance use isolates, but the Eucharist is celebrated in community. Being invited to the same table as everyone else heals the internal fracture of discard and recovers the awareness of the inalienable value of being a child of God.

■ Response to the objections

- **To the first:** Although science repairs the biological machinery, the spirit grants the purpose for living. The Eucharist offers a refuge of peace that stabilizes the mood in the face of anxiety, using transcendent motivation as a pillar that sustains technical results.
- **To the second:** The Church, as a field hospital, does not separate the spiritual from the material. Active listening and the Eucharist impel the community to commit to social needs, recognizing that there is no authentic charity without concrete service to those who hunger for bread and for meaning.

7.6.3 Article 3: Confession as a Path of Liberation from Guilt and Filial Restoration

■ Statement of the topic

In accompaniment, guilt acts as a backpack that paralyzes the subject, leading them to believe that their identity is their fall. It is necessary to discern how reconciliation manages to heal the self-perception of the individual and to disarm the internal sabotage born of a fracture that prevents projecting the future.

■ Central question

In what way does Confession allow the person to leave behind the burden of the past and recognize themselves once again as a beloved child?

■ Existing positions or objections

- **Objection 1:** Guilt is a psychological phenomenon linked to trauma; therefore, it requires a clinical approach and not a spiritual rite.

- **Objection 2:** A person with the decision-making system affected by substance use lacks the will necessary for a free repentance, invalidating the sacrament.

■ Foundation or criterion of discernment

Reconciliation allows releasing burdens and looking at one's history without fear. Divine forgiveness is an embrace that separates the error from the sacred identity. The sacrament offers a space of absolute freedom where grace acts upon fragility to initiate a reconstruction based on love.

■ Thesis and argumentative development

- **Enabling the word:** By enabling the word in an environment of active listening, pain is transformed into narrative. Confession allows externalizing that which causes shame, stripping the subject of the secrets that fuel the desire for substance use.
- **Breaking self-contempt:** Sacramental forgiveness breaks the cycle of self-disqualification. Upon discovering themselves forgiven, the person feels empowered to forgive themselves through a fraternal dialogue with their own history.

■ Response to the objections

- **To the first:** Psychology helps to understand the origin of the wound, but confession heals the spiritual bond with life. This sacramental theotherapy restores a “for whom” to live, integrating the pain into a horizon of redemption.
- **To the second:** Although the will is biologically weakened, the longing for fullness remains in the heart. Confession acts upon that remainder of freedom so that the subject accepts being loved in their weakness, transforming the chemical powerlessness into openness to the spirit.

7.6.4 Article 4: The Value of Eucharistic Adoration as a Refuge of Silence and Stability

■ Statement of the topic

It is debated whether dedicating time to contemplation constitutes a pillar for stability or whether it is a secondary practice in the face of therapeutic urgency. It is necessary to judge whether the space before the Blessed Sacrament is an evasion or an effective means of finding an anchor in the midst of disorder.

■ Central question

What therapeutic and spiritual value does Eucharistic Adoration have as a refuge of silence in the face of the noise and anxiety of substance use?

■ Existing positions or objections

- **Objection 1:** Silence is a passive activity, while substance use disorder requires active and dynamic group interventions.
- **Objection 2:** The impulsivity of a recent abstinence makes absolute silence counterproductive or unattainable for the brother.

■ Foundation or criterion of discernment

The silent presence of Jesus offers peace and meaning. For many, this is the first moment of silence after years of confusion. The encounter helps to recognize the gratuitous love that restores the unity of the person.

■ Thesis and argumentative development

- **Space of non-judgment:** Before the Blessed Sacrament, the subject discovers that they are loved just as they are, disarming the damaged self-image. This act of acceptance is vital for those who have lived under constant disqualification.

- **Reordering of desire:** In contemplating Christ, desire is reoriented from objects that do not satisfy toward transcendence. One moves from a failed search to a real connection with the vital purpose.

■ Response to the objections

- **To the first:** Contemplation is a profound activity that allows reprocessing of bonds. Prayerful silence is not emptiness but the foundation for the subject to value their existence and commit to their change through testimony.
- **To the second:** The silence of adoration offers the necessary counterpoint to regulate the nervous system. The peace that emanates from the encounter helps to lower the levels of alertness generated by the anxiety of substance use, acting as a regulating balm.

7.6.5 Article 5: The Anointing of the Sick in Limit Situations of Health and Lack of Protection

■ Statement of the topic

In the work with persons living on the streets or in prisons, we face extreme physical fragilities. It is a matter of discerning whether the Anointing is a farewell rite or a gesture of proximity that manifests that the community does not abandon its children on the threshold of life.

■ Central question

How does the Anointing of the Sick become an experience of a living Church and a proclamation of hope in limit situations of health?

■ Existing positions or objections

- **Objection 1:** Those who have lived years of rejection by ecclesial structures feel unworthy of receiving sacred rites in their final moments.
- **Objection 2:** The anointing can be perceived with a fatalistic gaze, confirming that there is no longer hope for those who have lived in marginalization.

■ Foundation or criterion of discernment

Accompaniment in fragility is a ministry of resurrection. The anointing is the oil of mercy that bandages wounds and restores the sick person's sacred value. The Church acts here as a field hospital that offers warmth and strength without demanding merits.

■ Thesis and argumentative development

- **Humanization of the journey:** The health system usually attends only to the diagnosis. The sacrament restores the filial identity; upon being anointed, the brother ceases to be a number and becomes a beloved being, giving meaning to their struggle for health.
- **Mending of orphanhood:** Upon receiving the anointing, the excluded person experiences that the community-family is present. This gesture of proximity heals the fracture of abandonment through the active listening prior to the rite.

■ Response to the objections

- **To the first:** The sacrament is not based on merits but on the need of the wounded. God lowers himself to touch the suffering flesh of all his children without distinction, ensuring that the brother feels dignified and not judged.
- **To the second:** The anointing is the strength of the spirit that accompanies the battle, not a surrender. It is the sign of the union with Christ who conquered death, assuring that life has a purpose that transcends illness and is manifested in the final testimony.

7.7 | Spiritual Wisdom

Spiritual wisdom constitutes the fundamental instance for understanding the dynamism of the spirit in the process of integral health, offering the necessary tools to find paths of resolution in the face of the challenges posed by dependence. Far from being abstract knowledge, it manifests as an incarnate discernment that allows the subject to take distance from their own reality to examine it without prejudices, integrating their emotions and bonds in a life project with meaning. This wisdom is nourished by the testimony of the community, functioning as an anchor that helps to navigate pain and crises as opportunities for genuine change. By centering on the full experience of the present and on openness to the love of God, spiritual wisdom empowers the person to rediscover their inalienable value as the protagonist of their own history.

7.7.1 Article 1: The Signs of Authenticity in Spiritual Recovery

■ Statement of the topic

It has been established that spirituality is the axis that sustains all true recovery, for without it the person runs the risk of being rebuilt only on the outside. However, in accompaniment the need arises to discern whether the change experienced by the brother is a deep transformation of the soul or a superficial behavioral adaptation. It is imperative to judge which visible fruits manifest a true spiritual reconnection in the face of the prior void of meaning.

Gal 5, 22 — *The fruit of the Spirit is love, joy, peace, patience, kindness, generosity, faithfulness, gentleness, and self-control*

■ Central question

What everyday signs allow one to judge that a process of spiritual recovery is authentic?

■ Existing positions or objections

- **Objection 1:** Spirituality is a subjective and invisible dimension; therefore, any attempt to observe it externally would result in an undue judgment upon the conscience of the other.
- **Objection 2:** The only objective sign of improvement in substance use

disorder is physical abstinence; if the subject does not use, the process is authentic.

■ Foundation or criterion of discernment

It is established that spiritual growth is not an isolated event but a continuous journey that manifests in a reconfiguration of one's gaze upon reality. Spiritual wisdom is verified when the subject moves from desolation to an affective communion with the community and with God. The fruits are tangible signs that allow recognizing that the potency of being has manifested itself once again.

■ Thesis and argumentative development

We respond that the authenticity of recovery is manifested through signs that reflect the healing of the internal fracture:

- **Interior serenity and decentering:** The subject ceases to be the center of their fears and recognizes themselves as part of an interdependent community. It is manifested in the capacity to act calmly in the face of setbacks without resorting to the flight of substance use.
- **Dedication to service:** The most solid verification is the transition from being an assisted person to being a server, assuming an active responsibility in the well-being of brothers and sisters through testimony.

■ Response to the objections

- **To the first:** Although the root is invisible, the tree is known by its fruits. Authentic spirituality is relational; if it does not translate into gestures of love and active listening toward the neighbor, it has not reached the maturity necessary to sustain life.
- **To the second:** Abstinence is necessary but insufficient. A person can not use and live in pride; spiritual wisdom seeks the integral restoration of dignity and not only the absence of substances.

7.7.2 Article 2: Spiritual Wisdom and the Wonder at the Simplicity of Daily Life

■ Statement of the topic

Spiritual wisdom is an incarnate discernment that integrates history and bonds in a project with meaning. In contexts where life was reduced to the search for a “magic instant” to anesthetize pain, the need arises to discern whether the appreciation of the small is the manifestation of a healing of the spirit that recovers the connection with reality.

■ Central question

How does spiritual wisdom manifest in the capacity to marvel at the everyday and at the simplicity of life?

■ Existing positions or objections

- **Objection 1:** In recovery, the priority must be material success; dedicating oneself to contemplating simplicity seems like a waste of time in the face of the urgencies of life.
- **Objection 2:** The brain of a person affected by substance use cannot find satisfaction in the simple due to its habituation to stimuli of extreme intensity.

■ Foundation or criterion of discernment

The capacity to marvel at simplicity is a fundamental sign of spiritual growth. It allows transforming the perception of the environment, moving from seeing the world as a threat to recognizing it as a loving and safe space.

■ Thesis and argumentative development

- **Mending of the existential rift:** Everyday wonder is the sign that the interior void has been inhabited by the presence of God and community affection.

- **Experience of the present:** Spiritual wisdom anchors the person in the concrete present, allowing them to enjoy simple pleasures without resorting to chemical evasion.

■ Response to the objections

- **To the first:** Economic autonomy must be a consequence of spiritual well-being. Finding meaning in the everyday ensures that subsequent social performance is sustainable and not a mask of functionality.
- **To the second:** Spiritual wisdom allows a different perception where inner peace replaces the urgency of chemical euphoria with the lasting satisfaction that springs from the encounter with others through fraternal dialogue.

7.7.3 Article 3: Interior Serenity and the Decentering of the Self as Fruits of Faith

■ Statement of the topic

In integral health, the transition from agitation and egocentrism toward calm and openness to the neighbor is often observed. It is vital to discern whether this serenity constitutes an authentic fruit of an incarnate faith that has transformed the root of being or whether it is a biological byproduct.

■ Central question

In what way do interior serenity and the diminishment of egocentrism reflect authentic growth in faith?

■ Existing positions or objections

- **Objection 1:** Serenity in recovery is exclusively the result of neurochemical stabilization and the use of psychopharmaceuticals after the cessation of substance use.
- **Objection 2:** A state of calm can be achieved through personal discipline without the need to appeal to the dimension of faith.

■ Foundation or criterion of discernment

It is established that faith is cultivated through the daily exercise of the presence of God. Spiritual growth is manifested when the subject achieves a perception of the universe as a loving place, the result of knowing themselves sustained by grace.

■ Thesis and argumentative development

- **Trust in Grace:** The appearance of inner peace is the sign that the person has ceased to fight alone, feeling themselves sheltered in a covenantal relationship.
- **Relational freedom:** As egocentrism diminishes, the subject discovers the joy of being a people and of serving through testimony.

■ Response to the objections

- **To the first:** Although science repairs the machinery, faith is what grants the “what for” of living. Spiritual serenity is an ontological security that is born from knowing oneself unconditionally loved by God.
- **To the second:** The spiritual dimension endows serenity with a horizon of transcendence. By recognizing Christ as the way, peace ceases to be a fragile psychological balance and becomes a firm anchor against existential voids.

7.7.4 Article 4: Forgiveness and Gratitude as Motors of Deep Healing

■ Statement of the topic

Recovery is not only the suppression of substance use but a reconfiguration of the soul. Forgiveness and gratitude are tools of restoration that allow the subject to free themselves from the burden of the past and reconnect with the meaning of their existence.

■ Central question

What role do forgiveness and gratitude play as motors of integral healing?

■ Existing positions or objections

- **Objection 1:** Forgiveness is impossible or re-victimizing in the face of extreme abuse; resentment is a logical defensive response.
- **Objection 2:** Gratitude can be seen as a denial mechanism that does not resolve the social vulnerability of the person.

■ Foundation or criterion of discernment

Forgiveness and repentance constitute a fundamental impulse for the liberation from dependencies. By recognizing that the value of being is superior to one's falls, the subject finds in mercy the energy to reconstruct their identity.

■ Thesis and argumentative development

- **Liberation from guilt:** Forgiveness of oneself separates the sacred identity from the errant behavior. Forgiveness of others heals memory through fraternal dialogue.
- **Joy of living:** Gratitude reduces anxiety and strengthens the will against the impulsive desire for substance use through active listening.

■ Response to the objections

- **To the first:** Pastoral accompaniment allows the person to process their pain and discover that their suffering can be redeemed, opening a path of resurrection that heals the memory without forcing forgetfulness.
- **To the second:** Gratitude is not naive optimism but the daily decision to recognize everyday miracles. This disposition has a real protective impact that diminishes the triggers of substance use.

7.7.5 Article 5: Spiritual Discernment in the Face of the False Solutions Offered by the Market

■ Statement of the topic

In the current cultural environment, the market promises immediate happiness through substances. It is imperative to judge whether this promise is a real solution or a driver that deepens the interior void. Discernment arises as the faculty necessary to choose a path of authentic freedom.

■ Central question

In what way does spiritual discernment help to identify and overcome the “false solutions” offered by the market?

■ Existing positions or objections

- **Objection 1:** The market offers tangible relief to psychic pain through chemical effects; therefore, it is not a “false” solution in the face of intolerable suffering.
- **Objection 2:** The cognitive deterioration caused by the disorder would prevent carrying out a process of deep spiritual reflection.

■ Foundation or criterion of discernment

Discernment allows the demythologization of false answers to the meaning of life. This capacity is cultivated in the community and allows the person to recover the protagonism of their own history.

■ Thesis and argumentative development

- **Dismantling of illusions:** Through active listening, the brother learns to distinguish between ephemeral pleasure and the lasting joy of healthy bonds.

- **Identity versus merchandise:** Discernment empowers the person to value their existence from their intrinsic dignity and not from their capacity to consume.

■ Response to the objections

- **To the first:** Although the substance calms the discomfort momentarily, discernment reveals that it is a flight that deepens devitalization. Authentic healing processes the personal history in an environment of safety.
- **To the second:** Pastoral accompaniment helps to “lower one’s guard.” The support of peers allows the brother to accept their own fragility, opening the way to a wisdom that is born from humility and trust in a Higher Power.

7.8 | Spirituality in Women

This section explores spirituality in women as a vital response to the double condemnation imposed by the system: the stigma for substance use and the censure for not fulfilling the traditional roles of care. Women usually face the health process in profound solitude, which demands a spirituality of tenderness that acts as a field hospital. The proposal centers on a trauma-informed approach, where faith allows recognizing the inalienable dignity beyond the wounds. Through artisanal accompaniment and caring figures, the aim is to restore the capacity to love and to mother, promoting a personal encounter with Christ that restores the protagonism of life.

7.8.1 Article 1: The Specificity of Spiritual Needs and Potencies in Women

■ Statement of the topic

When addressing the spiritual dimension, the need arises to discern whether the soul possesses a configuration that requires differentiated treatment. In pastoral ministry, it is observed that the trajectory of women is traversed by specific violences and abandonments that are often ignored by standardized models. It is fundamental to judge whether the recognition of these particularities allows a deeper healing based on the incarnate reality of the subject.

■ Central question

Are there specific spiritual needs and potencies in women that pastoral ministry should contemplate differently?

■ Existing positions or objections

- **Objection 1:** Ontological dignity is equal for every human being; therefore, the spirit has no gender, and grace acts in the same way in all individuals without distinction.
- **Objection 2:** The sacraments and the word of God are universal; proposing a feminine spirituality could fragment the unity of faith and of the evangelical message.

■ Foundation or criterion of discernment

It is established that, although the spiritual essence is universal, its manifestation is incarnate. The Church must first heal the most bleeding wounds, which in women are linked to trauma and to a double social condemnation. The pastoral judgment requires a pedagogy of proximity that recognizes the sacred ground of the feminine history in order to offer a response of integral health.

■ Thesis and argumentative development

- **Healing of the specific stigma:** Women suffer a greater disqualification by being judged for failing in their role as caregiver. Spiritual restoration returns to them their inalienable dignity, reminding them that their value does not depend on social expectations but on their identity as beloved daughters.
- **Activation of communal motherhood:** Women possess a unique creative potency for generating bonds. Fostering their protagonism through shared testimony allows their recovery to positively impact their entire family nucleus.

■ Response to the objections

- **To the first:** Although the ontological root is identical, the social and existential dimension of women is more wounded by systematic exclusion. Accompaniment must restore the subjective perception of that infinite value that gender stigma has attempted to erase.
- **To the second:** The universality of the gospel is enriched by inculturation. Jesus applied a differentiated pedagogy, lowering himself to touch the flesh of each person according to their specific need for consolation, which today translates into an artisanal accompaniment that respects the feminine identity.

7.8.2 Article 2: The Impact of the Double Condemnation on the Interiority and Self-esteem of the Mother-Woman

■ Statement of the topic

The mother-woman who goes through a substance use disorder faces a social pressure different from that of the man. While there is a certain tolerance toward the sick man, a censure is discharged upon the woman that labels her as a “bad mother.” It is necessary to judge how this double condemnation affects her interiority and her possibility of spiritual recovery.

■ Central question

How does the double social and moral condemnation affect the interiority and self-esteem of the mother-woman who uses substances?

■ Existing positions or objections

- **Objection 1:** The feeling of guilt is a necessary reaction to the failure to fulfill parental duties, functioning as a mechanism that should motivate change.
- **Objection 2:** The treatment of addictions must be identical for all genders, since the biological impact of substances on the brain is the same.

■ Foundation or criterion of discernment

Social disqualification destroys self-esteem from the base and generates a barrier to health. The love of God does not place labels, and the community must be the first space where the woman feels free from condemnation to begin her path of resurrection. The pastoral judgment must prioritize the unconditional welcome of life as it comes.

■ Thesis and argumentative development

- **Internalization of rejection:** The woman ends up believing the message of discard. By feeling “doubly sinful,” she blocks her openness to grace. The testimony of other women is vital for disarming this belief of unworthiness.

- **Sabotage born of guilt:** The pain of feeling that she has failed her children can lead her to use substances to anesthetize the anguish. Active listening allows processing this guilt, separating her value as a person from her past errors.

■ Response to the objections

- **To the first:** Guilt in women is usually experienced as a wound of contempt that paralyzes hope. Pastoral ministry must transform that burden into a desire for the future through mercy, allowing responsibility to be born from love and not from judgment.
- **To the second:** The social consequences for women are more punitive, such as the loss of custody. They require, therefore, an artisanal accompaniment that includes the repair of the maternal bond in an environment of safety and tenderness.

7.8.3 Article 3: The Restoration of the Image of God after Trauma through the Pedagogy of Tenderness

■ Statement of the topic

Accompaniment reveals that the history of women is usually marked by violence that damages the perception of one's own value. It is necessary to discern whether complex trauma alters the spiritual essence or whether it acts as a veil that hides the sacred identity. It is fundamental to judge how tenderness constitutes the necessary health tool for restoring the image of God in those who have been violated.

■ Central question

In what way does trauma disfigure the image of God in women and how is healing initiated through the pedagogy of tenderness?

■ Existing positions or objections

- **Objection 1:** Dignity is an indestructible gift; therefore, no violence can affect or disfigure the image of God in the soul.

- **Objection 2:** Complex trauma is a neurobiological phenomenon that must be treated only with clinical and pharmacological tools; appealing to tenderness lacks professional rigor.

■ Foundation or criterion of discernment

The wounds of life can overshadow dignity, making it difficult for the person to recognize their original value. The tenderness of Christ is a proximity that bends down to bandage wounds, allowing the person to feel sheltered in a love that demands no merits. The Church, as a field hospital, recognizes that God manifests himself especially in fragility.

■ Thesis and argumentative development

- **Tenderness as relational safety:** Healing begins when the environment offers an experience opposite to violence. Active listening mediated by tenderness allows the nervous system to move from alertness to safety, enabling the spirit to reconnect with God.
- **Restoration of the true self:** Artisanal accompaniment allows processing pain within a framework of unconditional love. Upon feeling valued, the woman moves from being a devitalized victim to being the protagonist of her history through testimony.

■ Response to the objections

- **To the first:** Although the root is indelible, trauma “overshadows” its operative manifestation. Spiritual healing removes the obstacles of shame and fear so that the light of the spirit may once again guide the subject’s life project.
- **To the second:** Scientific technique is a necessary mediation, but tenderness is the fertile soil where clinical work bears fruit. An approach that ignores the affective bond is insufficient to treat a wound that is a spiritual and relational missed encounter.

7.8.4 Article 4: Feminine Resilience as a Theological Force and Motor of Family Transformation

■ Statement of the topic

Resilience is usually categorized merely as a biological capacity for stress adaptation. However, it is fundamental to discern whether in women this force possesses a transcendent dimension that acts as a motor for the reconstruction of the relational system. The aim is to judge how the capacity to rise after helplessness becomes a potency that begets new life for the entire household.

■ Central question

In what way does feminine resilience become a theological force capable of transforming the reality of the entire family?

■ Existing positions or objections

- **Objection 1:** Health processes are strictly individual; to claim that the restoration of the woman involves the family is a burden that ignores the free will of others.
- **Objection 2:** Structural obstacles such as poverty are realities so heavy that the mere inner strength of the woman is insufficient without massive external intervention.

■ Foundation or criterion of discernment

It is recognized that women possess a unique creative potency for generating healing bonds. Upon recovering their value as a living image of God, the woman becomes the pillar that sustains her children, radiating the force of resurrection. Her strength is born not only from the will but from a mystique of proximity that is nourished by divine love.

■ Thesis and argumentative development

- **Creative potency of being:** The woman in recovery moves from being an object of assistance to being a protagonist. Upon discovering her dignity, she activates a creative process that allows her to dream of a future without substance use, serving as a light for her children.
- **Synergy of tenderness:** Resilience is fully activated in the community-family. Fraternal dialogue allows her inner strength to become an operative charity, transforming a broken history into hope for all her own.

■ Response to the objections

- **To the first:** The human being is constitutively relational; no one heals alone. Because the woman is usually the organizer of affects in the neighborhood, her spiritual stability generates safety in her children, facilitating the spiritual awakening of the entire system.
- **To the second:** Spiritual wisdom does not replace justice but is what humanizes the journey. By recognizing her infinite value, the woman activates her agency to demand rights, converting her fragility into the foundation of a worthy struggle for the life of her family.

7.9 | The Anchor of Community

The community acts as the indispensable anchor that sustains the spiritual dimension of the human being, especially in the face of the advance of consumer logics that seek to fill interior voids with immediate gratifications. This communal space is constitutive of the interiority of each person and of their process of integral health, under the premise that there is no isolated spirituality; rather, the testimony and the shared path with others are required to find one's own place in the world. By offering an environment of belonging, affection, and care, the organized community functions as the firm ground where the subject can strip away prejudices and disarm the failed responses that solitude attempted to impose. Ultimately, the community anchor ensures that the processes of change are not isolated attempts but a shared history that humanizes the journey and restores to the person their sacred value and their capacity to transcend.

7.9.1 Article 1: The Impossibility of a Spiritual Experience Isolated from the Community Fabric

■ Statement of the topic

In the analysis of the human spirit, the doubt often arises whether the spiritual experience can fully develop in the intimacy of consciousness. In contexts of extreme exclusion, where the individual has learned to survive alone, it is necessary to discern whether spirituality can be a purely internal refuge or whether the disconnection from others constitutes a fracture that impedes the integral health of the person who suffers from substance use disorder.

■ Central question

Is full spiritual experience possible without the mediation of the community fabric?

■ Existing positions or objections

- **Objection 1:** Spirituality is a process of deep reflection that the subject can carry out in the intimacy of their own consciousness, independently of their social environment.

- **Objection 2:** The encounter with the divine is a personal act of faith; if the relationship with God is intrinsic, it should not depend on external mediations.

■ Foundation or criterion of discernment

It is established that there is no spirituality without others. The human being is constitutively relational; there is no person without relationship. Others present testimonies of life that function as necessary mirrors for the subject to be able to pose their own response in the world. Those who refuse to share enclose themselves in an isolation that devitalizes the spirit.

Cf. Recovery Capital and its types (ch. 8)

■ Thesis and argumentative development

- **The person as being-in-relation:** Relationships are not an accident but a substantial element of human nature. To disconnect from the community is to disconnect from one's own essence. The community allows the spirit to recognize its natural home through genuine encounter.
- **Healing through the bond:** Given that addiction is fundamentally a missed encounter, the response is communion. The exchange allows improvement attempts to become shared history through active listening.

■ Response to the objections

- **To the first:** The meaning of life is only discovered by recognizing oneself as part of an interdependent whole. The human being does not suffice unto themselves; they require the neighbor to awaken their capacity for transcendence and not remain trapped in the egocentrism of substance use.
- **To the second:** The relationship with God is verified in the relationship with the brother. By discovering the face of the other in a fraternal dialogue, the subject becomes empowered to recognize God; isolation runs the risk of becoming a mysticism that does not sustain life in the face of crisis.

7.9.2 Article 2: The Mystique of “See How They Love One Another” as a Motor of Spiritual Awakening

Jn 13, 35 — *By this everyone will know that you are my disciples, if you have love for one another*

■ Statement of the topic

In accompaniment, the question arises whether the spiritual awakening requires an external sign that activates it. One must discern whether the observation of a community that lives reciprocal love possesses the necessary force to captivate the excluded brother, offering them a new horizon in the face of the desolation caused by isolation and substance use disorder.

■ Central question

In what way does the mystique of “see how they love one another” become the first motor of spiritual awakening for the weakened person?

■ Existing positions or objections

- **Objection 1:** Spiritual awakening is an internal and sovereign grace that does not depend on the observation of social behaviors of third parties.
- **Objection 2:** Only technical accompaniment produces measurable changes; focusing on the mystique of love could diminish the rigor of the integral health process.

■ Foundation or criterion of discernment

Spirituality is not an imposition but a dimension that must be awakened by others. Brothers and sisters function as necessary mirrors. For a person to understand the health process, it is imperative that the teams first live reciprocal love, recognizing that affection is the principal restorative agent.

■ Thesis and argumentative development

- **Testimony as the gateway:** Those who have lived under stigma usually have a closed heart. By observing a community that cares for itself without

distinctions, the brother experiences the relational safety necessary to lower their defenses.

- **Verification of faith in praxis:** For the excluded, abstract words carry no weight. Communal love is the practical translation of faith through patience and service, which generates trust for natural reconnection.

■ Response to the objections

- **To the first:** Although grace is a gift, God uses human mediations. The visibility of love among brothers and sisters is the sensible sign that allows the subject to believe in an unconditional love that previously seemed nonexistent to them due to the mistreatment received.
- **To the second:** Technique and spirituality are complementary. Professional rigor repairs physical health, but it requires the affective ground that fraternal dialogue provides for changes to be deep and sustainable through the testimony of life.

7.9.3 Article 3: The Church as a “Field Hospital” and the Primacy of Caring for Wounds

■ Statement of the topic

The conflict often arises between maintaining a normative order and attending to the pain of the person. There is a tendency to demand that the brother first conform to certain structures in order to be received. It is fundamental to judge whether the community should act as a field hospital that prioritizes the bandaging of wounds without imposing prior conditions that exclude the most weakened.

■ Central question

In what way does the Church as a “field hospital” prioritize the care of wounds before the demand for norms?

■ Existing positions or objections

- **Objection 1:** Postponing the demand for norms could be interpreted as a validation of disorder in the subject's life, weakening the moral mission of the Church.
- **Objection 2:** Without immediate norms and clear limits, the recovery process lacks the pedagogical efficacy necessary to reorder the will.

■ Foundation or criterion of discernment

The Church urgently needs to heal wounds and warm hearts. Mercy organizes the community to love before structuring. It is useless to ask a wounded person about their cholesterol if they have bleeding wounds; the wounds must be healed first. Life is received as it comes, recognizing chaos as a sacred place.

■ Thesis and argumentative development

- **Primacy of the person over order:** The field hospital does not wait for the wounded to be healthy in order to receive them. It allows the pain of the other to alter the schemas, recognizing that the affective bond is the first step of healing.
- **Non-specific accompaniment:** Love is not conditioned upon the success of a treatment. One "takes the initiative first" in proximity, offering the embrace and active listening before proposing behavioral changes.

■ Response to the objections

- **To the first:** Mercy does not deny truth; it incarnates it in the time of the other. By not reducing the person to their errors, their ontological dignity is protected, which is the necessary ground for the subject to desire to freely embrace the good.
- **To the second:** Discipline is necessary, but the most effective limit is tenderness. Forcing norms in desolation generates rejection; an environment of unconditional love allows change to arise from one's own will upon feeling valued.

7.9.4 Article 4: The Spiritual Value of “Street Outreach” in Seeking the Excluded

■ Statement of the topic

The **street outreach** is defined as the organized action of going out to find the life that suffers on street corners or under bridges. This practice challenges the traditional structure that waits for the faithful. It is necessary to discern whether this movement possesses a spiritual depth of its own or whether it is merely a social assistance strategy in the face of substance use disorder.

■ Central question

What is the spiritual value of street outreach as an action of a God who goes out to seek his children in the peripheries?

■ Existing positions or objections

- **Objection 1:** Spiritual life occurs primarily in the temple; the street is a profane space that distracts from deep meditation and prayer.
- **Objection 2:** Going out to the peripheries without prior solicitation can be seen as an intrusion that does not respect the privacy of subjects in their vulnerability.

■ Foundation or criterion of discernment

The Church going forth must “take the initiative first”, without fear. Street outreach allows learning the dynamic of the heart of God who goes out to seek his children time and again. By shortening distances, the community touches the suffering flesh of Christ, turning the periphery into a theological place.

■ Thesis and argumentative development

- **Imitation of the divine initiative:** The **street outreach** is a theological gesture where ideal conditions are not awaited in order to love. One

goes out to the encounter with life as it comes, reflecting the God who does not despise any kind of soil.

- **Mending of helplessness through proximity:** By “putting the body on the line” on the street, the word of the gospel becomes credible. The accompaniment on the corner generates the relational safety necessary for the excluded person to feel themselves part of the family once again.

■ Response to the objections

- **To the first:** Jesus himself was itinerant, and his presence sanctified the roads. Spirituality is built from the cross of Christ present in the fragilities of others, integrating the reality of suffering in the fraternal dialogue with the Father.
- **To the second:** The **street outreach** is inspired by the Good Shepherd. It is not intrusion but a mystique of proximity that seeks to tear down the walls of stigma and loneliness to offer the warmth of the community through active listening.

7.9.5 Article 5: The Construction of “Political Charity” and Advocacy in Structures of Justice

■ Statement of the topic

In accompaniment, it is not possible to limit action to isolated individual assistance. Suffering is the fruit of structures of exclusion that precede it. The need arises to discern whether community action should transcend the assistance sphere to enter the terrain of political advocacy, seeking to transform the logics that discard the most vulnerable.

■ Central question

How is **political charity** built by advocating in social structures that generate justice and dignity for the most broken?

■ Existing positions or objections

- **Objection 1:** The Christian mission is the salvation of souls; politics is a secular activity that can distort the religious identity of accompaniment.
- **Objection 2:** The urgency of helplessness requires immediate assistance responses; dedicating time to political advocacy seems like a distraction from the task of saving lives.

■ Foundation or criterion of discernment

Charity is the heart of the spirit of politics and is always a preferential love for the last. Caring for fragility means taking charge of the marginal present and endowing it with dignity. When social processes of fraternity and justice are generated, one enters the field of **political charity**, working for the civilization of love.

■ Thesis and argumentative development

- **From the territory to public policy:** **Political charity** is born from pastoral responses that prove to be effective in restoring dignity. One must demand that the system transform these into permanent care policies based on territorial testimony.
- **Dispute over meaning and language:** It involves establishing conceptual frameworks such as that of the “peer companion,” challenging the gaze that treats users as waste. The aim is for ontological dignity to be the pillar of alternative structures.

■ Response to the objections

- **To the first:** Faith and the defense of dignity are inseparable. **Political charity** is the social manifestation of the gospel; a commitment to the common good that reflects the love of God for the smallest in the structures of society.

- **To the second:** Although wounds must be healed immediately, limiting oneself to assistance without questioning the causes is inefficient. **Political charity** empowers the person to move from being an assisted person to being an active subject in a fraternal dialogue with their environment.

CHAPTER 8

The Psyche

The **psychological dimension** presents itself as a fundamental axis that transcends the stigma of diagnosis, defining **Substance Use Disorder (SUD)** not as a closed personality structure, but as a phenomenon that is added to the **singularity of each individual**. Through an integral and **biopsychosocial-spiritual** perspective, this section seeks to avoid reductionisms, recognizing that use is frequently a symptom of an **internal fracture**, abandonment or prior trauma that requires a deep approach beyond mere abstinence. To this end, contributions from various schools are integrated —such as **Cognitive-Behavioral Therapy**, **Gestalt** and **Logotherapy**— within the framework of the **Transtheoretical Model of Change**, which allows understanding motivation as a dynamic and not static process. Finally, **recovery is proposed as a process of continuous growth** and self-directed, where the strengthening of **self-efficacy** and community bonds allow the person to responsibly take on their own life project.

8.1 | Foundations of Mental Functioning and the Psychological Approach

This section establishes that Substance Use Disorder (SUD) does not constitute a diagnosis of structure or a closed personality, but rather is defined as a phenomenon that is added to the singular identity of each individual. The psychological approach starts from understanding the functioning of the central nervous system and the memory networks (adaptive and maladaptive), which automatically determine how the person assigns meaning to stimuli and responds to environments that, due to traumatic experiences, may be perceived as hostile or intolerable. By promoting the terminological transition toward the concept of «person first», the aim is to overcome stigma and recognize that use frequently functions as a self-therapeutic attempt or symptom of an «internal fracture», abandonment or deep pain that requires healing beyond mere abstinence. Under this perspective, psychology is integrated into a biopsychosocial-spiritual model that avoids reductionisms, restoring to the subject their role as the protagonist of a dynamic, intentional process of change oriented toward reaching their maximum human potential.

8.1.1 Article 1: On the psychological status of SUD and the foundation of the person

■ Statement of the topic

The definition of SUD often falls into the error of labeling the individual in a totalitarian manner, suggesting that addiction is their very essence. Faced with views that reduce the subject to their diagnosis or to a supposed «addictive personality», it is necessary to establish a psychological status that recognizes the distinction between the being and the affliction, placing the identity of the person above any transitory condition.

■ Central question

Is SUD a closed personality structure or a phenomenon that is added to the identity of a subject with inalienable dignity?

■ Existing positions or objections

- **Objection 1:** It seems that SUD is a diagnosis of a closed personality structure, given that the label of addict is usually used to define the totality of the individual's being.
- **Objection 2:** There is the belief in a pre-existing addictive personality, suggesting that the subject is born with a fixed psychic configuration that inevitably condemns them to use.
- **Objection 3:** It is claimed that if addiction causes permanent neuro-chemical changes, SUD would cease to be an added phenomenon and would become the new and sole biological and mental structure of the individual.

■ Foundation or criterion of discernment

The integral perspective holds that SUDs do not constitute a structural diagnosis, but rather a phenomenon that is added to the personality. This approach is based on the primacy of the Person First, understanding the human being as a unity of body, soul and spirit whose dignity is ontological and pre-existing to any symptom.

■ Thesis and argumentative development

It must be said that the person is an «individual substance of rational nature» whose essence cannot be absorbed by a disorder. The psychological status of SUD is defined under the following pillars:

1. **Ontological Dignity and Person First:** The human person possesses an inalienable dignity by being the image of God. SUD is a health condition or symptom, but does not define the core of the subject.
2. **The Biopsychosocial-spiritual Model:** The approach cannot be unilateral; the human being is recognized as an incarnate spirit where the biological, the psychological, the social and the spiritual interact systemically.
3. **The Internal Fracture as the Driver of Use:** SUD is frequently a symptom of a deep wound (trauma or abandonment) that the subject attempts to anesthetize. Use is, in origin, a self-therapeutic attempt to cope with a pain that has become intolerable.

Cf. art. 6 (Judge,
Very Brief Glossary)

4. **Singularity and Plasticity:** There is no single profile of a user. Thanks to neuroplasticity and community accompaniment, the subject can rebuild their life project, demonstrating that the personality is capable of transcending the disorder.

■ Response to the objections

- **To the first:** The use of totalitarian labels is a terminological error that feeds social stigma. The patient's health condition does not exhaust their humanity or their intrinsic value.
- **To the second:** Research has disproven the existence of an innate addictive personality structure; the observed traits are consequences of the process of use and not its original cause.
- **To the third:** Although chronic neurobiological changes exist, the person always subsists with the capacity for freedom and transcendence. Treatment seeks to restore the integral unity of the subject beyond mere abstinence.

8.1.2 Article 2: On neurobiological determinism and the signification of stimuli

■ Statement of the topic

The study of human behavior in the realm of substance use cannot be limited to the conscious will of the subject. It is necessary to understand that behavior is profoundly conditioned by the functioning of the central nervous system and by how it processes information from the environment. Responses to reality are not always deliberate, but rather often result from automatic mechanisms based on information previously stored in memory.

■ Central question

Do the processes of the central nervous system and memory networks determine the behavior and meaning that the person assigns to their reality?

■ Existing positions or objections

- **Objection 1:** It seems that human behavior depends solely on free will and conscious volition, so that neurobiological processes would be secondary in the response to a stimulus.
- **Objection 2:** It seems that external stimuli have an objective and equal meaning for everyone, suggesting that if a person over-reacts with anxiety or fear, this is due to a lack of character or moral weakness.

■ Foundation or criterion of discernment

The central nervous system is the organ responsible for processing information to ensure survival. Most responses to the environment are automatic and unconscious, being conditioned by information previously stored in memory networks.

■ Thesis and argumentative development

It must be said that mental functioning operates as a processing system where the signification of stimuli is not a purely rational act, but rather the result of the interaction between the nervous system and memory networks. This process is explained through the following points:

1. Components of memory: Each fragment of information is stored in the brain through four inseparable elements: image, cognition (what one thinks about the event), emotion and physical sensation.
2. Adaptive memory networks: These are groups of processed memories that allow assigning adequate meanings to new stimuli, moderating negative emotions and strengthening self-esteem, providing flexibility to behavior.
3. Maladaptive memory networks: They store traumatic or negative experiences that were not correctly processed. When activated by a current stimulus, they trigger disproportionate emotional and physical responses, such as an elevated burden of anguish or anxiety.
4. Survival mechanisms: In the presence of an active maladaptive network, the brain detects a threat and activates the amygdala, dysregulating the autonomic nervous system through the release of cortisol and adrenaline. This forces automatic behaviors of fight, flight or collapse.

■ Response to the objections

- **To the first:** Although the human being possesses will, the processing of new information is carried out on the basis of information available in memory networks. If these networks are saturated with traumas, the capacity for choice is clouded by automatic responses aimed at subsistence, limiting the real freedom of the subject.
- **To the second:** The meaning of a stimulus is not universal. A person with an internal fracture or unresolved trauma will signify as threatening what for another is harmless. The use of substances usually appears here as a self-therapeutic attempt to anesthetize a life that, due to biological dysregulation, has become intolerable.

8.1.3 Article 3: On the terminological transition and the fight against stigma

■ Statement of the topic

Language is not a neutral instrument, but a constructor of social realities. In the realm of substance use, the use of totalitarian labels such as addict or drug addict functions as a symbolic barrier that reduces the complexity of a human being to their clinical affliction. This stigmatizing terminology facilitates active discrimination and obstructs people's access to fundamental rights and health services.

■ Central question

Why is the transition toward the concept of person first indispensable for dismantling stigma and ensuring the efficacy of accompaniment?

■ Existing positions or objections

- **Objection 1:** It seems that the term addict is the most adequate due to its clinical precision for describing dependence, and that changing words does not modify the reality of the disorder.
- **Objection 2:** It seems that focusing on language is a distraction from the urgent tasks of medical treatment, since labels facilitate technical communication among professionals.

- **Objection 3:** It is claimed that softening the language could weaken the individual responsibility of the subject over their acts, especially if these have had moral or legal consequences.

■ Foundation or criterion of discernment

Words have a decisive therapeutic and social weight. Stigma is not just a negative thought, but a discrimination that excludes. Therefore, the terminological transition seeks to recognize that the intrinsic value of the person is prior and superior to any diagnosis or circumstance.

■ Thesis and argumentative development

The adoption of humanizing terminology is an act of justice and a requirement for the success of the process of change, based on the following points:

1. Breaking the cycle of stigma: Pejorative language is internalized by the individual, generating a self-perception of shame that sabotages their recovery. By putting the person first, the rejection toward oneself is broken and the possibility of real change is enabled.
2. Strengthening of the bond and trust: The use of labels generates fear of humiliation, which leads people to hide their use and delay seeking help. Respectful language is the foundation of the field hospital where the user feels safe to begin their treatment.
3. Differentiation between being and behavior: While the term addict purports to define the essence of the subject, the expression person with substance use disorder allows visualizing a human being with strengths and values, whose medical condition is a symptom of an internal fracture and not their definitive identity.

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■ Response to the objections

- **To the first:** Terms like clean or dirty are not clinical, but moral. Technical precision must be at the service of integral health and not of social judgment that condemns the patient.
- **To the second:** Language is the vehicle of accompaniment. If technical communication is dehumanizing, the health system expels those who most need to be received.

- **To the third:** Effective responsibility only arises when the person previously feels recognized in their humanity. Pastoral correction is only possible after the establishment of a bond based on tenderness and respect for the dignity of the other.

8.1.4 Article 4: On the biopsychosocial-spiritual model and reductionisms

■ Statement of the topic

The complexity of the human being and of the phenomenon of addictions demands an approach that transcends partial views. When one attempts to explain substance use disorder from a single discipline, one runs the risk of fragmenting the person, ignoring essential dimensions that are determinant for their health and their sense of life. The challenge lies in sustaining an integrative perspective that recognizes the constant interaction between biology, psychology, the social environment and openness to transcendence.

■ Central question

Is the biopsychosocial-spiritual model the adequate way to address addiction in order to avoid fragmented views of the human being?

■ Existing positions or objections

- **Objection 1:** It seems that biologicism is sufficient, given that science defines addiction as a chronic brain disease, so that treatment should focus exclusively on detoxification and neurochemical balance.
- **Objection 2:** It seems that spiritualism is the only true path, holding that addiction is a disease of the soul and that prayer should replace technical or medical treatments.
- **Objection 3:** It seems that the problem is purely individual and centered on the will, suggesting that the social or family context is secondary to the personal decision to use.

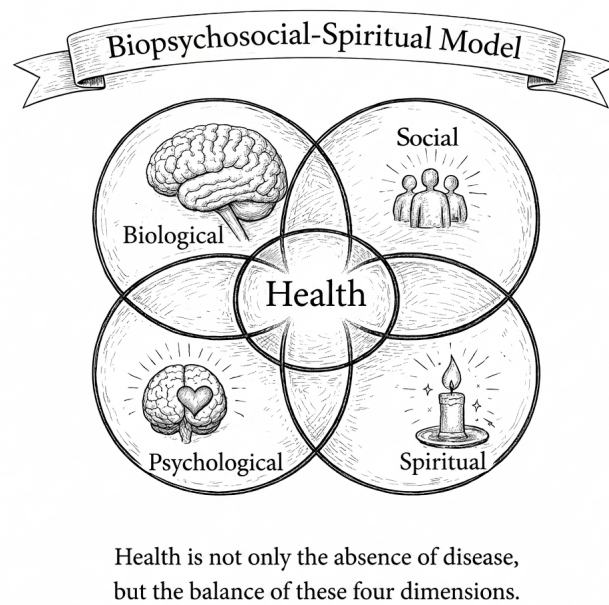


Figure 8.1: Bio-psycho-social-spiritual model

■ Foundation or criterion of discernment

The human being constitutes an inseparable unity of body, soul and spirit. Therefore, the response to afflictions cannot be unilateral, but must be organic and integral, since the pain of the one who suffers encompasses the totality of their life and their bonds.

■ Thesis and argumentative development

The application of this integral model functions as an antidote against the temptations that divide the person. This approach allows overcoming the four main reductionisms:

1. Overcoming biologicism: It recognizes that, although a real neurobiological basis exists, the human being is not merely an organism, but an incarnate spirit. Medical science is necessary but insufficient if it does not attend to the history and identity of the subject.
2. Overcoming spiritualism: It avoids the idea that prayer alone suffices, ignoring physical realities such as withdrawal syndrome or neurological damage. Spirituality acts in dialogue with the health sciences, giving meaning to recovery.

3. Overcoming individualism: It understands that the person is constitutively relational. Pathology often reflects fractures in primary bonds or in the social fabric, which is why change requires a community of belonging.
4. Overcoming collectivism: While recognizing that social determinants such as poverty and exclusion are fundamental, the model reminds us that care must be individualized for each concrete person.

■ Response to the objections

- **To the first:** The brain is the affected organ, but the person is the one who suffers. Reducing treatment to the biological ignores the driver and their destination; technique must illuminate, but not cloud the integral understanding of the being.
- **To the second:** Grace acts upon human nature. Ignoring medical or psychological means under a pretext of faith is a form of fideism that denatures the mission of healing the human being in their totality.
- **To the third:** No subject is born determined, but human freedom is conditioned by traumas or hostile environments. Community accompaniment is what allows that freedom to be truly liberated from its conditionings.

8.1.5 Article 5: On Trinitarian/Pauline anthropology and the psychology of emotions

■ Statement of the topic

The understanding of emotions in the realm of addictions tends to oscillate between biological determinism and a purely spiritualist view. However, to understand the suffering of those who have a substance use disorder, it is necessary to resort to an integral vision that recognizes the unity of the human being. Emotions and passions are not isolated events, but manifestations of a person who seeks, sometimes erratically, balance and meaning in all their dimensions.

■ Central question

In what way does the unity of body, soul and spirit illuminate the understanding of emotions and passions in the person with a substance use disorder?

■ Existing positions or objections

- **Objection 1:** It seems that emotions and passions are purely biological phenomena, the exclusive result of electrical impulses and neurotransmitters, so they would not require an anthropological or spiritual explanation.
- **Objection 2:** It seems that the disordered passions of the user are exclusively problems of the spirit that must be treated only through sacramental life, ignoring the psychological structure of the soul.

■ Foundation or criterion of discernment

The human being is an inseparable unity and their anthropology is unitary: an incarnate spirit where what affects one dimension necessarily impacts the others. This structure allows addressing emotional pain without fragmenting the subject.

■ Thesis and argumentative development

Trinitarian and Pauline anthropology offers a three-dimensional structure that allows a deep understanding of emotions through the following foundations:

1. The distinction of faculties: It is recognized that the soul is the seat of psychological life where emotions and feelings reside. While the spirit enables the relationship with the transcendent and the body the relationship with the physical world, the soul functions as the space of mediation where suffering is processed and can become an internal fracture or trauma.
2. Trinitarian relationality: Being created in the image of the Trinity, the person is constitutively relational. Emotions are not isolated internal states, but are generated in the encounter with the other. In addition, emotional disconnection usually manifests as a disconnection from this relational essence.
3. Systemic unity of the passions: Due to the condition of incarnate spirit, a biological stimulus such as the substance floods the pleasure centers of the body, but directly impacts the soul, altering the capacity to desire and choose freely. Passions are movements of an integral person who seeks a sense of transcendence.

■ Response to the objections

- **To the first:** Although emotions have a biological correlate, this constitutes only the matter of the emotion. Its meaning belongs to the rational soul that integrates the history and identity of the subject. Reducing them to biology ignores that, although the brain is the organ, it is the person who loves and suffers.
- **To the second:** Treating addictions only as a spiritual void ignores that grace acts upon human nature. To heal the spirit, it is often indispensable to first heal the psychological wounds of the soul, such as traumatic emotions, and stabilize the equilibrium of the body. The healing of the broken Christ must occur in the totality of His Trinitarian unity.

8.1.6 Article 6: On the nature of the relationship between the subject and substances

■ Statement of the topic

The study of the bond between the individual and psychoactive substances (PAS) requires transcending reductionist views that equate any use with pathology. This interaction is not an isolated event, but rather manifests as a dynamic spectrum of bonds defined by intentionality, frequency and the real impact on the autonomy of the person. The relationship is mediated by a complex interaction between the pharmacology of the substance, the psychic structure of the individual and the sociocultural environment.

■ Central question

Why is it fundamental to understand the specific nature of the bond that a person establishes with PAS in order to guarantee an integral and humanizing accompaniment?

■ Existing positions or objections

- **Objection 1:** It seems that any contact with a psychoactive substance must be automatically classified as a pathology or addiction, regardless of the intention or context of the subject.

- **Objection 2:** It seems that the relationship is determined exclusively by the pharmacology of the substance, assuming that the chemical component possesses an intrinsic power that immediately annuls the will of the person who uses it.
- **Objection 3:** It seems that the type of relationship with use depends solely on a moral decision or willpower, ignoring contextual factors or the prior psychic pain of the individual.

■ Foundation or criterion of discernment

The interpretation of any episode of use requires the analysis of the Zinberg Triad, which establishes that the biopsychosocial experience is determined by three interconnected vectors: the Subject, the Substance and the Context. Without the analysis of these three elements, any diagnosis is insufficient and dehumanizing.

Cf. art. 7 (Judge, Very Brief Glossary)

■ Thesis and argumentative development

It must be said that the subject-substance relationship is a multicausal phenomenon where use usually fulfills a specific function within the internal organization of the individual. This bond is articulated under the following principles:

1. **The Continuum of Use:** The relationship is not a binary state, but a spectrum that includes instrumental use (the substance as a tool for a specific purpose), recreational or social use (under the control of group norms) and harmful use or dependence, characterized by neuroadaptation and the loss of decision-making capacity.
2. **The Self-Medication Hypothesis:** The choice of a substance usually responds to an attempt by the subject to regulate painful affective states or compensate for deficits in their psychic structure. The drug acts here as a substitute for absent psychological functions.
3. **Use as an Identity Marker:** The use of PAS can be integrated into the habitus of the subject, functioning as a symbol of distinction or group belonging. In contexts of high vulnerability, it can even be a response to structural violence.
4. **Cultural Regulatory Frameworks:** Culture provides a scaffolding of social controls through rituals and sanctions that dictate the acceptability of use.

The transition toward a profane-modern use without these frameworks significantly increases the risk of abuse.

■ Response to the objections

- **To the first:** It is imperative to distinguish between use and pathology according to the impact on autonomy. The severity does not reside in the substance itself, but in the clinical and social deterioration that the bond generates in the person.
- **To the second:** Although pharmacology is a real vector, the signification of the stimulus depends on the history and emotional state of the Subject and the norms of the Context. The substance does not act upon a passive organism, but upon a person with a singular identity.
- **To the third:** The approach must focus on strengthening the psychic structure and modifying contextual variables. True recovery is not based on mere prohibition, but on the strengthening of cultural bonds and the integral life project of the individual.

8.1.7 Article 7: On the importance of cultural contexts in substance use

■ Statement of the topic

The use of psychoactive substances (PAS) does not occur in an aseptic vacuum, but is deeply rooted in a web of social and cultural significations. The environment, or setting, is not simply a physical space, but a network of rituals, norms and values that condition the experience of the subject. Ignoring these variables leads to decontextualized interventions that fail to understand why a practice of use is sustained or becomes problematic in a specific community.

■ Central question

In what way does the cultural and social context determine a person's relationship with substances, and why is its analysis indispensable for an integral approach?

■ Existing positions or objections

- **Objection 1:** It seems that context is a secondary factor, since addiction is fundamentally a chronic neurobiological disease that affects the reward circuits regardless of the individual's culture.
- **Objection 2:** It seems that focusing on the social environment is a form of collectivism that dilutes individual responsibility, offering the subject an excuse based on their circumstances of poverty or exclusion.
- **Objection 3:** It is claimed that prevention strategies should be universal and standardized, assuming that the same technical program will be equally effective in diverse environments, whether a large city or a rural community.

■ Foundation or criterion of discernment

The experience of use is the result of a systemic interaction between three vectors: the Subject, the Substance and the Context. Culture functions as a scaffolding of social controls that dictates the acceptability or rejection of certain behaviors through rituals and sanctions that represent the value judgments of the group.

■ Thesis and argumentative development

The analysis of the cultural context allows understanding that use is a situated phenomenon that requires a reading of the following dimensions:

1. **Ritualization vs. Profane Use:** Historically, cultures integrated the use of substances within sacramental frameworks that limited their abuse. In modernity, the transition toward profane use without traditional regulatory frameworks has increased the risk of compulsive use.
2. **Use as an Identity Marker:** The use of PAS often integrates into the habitus of the subject, functioning as a symbol of distinction or of belonging and group cohesion. In many sectors, using constitutes a requirement to avoid being excluded from the immediate social fabric.
3. **Response to Structural Violence:** In contexts of high vulnerability, use can be an adaptive response to structural violence and the lack of access to basic rights. The substance acts here as a resource to anesthetize a reality perceived as intolerable.

4. Cultural Recovery Capital: The efficacy of a process of change depends on recovery options incorporating the values, practices and worldview of the community with which the subject identifies.

■ Response to the objections

- **To the first:** Although neurobiology is a real vector, the brain processes information and assigns meanings based on information stored in the environment. An environment that normalizes use triggers automatic responses that pharmacology alone cannot modify.
- **To the second:** Recognizing social determinants does not annul freedom, but rather allows understanding the pressures that condition it. The objective is to strengthen the internal resources of the subject while modifying the environmental variables that suffocate their capacity for choice.
- **To the third:** Standardization ignores the singularity of peoples; the most successful programs are those that validate territorial and community knowledge, adapting professional technique to local wisdom.

8.1.8 Article 8: On the elements to consider when evaluating PAS use

■ Statement of the topic

The evaluation of psychoactive substance (PAS) use must transcend the mere identification of the substance or frequency of use to constitute an integral perspective on the person. It is not a static act of labeling, but a dynamic process that seeks to understand the specific function that use fulfills in the psychic and social economy of the individual. A humanizing evaluation avoids reducing the subject to a diagnosis, recognizing that the phenomenon of use is added to a singular and pre-existing identity.

■ Central question

What fundamental elements must integrate an integral and humanizing evaluation of PAS use in order to transcend the merely clinical and punitive approach?

■ Existing positions or objections

- **Objection 1:** It seems that the evaluation should focus exclusively on the pharmacology of the substance (type, quantity and purity), since these would be the objective factors that determine the severity of the harm.
- **Objection 2:** It seems that the only relevant criterion is the binary distinction between dependence and non-dependence, ignoring the risks associated with uses that do not present neuroadaptation but do have a strong social or physical impact.
- **Objection 3:** It seems that evaluation is a technical act reserved for an expert who observes from outside, where the user is a passive object of study and not a protagonist of their own process.

■ Foundation or criterion of discernment

The evaluation is grounded in the analysis of the Zinberg Triad, which establishes that the experience of use is the result of the interaction between the Subject, the Substance and the Context. This systemic criterion, framed within the biopsychosocial-spiritual model, prevents isolated interpretations of the drug and requires considering the life history and environment as inseparable components of the phenomenon.

■ Thesis and argumentative development

A complete evaluation of the subject-substance relationship must consider the following fundamental pillars:

1. Functional analysis and intentionality: It is necessary to identify whether use has an experimental, recreational, instrumental character or whether it responds to a self-medication hypothesis. In the latter case, use functions as a symptom of an internal fracture or prior trauma that the person attempts to anesthetize.
2. Placement on the continuum of use: It must be determined at what point on the spectrum the bond is located, evaluating the degree to which autonomy and decision-making capacity have been deteriorated by neuroadaptation.

3. State of memory networks: Evaluate whether use is triggered by maladaptive memory networks that store traumatic experiences. This allows understanding use as an automatic response to an environment perceived as hostile or intolerable.
4. Identification of recovery capital: The evaluation does not only look at the deficit, but at available resources: personal capital (health, skills), family/social capital (support networks) and community/cultural capital (sense of belonging).
5. Cultural signification of the act: Analyze whether use is mediated by community rituals or whether it has become a profane-modern and solitary use, where the loss of the social regulatory framework increases vulnerability.

■ Response to the objections

- **To the first:** Although the substance is a real vector, its effect depends on how the Subject assigns meaning to the stimulus according to their history. Focusing solely on chemistry is a reductionism that ignores that the brain is the organ, but the person is the one who loves and suffers.
- **To the second:** The evaluation must contemplate harmful use even before clinical dependence exists. Ignoring the risks of dysregulated use prevents effective prevention and the strengthening of self-efficacy.
- **To the third:** Effective accompaniment must be based on active listening and hospitality, recognizing that the person is an expert in their own life. An evaluation that does not validate the word of the subject blocks recovery by generating a rejection toward oneself.

8.2 | Trauma, Personality Structures and Dual Pathology

This section addresses the deep relationship between the traumatic history of the individual and the development of addictive behaviors, understanding that substance use frequently functions as a self-therapeutic attempt to anesthetize a pain derived from an internal fracture or early helplessness. It delves into the clinical distinction between psychotic, neurotic and borderline personality structures, analyzing how the degree of consolidation of the subject and the robustness of their memory networks determine their capacity to process reality without resorting to mechanisms of evasion or disconnection. The core of the analysis resides in dual pathology, defined as the coexistence of underlying mental disorders with problematic substance use, which demands a specialized approach that does not limit itself to treating the symptoms of use, but seeks the healing of deep traumas and the stabilization of the dysregulated nervous system. Finally, an intervention model is proposed that transcends the merely pathologizing, centering the response on the establishment of a community of secure attachment and a therapeutic culture that allows the gradual integration of the personality and the restoration of the person's dignity.

8.2.1 Article 1: On the manifest nature of the problem of addictions

■ Statement of the topic

The problem of substance use presents itself today as an undeniable reality that generates immense suffering in individuals, families and communities. Far from being an isolated or static phenomenon, it manifests as a crisis that cuts across all layers of society, demanding a perspective that does not remain on the surface of the substance, but recognizes the human pain that underlies use. The Church and social organizations face the challenge of responding to a scourge that acts in an expansive and devastating manner.

■ Central question

Is substance use a manifest problem that requires an urgent and integral response from the Church and society?

■ Existing positions or objections

- **Objection 1:** It seems that the problem is not so serious or manifest, because many types of use are socially normalized and are considered part of the culture of well-being or recreation.
- **Objection 2:** It seems that addiction is a problem that only concerns the most vulnerable or dispossessed sectors, so it would not constitute a universal challenge for the entire ecclesial community.
- **Objection 3:** It is claimed that the real problem is drug trafficking and that, therefore, the solution must be strictly legal and policing, leaving pastoral or educational intervention in the background.

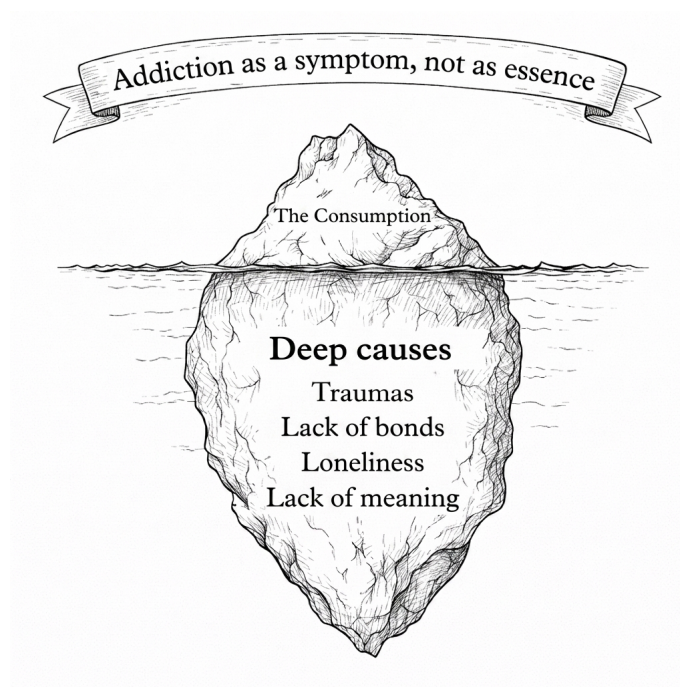


Figure 8.2: Use as a symptom

■ Foundation or criterion of discernment

The problem of addictions is comparable to an oil stain that invades everything, without recognizing geographic or human boundaries. It attacks all social sectors equally, which prevents the community from remaining indifferent to a reality that compromises the integrity of the person and the life of the youngest.

■ Thesis and argumentative development

The problem of substance use disorders is a growing and multicausal reality that requires an immediate response based on the following points:

1. Global growth and new substances: The phenomenon expands with the annual appearance of hundreds of new psychoactive substances, whose effects are usually unknown to the user, increasing the risk of irreversible harm.
2. Impact on integral health: Use contributes significantly to the global burden of disease and premature mortality. It is not only about dependence, but about being a vector of transmission for severe pathologies and a factor of chronic physical and mental deterioration.
3. A crisis of persons before substances: Beyond the chemical composition of the drug, the manifest problem resides in persons devastated by exclusion, lack of meaning or deep pain. The subject resorts to the substance as a means of escaping a hopeless reality.
4. Social cost and culture of death: The phenomenon generates a form of dependence that reduces productivity and the joy of living, imposing a logic of discard that especially affects the youth.

■ Response to the objections

- **To the first:** The normalization of legal or functional substances is a symptom of a society that often denies the illness until the deterioration is absolute. Apparent well-being conceals a dependence that erodes the freedom of the individual.
- **To the second:** Although sectors with fewer resources suffer more due to the lack of support networks, addiction is a transversal pandemic that strikes all social classes without distinction.
- **To the third:** The punitive approach focused solely on supply has proven to be insufficient. The real problem manifests in the demand, which can only be addressed through prevention, education in values and human accompaniment of the person in their singularity.

8.2.2 Article 2: On the clinical distinction of personality structures and dual pathology

■ Statement of the topic

For a deep approach to human suffering, it is not enough to observe the behavior of use; it is imperative to understand on what psychic foundation that behavior rests. The distinction between the different personality structures, as proposed by the structural psychodynamic tradition, allows identifying the degree of fragility or solidity with which a subject processes their reality and their bonds. Understanding addiction as a symptom of a prior mental organization helps design accompaniment strategies that do not only seek abstinence, but the integration of a personality that is fractured.

■ Central question

Is there a clear clinical distinction between psychotic, neurotic and borderline structures, and in what way do they condition the appearance of dual pathology?

Cf. art. 8.2
(Judge, The Psy-
che, Trauma...)

■ Existing positions or objections

- **Objection 1:** It seems that it is not necessary to make clinical distinctions between personality structures, since substance use disorder should be treated as a uniform condition that affects the reward circuits of the brain equally in all subjects.
- **Objection 2:** It seems that focusing on underlying diagnoses diverts attention from the main problem, which is the individual's will to abandon use and their commitment to a moral or spiritual path.

■ Foundation or criterion of discernment

Cf. Dual pathol-
ogy (ch. 9, bio-
logical dimension)

The degree of subjective constitution and personality development are fundamental criteria for understanding that addiction is not the problem itself, but the symptom of an internal fracture. The intervention must be proportional to the fragility of the structure upon which use is mounted.

■ Thesis and argumentative development

It must be said that the distinction between personality structures depends on the level of consolidation that the subject achieved in relation to their experiences and their primary environment. Three major organizations are distinguished:

1. **Psychotic structure:** It is the most fragile, frequently originating in hostile environments or deficient primary bonds that prevented the integration of adaptive memory networks. In the face of crises, these subjects use mechanisms of dissociation and disconnection, which produces an alteration of reality testing and the appearance of hallucinations or delusions.
 2. **Neurotic structure:** It presents greater solidity, having usually had sufficiently good primary bonds that installed sensations of calm. Their reality testing remains preserved and their defensive mechanisms do not completely separate them from the surrounding world.
 3. **Borderline structure:** It is located on the border between the previous ones. It is characterized by a notable impulsivity and loss of contact with reality during moments of decompensation, without reaching total psychotic fragmentation but without achieving neurotic integration.
- **Warning:** This distinction into three organizations comes from the structural psychodynamic model, a clinical tradition of wide dissemination in Latin America that has demonstrated particular utility for understanding the relationship between personality fragility and vulnerability to use. It is necessary to note that other classificatory frameworks organize personality disorders differently. The DSM-5 uses a system of discrete diagnostic categories (borderline disorder, antisocial disorder, etc.) that is not organized according to levels of structural integration. The ICD-11, in effect since 2022, has adopted a dimensional model that evaluates the severity of personality disorder on a continuum (mild, moderate, severe) along with predominant traits, moving significantly away from the categorical approach. This manual opts for the structural perspective because it allows the companion to quickly grasp the degree of fragility of the brother or sister before them and adjust the intensity and type of support offered, which proves operationally more useful in the territory than a classification by isolated diagnostic categories. Nevertheless,

teams working with professionals trained in other frameworks will find that the three organizations described here can dialogue with those systems without contradiction: what the structural model calls psychotic fragility corresponds, in general terms, to the severe severity levels of the ICD-11; the neurotic structure to the mild levels; and the borderline to the moderate ones.

Dual pathology is the coexistence of this underlying condition with problematic use. In these situations, the substance fulfills a function of psychic survival, acting as an anesthetic against a life perceived as a constant threat due to unprocessed traumas.

† Pastoral Discernment

In cases of dual pathology, psychiatric intervention and adequate medication frequently constitute a necessary condition for the accompaniment process to be sustained. A person with a decompensated psychotic structure or with a severe depressive episode cannot participate in a therapeutic group, elaborate their history in a listening space, nor sustain a spiritual experience if their nervous system has not reached a minimum threshold of stabilization. Psychiatric medication prescribed and supervised by a professional is not a contradiction with the integral model that this manual proposes; it is part of it. Just as article 8.1.4 warns that treating addictions only with prayer while ignoring biology is a form of reductionist spiritualism, it is equally necessary to warn that rejecting legitimate medication under the argument that “one drug is being replaced with another” is a form of ignorance that can cost lives. Medication does not heal on its own — the manual has been clear that bond, community and meaning are indispensable — but in many cases it creates the minimum biological conditions for the person to be available for the healing encounter that the community offers. Pastoral teams that accompany persons with dual pathology must coordinate with the territory’s mental health services to ensure that the pharmacological dimension of treatment is not neglected due to lack of access, institutional stigma or a mistaken conception of what integral recovery means.

■ Response to the objections

- **To the first:** Although neurobiology is real, an approach that only looks at the substance is inefficient. Stable recovery depends on healing the non-integrated interior and compensating the underlying condition that motivates the flight behavior.
- **To the second:** Addiction is not a mere question of will. In the most fragile structures, use is a survival tool against unbearable pain. Therefore, the response must be a therapeutic culture that offers secure attachment so that the personality can achieve a greater degree of integration.

8.2.3 Article 3: On the implementation of Trauma-Informed Treatment

■ Statement of the topic

The vast majority of persons who present substance use disorders have gone through histories of complex trauma, neglect or abuse in childhood that have marked their maladaptive memory networks. Trauma-informed treatment proposes a paradigm shift: the aim is not solely to treat the superficial addictive behavior, but to address and heal the subjective wound that sustains it, understanding that use is the language of a pain that has not been able to be named in any other way.

■ Central question

How should Trauma-Informed Treatment be implemented, recognizing that emotional pain usually precedes addiction?

■ Existing positions or objections

- **Objection 1:** It seems that treatment should focus exclusively on abstinence and the neurobiological repair of the brain, considering that investigating the past or emotional pains is secondary to the urgency of stopping use.
- **Objection 2:** It seems that focusing on trauma could victimize the subject, diminishing their individual responsibility over their process of change and allowing them to justify their present behavior as an inevitable consequence of prior pain.

■ Foundation or criterion of discernment

Cf. The restoration of the image of God after trauma (ch. 7)

Addiction is frequently a symptom of an internal fracture or a self-therapeutic attempt to alleviate a life that has become intolerable due to traumatic experiences. Therefore, any approach that ignores the primary distress that precedes use will be inefficient in achieving integral healing.

■ Thesis and argumentative development

It must be said that Trauma-Informed Treatment does not seek only to treat behavior, but to heal the wound that sustains it. This approach recognizes that real recovery occurs when the dysregulated nervous system is stabilized and accumulated suffering is processed. The implementation of this model is based on the following pillars:

1. Priority of safety: Treatment must guarantee a physically and emotionally safe environment to avoid revictimization. The entire team must be trained to identify triggers or emotional warning signs that activate negative memory networks.
2. Sensitivity and tenderness: It is necessary to abandon moralizing language in favor of one of closeness and hospitality. Accompaniment must be a humanization of the journey where listening is the first step so that the subject can symbolize their pain.
3. Focus on resilience: Instead of focusing only on the deficit or on what the person has lost, work is done on recovery capital, identifying the strengths and resources that the subject possesses to rebuild their life project.
4. Interdisciplinary integration: It is necessary to coordinate medical, psychological and spiritual care to address the existential crack where addiction took root. The community bond is the factor that truly allows integrating the fractured personality.

■ Response to the objections

- **To the first:** Although detoxification is necessary, science demonstrates that chronic stress from trauma alters the brain's reward circuits. If the primary distress is not treated, the brain will continue seeking the substance as the only known path of escape and relief.

- **To the second:** The focus on trauma does not annul responsibility, but empowers it. By understanding that their use was a failed survival mechanism, the person can stop identifying with the stigma and begin to see themselves as a worthy subject capable of choosing a different future.

8.3 | The Process of Change and Motivational Dynamics

This section addresses recovery as a dynamic process of continuous growth, in which the objective transcends mere abstinence to focus on the improvement of integral functioning and the pursuit of the person's maximum potential. Through the Transtheoretical Model of Change, it is understood that motivation is not a static trait, but an intentional and changing state that flows under internal and external influences, traversing specific stages: precontemplation, contemplation, preparation, action, maintenance and termination. This approach allows recognizing that the path toward healing is not linear, integrating relapse not as a definitive failure, but as an opportunity for learning and re-entry into the cycle of change. Finally, the importance of identifying and strengthening recovery capital is highlighted—the set of personal, family, social and cultural resources—as the necessary support for the individual to assume with autonomy a full, dignified and sustainable life project.

8.3.1 Article 1: On the stages of the process of change and their needs

■ Statement of the topic

Recovery in addictions should not be understood as a sudden event based solely on an act of will, but as a process of continuous and dynamic growth. Motivation for change is not a fixed personality trait, but an intentional state that fluctuates. Therefore, it is necessary to have a map that allows identifying at what subjective moment the person is in order to offer support appropriate to their specific needs. Among the various frameworks proposed by psychology for understanding this process, the Transtheoretical Model of Change constitutes one of the most influential and widespread tools in the field of addictions. This manual adopts it as the main organizational reference, recognizing both its pedagogical value and the limitations that subsequent research has pointed out.

■ Central question

Is the process of change in addictions a linear and static path, or does it consist of dynamic stages with specific support needs?

■ Existing positions or objections

- **Objection 1:** It seems that motivation for change is static. Under this view, a person either possesses or does not possess motivation, and if they do not have it, the companion has little ability to influence their decision, with the lack of will being the exclusive responsibility of the individual.
- **Objection 2:** It seems that relapse is a definitive failure. According to this logic, if a person returns to using, they have lost all prior progress and should be considered as someone who abandoned their commitment to change.
- **Objection 3:** It seems that the process of change always follows a sequence of ordered and predictable stages, which would suggest that all recovery follows a linear itinerary from precontemplation to termination, and that those who do not traverse these stages in the predicted order would be outside the model.

■ Foundation or criterion of discernment

Change is a dynamic process in which people traverse predictable stages at different paces, moving forward and backward according to their level of intentional motivation. The intervention must be artisanal and adjusted to the moment the subject is going through.

■ Thesis and argumentative development

Recovery is a cycle of learning where the Transtheoretical Model identifies six stages with particular characteristics and support needs:

1. **Precontemplation:** The individual has no intention of changing and often underestimates the problem. The support need lies in generating trust and increasing awareness of risks without exerting pressure.
2. **Contemplation:** The person recognizes the problem but experiences ambivalence. They require help to resolve that duality between wanting and not wanting to change, strengthening confidence in their ability to achieve it.
3. **Preparation:** There is an intention to act soon and small steps have been taken. Support should focus on choosing appropriate change strategies and negotiating a concrete plan.

4. **Action:** The subject actively modifies their behavior. It is the moment of greatest risk, where constant affirmation of achievements and learning of skills to manage abstinence are needed.
 5. **Maintenance:** Achievements are consolidated to prevent recurrence. Support is oriented toward developing new lifestyles, healthy friendships and goals that replace the role of the substance.
 6. **Termination:** Change has been fully integrated for more than two years and temptation has disappeared. The person no longer acts out of vigilance, but from a recovered freedom.
- **Scope and limitations of the model.** The Transtheoretical Model was originally developed for the study of smoking cessation, and its generalization to other substances and behavioral addictions has been the subject of discussion in the scientific literature. Subsequent reviews have questioned whether the stages are as discrete and sequential as the original model proposes; clinical and territorial experience confirms that many people oscillate between stages, skip them or traverse them simultaneously. Likewise, the model does not adequately integrate the dimension of abrupt or conversive change—what some authors call quantum change (*quantum change*)—in which an intense experience (an encounter, a crisis, a spiritual event) precipitates a profound transformation that does not follow the gradual logic of the stages. This dimension is particularly relevant for a pastoral ministry that recognizes the possibility of conversion and of the transformative encounter with Christ as a motor of radical change. The model is offered, therefore, as an orientation tool that helps the companion to situate the brother or sister in their process, but not as a mandatory itinerary nor as the only legitimate way of understanding recovery.

■ Response to the objections

- **To the first:** Motivation is dynamic and purposeful. The role of the companion is not passive; their task is to help the user understand their own doubts and goals in order to tip the balance toward change.
- **To the second:** Relapse or recurrence is an event that triggers a new cycle and must be seen as an opportunity for pedagogical learning. The person who relapses needs an evaluation to resume the process and repair trust in themselves, not a condemnation that excludes them.

- **To the third:** The model is a map, not the territory. The reality of human change is more fluid and less predictable than any schema of stages. Pastoral experience demonstrates that some brothers and sisters traverse the stages in a non-linear fashion, that others experience abrupt transformations that do not fit the predicted sequence, and that the singularity of each life process exceeds all classification. The value of the model lies in offering the companion a shared language to identify needs and adjust their response, not in prescribing a single path.

8.3.2 Article 2: On the stage of termination

■ Statement of the topic

In addiction treatment models, the horizon of arrival is often omitted, keeping the subject in a state of permanent alert. However, for an anthropology that seeks the maximum potential of the person, it is indispensable to define a state of total integration where change ceases to be a conscious effort and becomes a new nature. The stage of termination represents the culmination of the process where freedom is fully recovered and the individual transcends their prior identity as a patient.

■ Central question

Is it necessary to include the stage of termination after maintenance, and how is this state of integration of change defined?

■ Existing positions or objections

- **Objection 1:** It seems that it is not necessary to include a stage of termination, given that substance use disorders are defined as a chronic and recurring disease, which would oblige the individual to remain in a state of perpetual vigilance throughout their entire life.
- **Objection 2:** It seems that the maintenance stage is sufficient, since it consists of consolidating achievements and preventing relapses continuously; adding a stage of termination is redundant and could generate a false sense of security in the user.
- **Objection 3:** It is claimed that recovery is a process of management throughout one's entire life, so establishing an endpoint contradicts the nature of continuous human growth and the dynamism of the psyche.

■ Foundation or criterion of discernment

It is fundamental to contemplate the stage of termination in order to validate the capacity of the human being to transcend the disorder and achieve a self-directed life. In this phase, change has been integrated to such a degree that the temptation to return to the previous behavior has lost its power of determination over the subject's conduct, coexisting with a recovered freedom and a serene vigilance that does not distress but protects, allowing the person to cease being a recipient of services and become a full protagonist in their community.

■ Thesis and argumentative development

The inclusion of the stage of termination is necessary to account for the fullness of human development and is grounded in the following points:

1. Validation of therapeutic success: It prevents the person from remaining trapped in an eternal identity of sick person or dependent person, which contradicts the objective of reaching maximum potential and recognizing that ontological dignity is superior to any pathology.
2. Differentiation from the struggle: While maintenance requires a conscious effort and continuous vigilance against risk situations, termination marks the passage toward a state where freedom is no longer experienced as a constant struggle against the impulse, but as a stable disposition of the heart that, without denying the constitutive fragility of the human condition, allows the subject to inhabit their life from a life project and not from urgency. Healthy behavior is no longer an external imposition or a tense self-control, but a natural choice.
3. Criteria for total integration: It is defined by a temporality of at least two years of uninterrupted healthy behavior, the total absence of ambivalence toward use and full self-efficacy. The subject no longer uses to alleviate distress, but has constructed a lifestyle with purpose that replaces the dynamic of use.

■ Response to the objections

- **To the first:** Although neuroadaptation is a persistent biological datum, the spiritual and psychological dimensions allow the person to replace

learned habits with new healthy repertoires that become spontaneous. Termination celebrates recovered freedom in the face of clinical history.

- **To the second:** The redundancy is apparent. Maintenance is a state of alertness to risk, while termination is the state where the recovery plan has evolved into a transcendent sense of life in which the drug is no longer a response option to stress or pain.
- **To the third:** While human growth is perpetual, the specific change with respect to addictive behavior does have a point of satisfactory resolution. The objective of accompaniment is for the individual to recover their total autonomy and reintegrate as an active and healthy member of the human family.

8.3.3 Article 3: On the nature of motivation for change

■ Statement of the topic

Motivation is the fundamental motor of the recovery process, but it is often misunderstood as a resource that the individual possesses or does not possess permanently. For effective accompaniment, it is necessary to understand that the will to change is not a static personality trait, but a living force that fluctuates and is influenced by the interaction between the internal world of the subject and their social environment.

■ Central question

Is motivation for change distinguished by being a static state or, on the contrary, is it a dynamic and intentional process influenced by various factors?

■ Existing positions or objections

- **Objection 1:** It seems that motivation is static, understood as a personality trait. Under this view, if a user is not motivated, the companion has few possibilities to influence and the lack of progress is the exclusive responsibility of the individual.
- **Objection 2:** It seems that motivation is unilateral, centered solely on the desire to quit the substance. Therefore, if a person continues using, it is assumed that there is no motivation whatsoever for change.

- **Objection 3:** It is claimed that if addiction affects pleasure centers, motivation would be a simple biochemical reflex and not an intentional or psychological process.

■ Foundation or criterion of discernment

Motivation is not a fixed trait, but a dynamic state that can fluctuate over time and according to situations. It moves between contradictory goals and varies in intensity as the person resolves their doubts and ambivalences.

■ Thesis and argumentative development

It must be said that motivation is a dynamic, intentional and changing process. It recognizes that the individual can oscillate between the desire to recover and the impulse to use, being affected by two groups of influences:

1. Internal influences: These include emotional states (where hope increases motivation), life goals (the desire to work or form a family) and cognitive perceptions about the risks and benefits of current behavior.
2. External influences: These refer to social bonds (family and friends who support or undermine the effort), critical events (such as an arrest or the birth of a child) and community support that offers resources to sustain the decision.
3. The resolution of ambivalence: Dynamic motivation understands that it is normal to feel two personalities in conflict. The process of change advances as the subject manages to tip the balance toward their higher life values.

■ Response to the objections

- **To the first:** By understanding motivation as something dynamic, the role of the companion ceases to be passive. Their task consists of helping the person resolve their ambivalence, facilitating that the desire for positive change prevails through active listening.
- **To the second:** Motivation can vary drastically between different behaviors. A user may be highly motivated to improve their physical health but have low motivation to abandon a specific substance; accompaniment

must respect this singularity to work on what the subject is willing to change.

- **To the third:** Although biological processes condition behavior, the human being possesses a spiritual and volitional dimension that allows them to transcend their impulses. Treatment seeks to strengthen the life project so that the rational part regains command over the urgency of use.

8.3.4 Article 4: On the nature of relapse and its pedagogical value

■ Statement of the topic

In the approach to addictions, the breaking of abstinence is usually interpreted under a logic of failure or moral guilt. However, for an integral perspective, it is necessary to understand that the process of change is not a linear or predictable path. Recurrence of use does not nullify prior progress, but rather constitutes a critical event that, if managed adequately, allows deepening the knowledge of the subject's vulnerabilities and strengthening their recovery strategy.

Lk 22, 31-34.61-62 —
*I have prayed for you,
 that your faith may
 not fail. And when
 you have turned
 back, strengthen your
 brothers... And he
 went outside and
 wept bitterly*

■ Central question

Should relapse be interpreted as a definitive failure of the process or as an opportunity for learning and re-entry into the cycle of change?

■ Existing positions or objections

- **Objection 1:** It seems that relapse is a definitive failure, since if the objective is abstinence and it is broken, the prior effort is considered useless and the person would have lost everything gained.
- **Objection 2:** It seems that relapse demonstrates a lack of real will, suggesting that the user has returned to a stage of absolute denial of the problem.
- **Objection 3:** It is claimed that relapse justifies the interruption of accompaniment or institutional expulsion, under the premise that the subject is not ready for the process.

■ Foundation or criterion of discernment

Cf. art. 9.3.4 (recovery trajectories from the biological perspective)

Relapse or recurrence is an expected event within the nature of chronic health disorders. Far from being the end of the road, it is the event that triggers a new cycle of change, offering vital information that was not previously available to the subject or their support network.

■ Thesis and argumentative development

Relapse must be interpreted as a dynamic turning point and a pedagogical opportunity, based on the following pillars:

1. Depathologization and health management: Since substance use disorder is a recurring condition, relapse is equated to crises in other chronic illnesses. This allows shifting the focus from moral guilt toward responsible management of integral health.
2. Relapse as a teacher of the process: Recurrence reveals triggering factors (places, people or emotions) and maladaptive memory networks that had not been detected. It allows evaluating which coping strategies were ineffective and which must be reinforced.
3. Differentiation between abstinence and recovery: Recovery is a broad process of improvement of well-being. A person may have a setback in abstinence but maintain their commitment to their life project, using the crisis to repair trust in their capacity for change.
4. Conscious re-entry into the cycle: The person who relapses does not return to the starting point of their original ignorance. The prior process leaves a degree of awareness and tools that facilitate a faster and more grounded resumption of the therapeutic process.

■ Response to the objections

- **To the first:** Relapse does not nullify progress; it is an event within a continuum of improvement. Accompaniment must sustain the life of the other especially in the fall, recognizing that the dignity of the subject is superior to their symptom.
- **To the second:** Ambivalence is a normal part of the process of change. The return to use does not mean abandonment of goals, but rather that

the subject faced an environmental or internal pressure that exceeded their current resources.

- **To the third:** The community must function as a field hospital that heals the wounds of relapse. Institutional abandonment only increases desolation; the response must be to offer a safe place to start again, strengthening the bond instead of cutting it.

8.3.5 Article 5: On the traps of motivational interviewing in accompaniment

■ Statement of the topic

Effective accompaniment must be person-centered and respond to their needs, avoiding moralization, arguments and a threatening attitude. These obstacles create barriers in communication and provoke misunderstandings that block the will to change. Motivational interviewing is a fundamental tool for resolving the ambivalence of the subject, but its success depends on the companion's ability to identify and avoid certain dynamics that can break the therapeutic alliance.

■ Central question

Are there traps or obstacles in motivational dialogue that companions must avoid so as not to block the bond or the user's will to change?

■ Existing positions or objections

- **Objection 1:** It seems that the companion should be direct and confrontational so that the person breaks their denial, so that pointing out errors and moral faults is necessary for the user to become aware of their reality.
- **Objection 2:** It seems that, due to the state of disorganization of the person who uses, the companion should give clear orders and act as a supervisor to establish the necessary order in their life.
- **Objection 3:** It seems that the best way to obtain information is through a constant interrogation of questions and answers, ensuring that no detail of the use history remains hidden.

■ Foundation or criterion of discernment

Accompaniment must be based on hospitality and active listening, recognizing that the person is an expert in their own life. Imposing an external truth or a hierarchical authority annuls the autonomy of the subject and reinforces the stigma that prevents integral healing.

■ Thesis and argumentative development

To maintain a bond of trust that facilitates change, it is necessary to avoid the following traps identified in motivational dialogue:

1. The interrogation trap (Question-Answer): It occurs when the companion exclusively uses closed questions, placing the user in a passive role and the companion in an expert role, which prevents the person from exploring their own internal motives.
2. The moralization and judgment trap: By qualifying behavior as bad or vicious, a social rejection is generated that is internalized, producing shame and guilt. These feelings paralyze recovery and lead the subject to hide their use out of fear of humiliation.
3. The expert or authority trap: Acting with academic arrogance or giving orders suffocates the freedom of the other. The bond must be face to face, remembering that the companion is a guide alongside and not a supervisor.
4. The reactivity and argument trap: Trying to defeat the user with logical arguments generates emotional reactivity. If the companion becomes defensive or judgmental, the speaker stops sharing vital information for their process.
5. The excessive interpretation trap: Trying to assign complex meanings or diagnostic labels before the user can symbolize their own pain usually leads to closed conclusions that ignore the singularity of the being.

■ Response to the objections

- **To the first:** Although limits are necessary, the healthiest limit is tenderness and understanding. Confrontation must be careful and based on the reality of the bond, not on a condemnatory judgment that only increases resistance to change.

- **To the second:** The companion accompanies, does not command. The objective is to move from a heteronomous will, dictated by others, to a progressive autonomy where the subject assumes responsibility for their choices.
- **To the third:** Interrogation saturates and distances the subject. Active listening should be prioritized through paraphrasing and reflection of feelings, which allows the person's story to emerge and the bond of trust to be strengthened.

8.4 | Contributions of the Schools of Psychology

This section integrates the contributions of various schools of psychology under an Integrated Intervention Model, recognizing that the complexity of the human being and of addictions requires a multiplicity of approaches and techniques rather than a single response. Through Behavioral Psychology, use is understood as a learned behavior capable of being unlearned through new healthy repertoires, while Cognitive-Behavioral Therapy offers tools to identify and alter irrational thought patterns and impulses. For its part, Gestalt Psychotherapy contributes a holistic perspective centered on the here and now so that the individual assumes responsibility for their actions, complemented by Logotherapy, which focuses on the search for meaning and transcendence in the face of existential void. Likewise, the Systemic Approach reorients intervention toward the family as a key piece for a sustainable solution, and Psychoanalysis allows deepening the understanding of the subject and their symptom. Finally, third-generation therapies—among which Dialectical Behavior Therapy, Acceptance and Commitment Therapy and mindfulness-based approaches stand out—contribute a complementary dimension by proposing that recovery does not consist solely in modifying or eliminating suffering, but in transforming the relationship that the person establishes with their own pain, learning to inhabit it without it governing their decisions. This set of tools allows accompaniment to rely on scientific evidence to help each person heal their wounds and reach their maximum human potential.

8.4.1 Article 1. On the contribution of behavioral psychology

■ Statement of the topic

Within the integrated intervention model, behavioral psychology contributes a pragmatic vision to the recovery process. This approach proposes that substance use is not a random event, but a behavior that the individual has learned through their interaction with the environment, family practices and the surrounding culture. If use is a behavior modeled by social learning, recovery consists of the systematic design of new experiences that allow the subject to acquire healthier habits.

■ Central question

Can addiction be understood as a learned behavior that can be unlearned through new healthy repertoires?

■ Existing positions or objections

- **Objection 1:** It seems that addiction is not a learned behavior, but a physiological brain disease that, by involving permanent chemical changes, cannot be unlearned through behavioral training.
- **Objection 2:** It seems that the user's behavior depends on their willpower and that use is a moral weakness that is not resolved with new repertoires or external learning.
- **Objection 3:** It is claimed that if the person presents mental disorders or dissocial traits, their behavior is a fixed structure and not a habit that can be modified by social learning.

■ Foundation or criterion of discernment

From the perspective of social learning, substance use is a behavior that people incorporated from society. Therefore, to achieve a sustainable change, it is necessary to systematically teach alternative behaviors that reduce suffering and promote autonomy.

■ Thesis and argumentative development

It must be said that behavioral psychology offers an optimistic path for recovery under the premise that if we learn to use drugs, we can also learn to quit them. This contribution is developed under the following points:

1. Substitution of repertoires: Recovery transcends mere abstinence to focus on the development of activities that cause less harm. This includes joining new peer groups, practicing sports, learning trades and integrating spirituality as a daily habit.
2. Training in specific skills: The approach proposes the teaching of concrete tools, such as refusal skills to learn to say no, time management techniques to avoid boredom and strategies to stop compulsive thinking.
3. The value of repetition and practice: It is recognized that mastering a new behavior requires time and effort. Constant practice allows the rational part of the brain to gradually recover control over automatic impulses, enabling the subject to learn even from their own mistakes.

■ Response to the objections

Cf. art. 6 (Judge,
Very Brief Glossary)

- **To the first:** Although real biological components exist, the act of using is modeled by the environment. New healthy habits can stimulate the same pleasure centers naturally, leveraging neuroplasticity to substitute chemical dependence with behavioral well-being.

- **To the second:** Instead of appealing to an abstract will, it is identified that the subject's discernment may be deteriorated by prior hostile learning. Accompaniment offers external aids to strengthen self-efficacy and the capacity for choice.

Cf. art. 8.2
(Judge, The Psy-
che, Trauma...)

- **To the third:** Substance use disorder is not a closed structure, but an added phenomenon. Even in cases of dual pathology, the establishment of clear norms and a therapeutic culture allows the individual to learn new ways of regulating their emotions and communicating with others.

8.4.2 Article 2: On the tools of CBT in the treatment of addictions

■ Statement of the topic

Cognitive-Behavioral Therapy (CBT) is based on the premise that thoughts, emotions and behaviors are interconnected. In the realm of substance use, this approach holds that irrational beliefs and automatic thoughts act as mediators that sustain addictive behavior. Therefore, recovery requires not only a change of habit, but systematic training to identify and modify the cognitive distortions that lead the individual to perceive themselves negatively or to react impulsively to environmental stimuli.

■ Central question

Are the tools of Cognitive-Behavioral Therapy effective for identifying and altering irrational thought patterns, automatic thoughts and impulses?

■ Existing positions or objections

- **Objection 1:** It seems that automatic thoughts and impulses cannot be altered through technique, as they are the result of chronic neurobiological changes that annul the subject's capacity for reasoning.

- **Objection 2:** It seems that focusing on cognitive processes is insufficient, since addiction is a disease of the soul that requires solely a spiritual conversion and not a technical analysis.
- **Objection 3:** It is claimed that the will is solely responsible for change, so that no thought-stopping technique will be able to prevent use if there is no prior moral commitment.

■ Foundation or criterion of discernment

The human being has the potential to think both rationally and irrationally. The beliefs that sustain addiction are learned and, therefore, can be modified through practice and the use of tools that allow the individual to recognize and reframe their mental patterns.

■ Thesis and argumentative development

It must be said that CBT offers a set of effective tools that allow the subject to regain command over their psychic life, with the following standing out:

1. Cognitive debate and reframing: It consists of identifying absolute irrational thoughts, such as negative self-definition based on the illness, in order to transform them into positive affirmations based on the reality of their strengths and their recovery potential.
2. Identification of totalitarian thoughts: The aim is to break the use of closed identity labels. It is taught that terms like patient or user describe a current state, but do not define the inalienable essence of the person.
3. Thought-stopping techniques: These include tools to interrupt the craving cycle, such as visualization (imagining an off switch), mild physical stimuli to redirect attention or deep breathing exercises to manage anxiety.
4. Urge Surfing: It proposes visualizing the desire to use as a wave that rises, reaches a peak and then fades, reinforcing the idea that impulses are transitory states and not orders that must be executed.
5. Strengthening of self-efficacy: Through the validation of small successes, the person is helped to rebuild the belief in their own ability to overcome doubts and sustain change.

■ Response to the objections

Cf. art. 6 (Judge,
Very Brief Glossary)

- **To the first:** Although neurobiological damage affects judgment, the repetition of new cognitive skills leverages neuroplasticity. This allows the rational part of the brain to gradually regain control over automatic impulses.
- **To the second:** Spirituality and science are complementary. CBT helps to heal secondary pain, such as guilt and shame, which often blocks spiritual growth and the capacity to feel worthy of love and mercy.
- **To the third:** The will is not a static trait, but a dynamic process. CBT techniques do not replace personal commitment, but provide concrete coping strategies for moments when motivation falters under internal or external pressure.

8.4.3 Article 3: On the contribution of Gestalt Psychotherapy and responsibility

■ Statement of the topic

Addictive behavior frequently functions as a form of affective evasion or dislocation from reality. For the recovery process to be effective, it is necessary for the subject to move from being a passive recipient of assistance to an active protagonist of their own life. Gestalt Psychotherapy contributes a holistic perspective that seeks to integrate the unity of the person, focusing on their capacity to perceive their real needs in the present moment in order to stop using the substance as a mechanism of flight.

■ Central question

Is the here and now approach and awareness-raising an effective tool for the individual to assume responsibility for their actions in the face of addiction?

■ Existing positions or objections

- **Objection 1:** It seems that the focus on the here and now is insufficient, given that addiction is deeply rooted in past traumas and childhood wounds that require historical analysis to achieve real responsibility.

- **Objection 2:** It seems that responsibility is an exclusive act of moral will and that, since addiction is a brain disease that affects self-control, the simple awareness of emotions is not enough to regain command of one's actions.

■ Foundation or criterion of discernment

Recovery requires increasing the capacity of people to attend to their present needs. Fostering responsibility for one's own actions empowers the individual, allowing them to recognize that they are not an object to be directed, but a subject with the capacity for choice.

■ Thesis and argumentative development

The Gestalt school contributes to healing by integrating the unity of the person through the present, based on the following pillars:

1. Awareness: It consists of fostering full awareness of thoughts, emotions and behaviors at the exact moment they occur. By identifying what they feel and what they need during an impulse, the individual breaks the automatic response of the addicted emotional part and allows the rational part to intervene.
2. Focus on the present: The here and now does not ignore the past, but addresses it as it manifests and affects the subject today. This prevents the person from using their prior history as an excuse for inaction, promoting a genuine lifestyle removed from avoidant patterns.
3. Taking responsibility and empowerment: By becoming aware of real needs such as hunger, loneliness or pain, the subject recovers the capacity to choose healthy alternatives instead of resorting to the substance to anesthetize their existence.

■ Response to the objections

- **To the first:** Although trauma occurred in the past, its wound bleeds in the present through maladaptive memory networks. The Gestalt approach allows processing that pain today, preventing the subject from continuing to flee from their own history through use.

- **To the second:** The will can only choose what reason presents to it as a good. Awareness allows the individual to identify strengths and potentialities that were previously hidden by stigma or guilt, making freedom cease to be a blind impulse and become a deliberate responsibility.

8.4.4 Article 4: On the contribution of Logotherapy in the reconstruction of meaning and transcendence

Mk 8, 36 — *What does it profit a man to gain the whole world and lose his soul?*

■ Statement of the topic

Logotherapy focuses on the spiritual dimension of the person, starting from the premise that the human being is motivated by a will to meaning. In the realm of addictions, use is frequently presented as an attempt to fill an existential crack or anesthetize a deep pain derived from the lack of purpose. This approach seeks for the individual to transcend their situation of affliction through the discovery of values that allow them to reconstruct their identity and their life project.

■ Central question

Does Logotherapy help reconstruct the sense of life, resilience and the capacity for transcendence in the face of existential void in persons with substance use disorders?

■ Existing positions or objections

- **Objection 1:** It seems that Logotherapy is secondary or unnecessary, since science defines addiction primarily as a chronic brain disease that requires biological and pharmacological interventions to manage neuroadaptation.
- **Objection 2:** It seems that existential void is a concept too abstract to be addressed while the person suffers from primary material needs, such as lack of shelter, food or physical health.
- **Objection 3:** It is claimed that recovery should be limited to measurable clinical objectives such as abstinence and harm reduction, making the search for transcendence irrelevant to the success of a standard treatment.

■ Foundation or criterion of discernment

Spirituality is the essence of the being that drives the person to seek meaning. Without this dimension, there is no integral rehabilitation, since only the encounter with a transcendent meaning offers the necessary criteria to order life and propose a project that fulfills the person in their totality.

■ Thesis and argumentative development

Logotherapy is fundamental for the psychological approach because it interprets addiction as a failed spiritual search. Its contribution is articulated in the following pillars:

1. **Overcoming existential void:** It identifies vital anguish as the space where use takes root to anesthetize an existence perceived as intolerable. Healing occurs when the subject manages to process their pain and discover a what for that endows their present with value.
2. **Fostering of resilience:** The capacity to rise from traumatic wounds is strengthened through the development of human capital, integrating values, hope and optimism. This allows the subject to face life's adversities without resorting to chemical evasion.
3. **Capacity for transcendence:** The human being possesses an intrinsic openness toward what is beyond themselves. Transcendence allows the individual to decenter from their own suffering to orient themselves toward love of neighbor and service, reconnecting them with God and with the community.

■ Response to the objections

- **To the first:** Although neuroscience explains the functioning of the brain, Logotherapy attends to the person who inhabits that body. Spiritual motivation is the indispensable motor that allows sustaining behavioral and biological changes in the long term.
- **To the second:** The human being is an inseparable unity. Attending to the physical without the spiritual leaves the subject in a state of defensive survival; the discovery of one's own dignity is what empowers the person to transform their material and social reality.

- **To the third:** Abstinence is necessary but insufficient. A humanizing treatment seeks for the subject to reach their maximum potential through a self-directed life, which is impossible without the capacity to transcend the compulsive impulse in favor of a higher value.

8.4.5 Article 5: On the circular causality of the systemic approach in the family

■ Statement of the topic

From systemic psychology, the family is understood as a living organism where all its members are interconnected and reciprocally influence one another. Substance use is not an isolated event of the individual, but rather often becomes the central axis around which family life is organized. For a solution to be sustainable in the long term, it is necessary to stop seeing the user as the sole component of the problem and understand the network of bonds that sustains or feeds the behavior.

■ Central question

Does the circular causality of the systemic approach allow understanding that the family organizes around the symptom and that its involvement is key to a long-term solution?

■ Existing positions or objections

- **Objection 1:** It seems that substance use is a problem of strictly individual responsibility, so that treatment should focus solely on the subject, with family participation being something secondary.
- **Objection 2:** It seems that the relationship between use and the family is explained through linear causality, where addiction is a simple effect caused by a biological cause and the family is only a passive victim.

■ Foundation or criterion of discernment

Substance use ends up being a functional symptom that plays a role within the family interaction. Therefore, integral recovery requires that the system collaborate and become involved in modifying its patterns of communication and coexistence. The community approach does not focus solely on the person who uses, but on deconstructing the relational dynamics that perpetuate the problem.

■ Thesis and argumentative development

The application of circular causality allows a deep approach based on the following principles:

1. **Use as a functional symptom and relational imbalance:** The disorder often reflects difficulties that fulfill a function within the family interaction, whether to balance, unite or emit an alarm in the system. By moving from the *why* to the *what for*, it is discovered that the family has learned to function around this symptom. This functioning is usually linked to **inadequate family boundaries** (diffuse or rigid) that hinder the development of autonomy, identity and emotional regulation, fostering risk behaviors in its members.
2. **The family as a carrier of the problem and patterns of authority:** Frequently, when the individual's symptoms remit, other latent conflicts appear in the other members. This demonstrates that the family is a carrier and generator of dysfunctional interactional patterns. Among these, **altered hierarchies** stand out, where reference figures do not adequately exercise their function of authority and parental guidance, and the existence of **dysfunctional coalitions** or inadequate alliances that generate profound emotional stress and keep the problem hidden under the veil of use.
3. **Maladaptation to crises and transgenerational repetition:** Problematic dynamics do not arise spontaneously; they usually intensify in the face of **difficulty adapting to changes in the life cycle** (family crises, separations, adolescence or role changes), where use appears as a disorganized form of coping. Likewise, these responses frequently respond to the **repetition of transgenerational patterns**, where adults unconsciously reproduce the patterns of unprotection and vulnerability learned in their own families of origin.
4. **Sustainability of the solution:** Lasting recovery requires changing the interactional patterns of the entire group. The family crisis thus presents itself as an opportunity to construct new strategies of difficulty resolution that prevent the system from becoming dysfunctional again, healing the relational fabric from its root.

■ Response to the objections

- **To the first:** Although the individual is responsible for their process, their identity develops in relation to others. The systemic approach does not annul responsibility, but integrates it into a mutual commitment to modify the functioning of the system (boundaries, hierarchies and communication) that conditions the subject.
- **To the second:** Linear causality is insufficient for complex problems. Circular causality explains that the behaviors of one feed the responses of others in a continuous cycle. Use is not a simple cause-effect, but a symptom sustained by relational feedback; intervening in the family structure allows breaking that cycle and finding a healthier organization.

8.4.6 Article 6: On the contribution of psychoanalysis to the understanding of SUD

■ Statement of the topic

Psychoanalysis contributes an essential depth to the psychological dimension by transcending the merely clinical to focus on the subject. Under this perspective, substance use disorder is not considered a closed personality structure, but a phenomenon that is added to the singular identity. Problematic use is not seen as the center of the problem, but as a self-therapeutic attempt to cope with a life that has become unbearable due to various circumstances.

■ Central question

Does psychoanalysis contribute to the understanding and resolution of the problem of addictions?

■ Existing positions or objections

- **Objection 1:** It seems that psychoanalysis is ineffective for addictions, since this field requires practical and immediate responses based on behavior modification, while psychoanalysis focuses on reflections about the unconscious.
- **Objection 2:** It seems that, since addiction is a brain disease explained by neurobiology, subjective introspection is irrelevant in the face of scientific data about dopamine and reward circuits.

- **Objection 3:** It is claimed that psychoanalysis, being non-directive, could delay the individual's adaptation to a healthy lifestyle and compliance with norms necessary for social reintegration.

■ Foundation or criterion of discernment

Substance use functions as the language of an internal fracture or a symbolic pain that the person has not been able to name. Therefore, the approach must allow the subject to move from being a passive recipient of assistance to being the protagonist of their own recovery, integrating their wounds into a life project with meaning.

■ Thesis and argumentative development

Psychoanalysis contributes to the resolution of the problem through the following foundations:

1. **Addiction as a symptom:** It teaches that use is a symptom and not the cause. By treating it in this way, the aim is to heal the underlying subjective wound, whether from trauma, abandonment or injustice, that motivates the behavior of flight and disconnection.
2. **Respect for singularity:** Facing the tendency to homogenize patients under labels, it defends that there is no single profile of a user. Each life trajectory is unique and requires an artisanal process of reconstruction of personal history.
3. **Enabling of speech:** The fundamental tool is deep and non-judgmental listening. By allowing the subject to express their fears and desires, it is facilitated that they assume responsibility for their own process of change.

■ Response to the objections

- **To the first:** While urgency requires brief interventions to stabilize the individual, if the subjective origin of the desolation is not addressed, any behavioral change will be fragile and prone to relapse.
- **To the second:** Neurobiology explains the functioning of the brain organ, but psychoanalysis attends to the person who inhabits that body.

Science alone cannot explain the meaning that an individual assigns to their own suffering.

- **To the third:** True autonomy is not achieved through the imposition of external norms, but through an internal organization born from the discovery of one's own value. Psychoanalysis prepares the ground so that freedom is real and not mere mechanical obedience.

8.4.7 Article 7: On the contribution of third-generation therapies: acceptance, regulation and commitment to values

■ Statement of the topic

The psychological schools presented in the previous articles share, to varying degrees, an orientation toward symptom modification: changing behavior, restructuring thought, resignifying history. However, clinical experience with highly complex populations —particularly with persons who present dual pathology, borderline personality structures or histories of chronic trauma— has demonstrated that the attempt to directly control or suppress painful emotions can prove counterproductive when the subject's capacity for regulation is severely compromised. The so-called third-generation therapies propose a shift: instead of fighting head-on against distress, they teach the person to modify the relationship they establish with their own suffering, developing the capacity to experience difficult emotions without these automatically determining behavior. Among these approaches, Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT) and mindfulness-based relapse prevention programs stand out.

Cf. art. 8.2
(Judge, The Psy-
che, Trauma...)

■ Central question

Do third-generation therapies contribute a therapeutic dimension distinct from that of the approaches already presented, and is this dimension relevant for the accompaniment of persons with substance use disorders in contexts of high vulnerability?

■ Existing positions or objections

- **Objection 1:** It seems that Cognitive-Behavioral Therapy already sufficiently covers the field, given that third-generation therapies are derivations or variants of CBT and do not contribute a qualitatively new paradigm for the approach to addictions.

- **Objection 2:** It seems that proposing acceptance of suffering instead of its elimination could be interpreted as a passive resignation that discourages the active struggle for recovery and contradicts the horizon of freedom that the manual promotes.
- **Objection 3:** It seems that mindfulness practices originate from Eastern contemplative traditions incompatible with the Christian spirituality that grounds this manual, which would make them tools alien to the proposed pastoral framework.

■ Foundation or criterion of discernment

Territorial experience confirms that many brothers and sisters, especially those with borderline structures or histories of complex trauma, cannot sustain change processes based exclusively on cognitive or behavioral control, because their emotional regulation system is severely damaged. Before being able to modify a behavior, these persons need to learn to tolerate the internal storm without resorting to the substance as their only survival resource. Third-generation therapies offer specific tools for this prior and indispensable task, complementing the contributions already developed without replacing them.

■ Thesis and argumentative development

We respond that third-generation therapies contribute a specific and complementary therapeutic dimension that is particularly necessary in the contexts of high complexity inhabited by this pastoral ministry. Their contribution is articulated in four axes:

1. **Dialectical Behavior Therapy and emotional regulation in dual pathology.** DBT was originally developed for persons with borderline personality disorder, a structure that the manual itself identifies as prevalent in the territories and that frequently coexists with substance use disorder. Its fundamental contribution is training in emotional regulation skills for subjects whose affective intensity overwhelms conventional strategies. DBT works on four modules: distress tolerance (learning to survive an emotional crisis without resorting to the substance or self-harm), emotional regulation (identifying, naming and modulating intense affective states), interpersonal effectiveness (sustaining bonds without falling into dependence or destructive conflict) and mindfulness (observing one's own internal states without reacting automatically). Its organizing principle

Cf. art. 8.2 (Judge, The Psyche, Trauma...)

is the dialectic between radical acceptance of what the person is today and the simultaneous impulse toward change, avoiding both complacency and excessive demand.

2. Acceptance and Commitment Therapy and value-oriented action.

ACT starts from the premise that psychological suffering is inevitable and that the attempt to avoid or suppress it usually amplifies it. In the context of addictions, this approach helps the subject identify that much of the use functions as a strategy of experiential avoidance: the substance is used to not feel what is intolerable. Instead of directly combating the painful emotion, ACT teaches the person to observe it, to create a functional distance from it and to choose their behavior not based on the immediate impulse but based on the values that give meaning to their life. The brother or sister learns that they can feel the craving and at the same time decide not to use, not because they have stopped suffering, but because their life project weighs more than their transitory distress.

3. Mindfulness-based relapse prevention. Programs that integrate contemplative mindfulness practices in relapse prevention train the subject in the capacity to observe their internal states —thoughts, emotions, bodily sensations, impulses to use— without identifying with them or reacting automatically. This training strengthens the function of the prefrontal cortex as a brake on impulses and allows the brother or sister in recovery to recognize the early signs of a possible relapse before the compulsive circuit is fully activated. The practice of mindfulness does not replace prayer or sacramental life; it operates in a different register, strengthening the psychological base upon which spiritual openness can unfold with greater depth.

4. The CRAFT model and working with families who have not yet accessed treatment. Complementarily, the Community Reinforcement and Family Training (CRAFT) model deserves specific mention for its relevance to pastoral ministry. This approach trains the family members of the person who uses —frequently mothers and wives— in concrete strategies to modify the relational dynamic so as to increase the probability that the person will accept help, without resorting to aggressive confrontation or passive enabling of use. CRAFT is coherent with the systemic approach developed in article 5 of this section and offers practical tools for the families that the pastoral ministry accompanies long before the brother or sister agrees to begin a formal process.

Cf. art. 3 (Judge, Substances and the organism, Definition..., Risks...)

■ Response to the objections

- **To the first:** While third-generation therapies share roots with the cognitive-behavioral tradition, their specific contribution is not a technical variation but a change of position in the face of suffering. Classical CBT seeks to modify the content of thoughts; third-generation therapies seek to modify the subject's relationship with their own thoughts and emotions. This difference is clinically decisive for populations with severe emotional dysregulation, where the direct attempt at cognitive control fails because the nervous system cannot sustain it. It is not about replacing CBT but about completing its reach.
- **To the second:** The acceptance proposed by these approaches is not resignation or passivity. It is the lucid recognition of an internal reality as a prior and indispensable step for acting with freedom. The dialectic of DBT expresses it clearly: I radically accept what I am today and, precisely because I accept it, I can work to transform it. This movement is analogous to what the Christian spiritual tradition describes when it speaks of the examination of conscience or Ignatian discernment: looking at the interior truth without fleeing from it in order to respond from freedom and not from compulsion.
- **To the third:** Mindfulness practices, as used in the contemporary clinical sphere, have been stripped of their Buddhist doctrinal content and are applied as attentional training techniques with neuroscientific support. The capacity to observe one's own interior movements without reacting automatically is not alien to the Christian tradition; it is, in fact, a disposition that masters of the spiritual life have cultivated for centuries under names such as *custodia cordis*, interior recollection or the prayer of quiet. Clinical mindfulness and Christian contemplation operate in different registers and should not be confused, but neither are they incompatible: the former strengthens the psychological capacity for interior observation that the latter needs as a human base to unfold.

8.5 | Recovery Capital, Family and Community

This section explores the concept of recovery capital as the sum of personal, human, family and social resources that strengthen a person's capacity to sustain a process of continuous change. It highlights that the family is not merely a passive environment, but a dynamic system that frequently organizes around the symptom and whose mutual commitment is key to lasting and sustainable healing. Likewise, the territorial community is presented as an essential health device, where closeness, presence and the affective bond allow overcoming the fragmentation of care and offer a framework of secure attachment for the restoration of dignity. By identifying and strengthening both internal resources —such as hope, self-efficacy and values— and external resources —support networks, faith and culture— this approach promotes an integral and relational recovery that returns to the subject their sense of belonging to a people and their maximum human potential.

8.5.1 Article 1: On Recovery Capital and its types

■ Statement of the topic

The recovery from a substance use disorder should not be understood solely as a heroic act of individual will, but as a process that requires an ecosystem of supports. The concept of recovery capital allows identifying the set of resources that a person has at their disposal to initiate and sustain change, shifting the perspective from what the subject has lost (the deficit) toward what they still retain or can develop (the strengths).

■ Central question

Is Recovery Capital a determinant factor for the success of the process of change and how are its resources classified?

■ Existing positions or objections

- **Objection 1:** It seems that the success of recovery depends exclusively on individual will and the decision to stop using, so that external resources or capitals would be secondary factors compared to personal effort.
- **Objection 2:** It seems that treatment should focus solely on the deficit or the illness —what is broken— and not on the strengths, making it irrelevant to speak of capital if the clinical diagnosis is severe.

■ Foundation or criterion of discernment

Recovery capital is the sum of personal and social resources that strengthen the individual's capacity and opportunities for recovery. It is a strengths-based tool that recognizes that healing is a process sustained by an ecosystem of integral supports.

■ Thesis and argumentative development

It must be said that recovery capital is a determinant factor that is classified into three fundamental types, allowing an intervention that strengthens the resilience of the subject:

1. **Personal Recovery Capital:** It is divided into physical capital, which includes basic material conditions such as health, safe housing, food and financial resources; and human capital, which comprises internal attributes such as values, self-esteem, self-efficacy, hope and life purpose.
2. **Family and Social Recovery Capital:** It encompasses intimate and family relationships willing to participate in the process, the presence of peers in recovery and connection with significant institutions such as religious organizations or places of study.
3. **Community and Cultural Recovery Capital:** Community capital involves local policies that reduce stigma and networks of resources such as 12-step groups; cultural capital includes recovery options that respect the values and worldview of the subject's community.

■ Response to the objections

- **To the first:** Although autonomy is essential, recovery is an intrinsically social and community process. Recovery capital provides the necessary sustenance for the decision to be sustainable; without housing or a support network, the risk of relapse increases drastically due to environmental pressure.
- **To the second:** Focusing only on the illness is a reductionist view that ignores the dignity of the subject. The recovery management model emphasizes resiliences—what remains of the image of God in the person—to mobilize the necessary energy toward the construction of a full life project.

8.5.2 Article 2: On the eight domains of recovery capital

■ Statement of the topic

The sustainability of the recovery process cannot depend on a single factor, but on the robustness of an ecosystem of resources surrounding the individual. Well-being in addictions is a multidimensional reality that spans from physical health and housing stability to the sense of transcendence. Identifying these domains allows moving from crisis management to recovery management, where the absence of resources (negative capital) is systematically addressed to prevent the environment from acting as a trigger for recurrence.

■ Central question

Do the eight domains of recovery capital have a determinant impact on the sustainability of well-being and the prevention of relapses?

■ Existing positions or objections

- **Objection 1:** It seems that well-being is a purely subjective state that depends on the individual's mood and not on external resources such as housing or employment.
- **Objection 2:** It seems that relapse prevention depends solely on medical treatment and biological abstinence, with social and cultural domains being secondary elements.
- **Objection 3:** It seems that if a person presents negative recovery capital due to a total lack of resources, recovery is impossible regardless of the accompaniment provided.

■ Foundation or criterion of discernment

Recovery is a process of integral change to improve health and well-being. While the presence of resources in various domains strengthens the process, their absence generates a vulnerability that hinders desired outcomes. The intervention must, therefore, concern itself with building and strengthening these capitals.

■ Thesis and argumentative development

The sustainability of well-being and relapse prevention are organized around eight domains of recovery capital, grouped in three fundamental axes:

1. **Stabilization of living conditions:** This includes the domains of physical and mental health, housing and environment, and resolution of legal problems. The lack of stable shelter or suffering from chronic illnesses immerses the person in an immediacy of survival that triggers the compulsive desire to use as anesthesia.
2. **Reconstruction of the relational fabric:** This encompasses family and social supports, peer-based support and community integration. Peer companions are experts by experience who demonstrate the possibility of change, while community integration returns to the subject their sense of belonging to a people, acting as an anchor against desolation.
3. **Development of human potential:** This comprises vocational and educational skills, along with meaning and life purpose. Rediscovering a what for allows filling the existential crack where addiction took root, transforming the desire for evasion into a dignified and productive life project.

■ Response to the objections

- **To the first:** Well-being is not just a feeling; it is the realization of maximum potential and the fulfillment of roles in the community. It requires objective conditions of health and safety to be sustained over time.
- **To the second:** Science demonstrates that if the environment (housing, bonds, culture) does not change, the neuroadapted brain will react to environmental stimuli by triggering automatic relapses. Social support is a clinical necessity.
- **To the third:** Recovery capital can be developed even if it never existed. The parish community and neighborhood centers act as generators of capital, providing the bonds and resources that other structures could not offer.

8.5.3 Article 3: On the role of foster families and community bonds

■ Statement of the topic

Many subjects who go through situations of problematic use and extreme vulnerability have grown up in functional orphanhood, where primary bonds are broken or nonexistent. In this scenario, accompaniment cannot be limited to the biological network, but must rely on the community as an alternative network of affection. Foster families and territorial bonds offer a safe place that allows covering basic needs and offers the embrace necessary for the person to project their life again.

■ Central question

Do foster families and community bonds fulfill a role as an active strategy of change for those who lack a biological network?

■ Existing positions or objections

- **Objection 1:** It seems that accompaniment should focus solely on the blood family, since it is the natural preventive nucleus, suggesting that without a biological network the individual is destined to fail.
- **Objection 2:** It seems that foster families are only a temporary assistance resource and not a real strategy of change, as they lack the legal or genetic bond to transform the identity of the subject.

■ Foundation or criterion of discernment

When the biological network is not present or is not favorable, we are the family. The community must constitute itself as a support network that accompanies from recognition and closeness, understanding that unconditional love is the motor that restores dignity.

■ Thesis and argumentative development

It must be said that community bonds and support families constitute an active strategy of change based on the following points:

1. Supplanting functional orphanhood: They offer a care environment where food and hygiene needs are met along with emotional support, allowing the person to leave the state of survival and begin to think about their future.
2. Repair of the relational model: Through community upbringing and figures of secure attachment (such as peer companions or neighborhood referents), the subject can unlearn models of violence and internalize trust in others.
3. Generation of Recovery Capital: These bonds act as nodes of a network that collects the broken fragments of the individual's history, providing the material and emotional sustenance so that they do not feel discarded by the system.
4. Progressive social inclusion: The community facilitates access to fundamental rights (health, identity, employment) that the State tends to fragment, humanizing a journey that would otherwise be bureaucratic and solitary.

■ Response to the objections

- **To the first:** Although the biological family is ideal, addictions are often illnesses of extreme isolation. In its absence, the ecclesial and neighborhood community must occupy that role to prevent the subject from being exposed to the solitude of the street and the risk of death.
- **To the second:** The community bond possesses an exceptional therapeutic strength. It does not seek to legally replace the family, but to offer a large family where belonging and mutual service allow the individual to move from being an assisted person to being an active and dignified member of society.

8.5.4 Article 4: On the management of the tension between professional knowledge and territorial knowledge

■ Statement of the topic

The integral response to addictions demands a balance between the scientific rigor of academia and the empirical wisdom of the territory. This interaction should not be seen as a competition of knowledges, but as a necessary convergence to address the complexity of human suffering. The integration of technical knowledge with the experience of those who have traversed the path of recovery allows constructing a response that not only treats the symptom, but shelters the person in their totality.

■ Central question

How should the tension between technical-professional knowledge and the experiential knowledge of peer companions be managed in multidisciplinary teams?

■ Existing positions or objections

- **Objection 1:** It seems that professional knowledge should prevail over territorial knowledge, since only specialists possess the academic training and scientific evidence necessary to treat complex health disorders.
- **Objection 2:** It seems that territorial knowledge is sufficient on its own, given that peer companions possess a legitimacy and empathy born of experience that academia cannot grant.

■ Foundation or criterion of discernment

True healing occurs when a framework of therapeutic culture based on the community bond is established. The ecclesial response incorporates technical specialization as an irreplaceable element, but transcends it by integrating it into a biopsychosocial-spiritual model where the center is the dignity of the person.

The efficacy of the peer companion is not explained solely by their experiential knowledge: it also resides in the fact that their very presence embodies what the psychology of *recovery* calls **recovery identity** —the concrete, visible and close possibility of being something else.

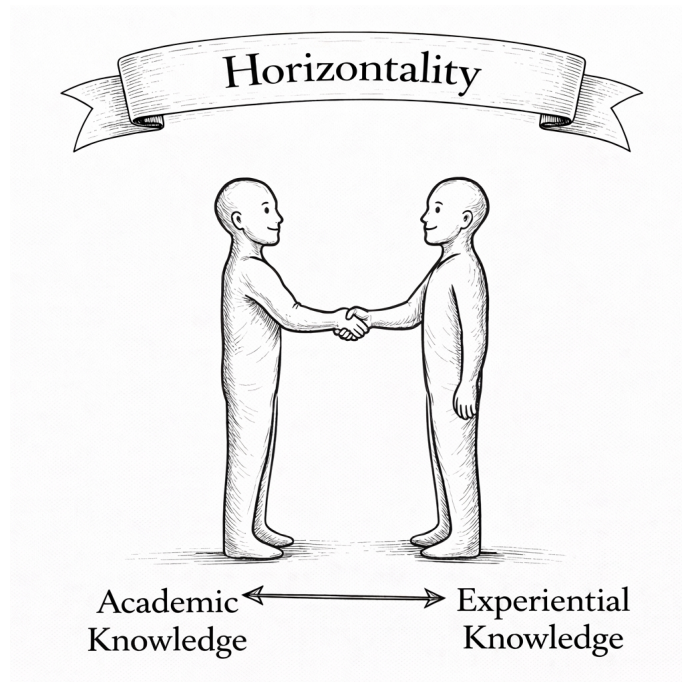


Figure 8.3: The horizontality and complementarity of knowledges

■ Thesis and argumentative development

The management of the tension between both knowledges is resolved through their harmonious integration under the following principles:

1. Recognition of complementary roles: The professional contributes the technique necessary to address dual pathologies or complex traumas, while the peer companion contributes the art of accompaniment and the capacity to reach the wound of the other from a place of equality.
2. Horizontal construction of the network: The team must function as a family, where the mystique of service breaks the hierarchy between helper and helped, valuing the specific contribution of each member.
3. Differentiation of accompaniment: A distinction is made between non-specific (territorial) accompaniment, which is transversal and humanizes the journey, and specific (professional) accompaniment, which attends to specific clinical, diagnostic or legal aspects.
4. Shared training: It is fundamental that the entire team participate in processes of mutual training where both science and popular wisdom are validated, allowing everyone to speak the same spiritual and technical language.

■ Response to the objections

- **To the first:** Professional technique runs the risk of being ineffective if applied in isolation. It only takes on meaning when the patient feels in an environment of secure attachment that territorial knowledge helps to build and sustain.
- **To the second:** Territorial knowledge can be overwhelmed by situations of high complexity, such as suicide risk or psychotic decompensations. Professionalization provides the team with critical tools and protects the caregiver from emotional exhaustion and compassion fatigue. What is required, in short, is a structured mercy that unites the firmness of the rule with the tenderness of the embrace.

8.6 | Singularity, Sex Differences and New Digital Challenges

This section delves into the singularity of the subject, starting from the premise that substance use disorder is a phenomenon that is added to the personality and not a closed structure that defines the identity. By recognizing that there is no single profile of the user, an artisanal approach is proposed that considers the specific needs of each stage of the life cycle, from childhood to late-onset use in older adults. The vulnerability of women is analyzed with rigor, as they face a double social condemnation—for using and for not fulfilling traditional roles of care—in addition to being more affected by complex trauma and relational abandonment. Likewise, the pastoral perspective integrates the travesti-trans population, understanding that in their trajectories identity, exclusion and use form a single fabric of survival in the face of systemic violence. Finally, the impact of new digital addictions is addressed, such as online gambling, video games and pornography, recognizing that these behaviors alter the brain's pleasure centers through mechanisms of impulsivity and compulsivity analogous to those of chemical substances.

8.6.1 Article 1: On the vulnerability and barriers of women in the process of change

■ Statement of the topic

The psychological vulnerability of women in the realm of substance use presents a unique complexity that significantly distinguishes it from that of men. This difference is not only biological, but is profoundly marked by the weight of chronic trauma, the overburden of caregiving roles and a specific social sanction that punishes women with greater severity. This reality hinders both initial access to health programs and permanence in the recovery process.

■ Central question

Does the psychological vulnerability of women differ from that of men, and what specific access barriers do they face in recovery?

■ Existing positions or objections

- **Objection 1:** It seems that substance use disorder affects men and women equally, since addiction is a brain disease that does not distinguish sex in its neurobiological mechanisms of reward and dependence.
- **Objection 2:** It seems that women have greater ease of access to treatment, given that society tends to be more protective of mothers and there are specific state programs designed for children and families.

■ Foundation or criterion of discernment

Women suffer a double social condemnation: for use itself and for not fulfilling the traditional role of mother or caregiver. This reality translates into a critical access gap, where statistics indicate that only one in eighteen women with problematic use accesses treatment, compared to one in seven men.

■ Thesis and argumentative development

It must be said that the vulnerability of women requires an approach with a gender perspective and sensitivity to trauma, based on the following pillars:

Cf. art. 9.4.3 (Judge, Substances and the Organism, Differences according to..., The physiological response...)

1. Telescoping effect : Women tend to progress more rapidly than men from first use to the development of a severe disorder and its medical consequences. This biopsychological progression demands early and specialized interventions.
2. Complex trauma as a precursor: The vast majority of women with addictions have experienced histories of chronic trauma, including physical, psychological violence or abuse. Use functions as a self-therapeutic attempt to anesthetize unresolved pains and deep emotional dysregulations.
3. Overburden of care and stigma: The cultural pressure to be the affective pillar of the home generates an internalization of social rejection. The fear of being judged as bad mothers produces a guilt and shame that paralyze the search for professional help.
4. Relational abandonment and structural barriers: Unlike men, who usually have the support of their partners or mothers, women are frequently abandoned by their partners when initiating treatment. Additionally, there is a shortage of centers that allow hospitalization with children, compounded by the threat of losing custody from the judicial system.

■ Response to the objections

- **To the first:** Although the brain reward mechanisms are analogous, metabolic factors and the context of gender-based violence make the impact more devastating and rapid in women. Ignoring the singularity of gender leads to ineffective treatments that do not accommodate the female subjective reality.
- **To the second:** The supposed institutional protection is usually punitive and bureaucratic rather than healing. The true solution requires trauma-responsive programs and figures of secure attachment that offer tenderness instead of moral judgments, guaranteeing that treatment does not force women to choose between their recovery and their motherhood.

8.6.2 Article 2: On the adaptation of the approach according to the life cycle

■ Statement of the topic

Recovery and prevention cannot be standardized processes that ignore the biography of the subject. Human development is a dynamic process where biological, psychological and environmental interactions change significantly over time. Therefore, accompaniment must be adjusted to the life trajectory of each person, recognizing that motivation, risk perception and neurological vulnerability vary drastically from childhood to old age.

■ Central question

Should the psychological and pastoral approach be adapted according to the person's stage in the life cycle, or is a standard model based on the substance sufficient?

■ Existing positions or objections

- **Objection 1:** It seems that the approach should focus primarily on the substance, since the neurochemical effects of the drug and diagnostic criteria are similar regardless of the individual's age.
- **Objection 2:** It seems that universal prevention programs in schools are sufficient to cover all early stages, minimizing the need for specific interventions for children or adolescents.

- **Objection 3:** It seems that use among older adults is a minor or nonexistent problem, so it is not considered necessary to develop specific strategies for those who have passed working age.

■ Foundation or criterion of discernment

There is no single profile of the user. The integral approach demands age-appropriate programs and risk dosing, understanding that each developmental stage presents unique challenges and potentialities for healing.

■ Thesis and argumentative development

The approach must be organized in an artisanal fashion according to the specific needs of each stage of the life cycle:

1. Childhood (6 to 11 years): The focus is placed on socialization and the development of basic skills such as impulse regulation and attention. Interventions should strengthen secure attachment and self-esteem, recognizing that early onset (8 or 9 years) prevents the healthy formation of neural networks.
2. Adolescence (12 to 17 years): It is the stage of greatest biological risk because the prefrontal cortex —the brain's brake— has not yet matured, while the reward system is highly sensitive. Work should focus on resistance to peer pressure, self-efficacy and the construction of an identity independent of the substance.
3. Adult Life: Treatment is oriented toward the recovery of social roles, labor inclusion, financial re-education and the reconstruction of family bonds damaged by years of use, seeking progressive autonomy.
4. Older Adults: It is fundamental to address late-onset use, frequently linked to retirement, loneliness or bereavement. Motivation for change at this stage is linked to the search for meaning in the face of the end of life and the management of slower metabolism of substances.

Cf. art. 3 (Judge, Substances and the organism, Definition..., Risks...)

■ Response to the objections

- **To the first:** Although the molecule is the same, the impact on a developing brain causes permanent cognitive deficiencies that do not occur in the same way in an adult, which demands differentiated pedagogical and clinical strategies.
- **To the second:** Universal prevention is necessary but insufficient for high-vulnerability groups, such as children of persons with substance use disorders, who require interventions that directly address trauma and emotional deprivation.
- **To the third:** Use in the elderly is a reality made invisible by stigma. Accompaniment must restore existential dignity to older adults, integrating them into the community so that they do not face their dependence in the solitude of social isolation.

8.6.3 Article 3: On the approach to digital addictions

■ Statement of the topic

The approach to so-called digital addictions—which include video games, online gambling and pornography—requires understanding the transition from impulse disorders to behavioral addictions. In these conditions, a dysfunction occurs in the brain's reward system where the release of dopamine reinforces compulsive habits in a manner analogous to what occurs with chemical substances. It is not simply a matter of excessive use of technology, but of an alteration in the capacity for regulation that compromises the subject's freedom in relation to the device.

Cf. art. 9.3.1 (Judge, Substances and the organism, Pharmacodynamics..., Art. 1...)

■ Central question

Should digital addictions be addressed under the same psychological criteria as substance addictions, considering that they activate similar brain circuits?

■ Existing positions or objections

- **Objection 1:** It seems that digital behaviors cannot be considered real addictions, since in them there is no intake of an external molecule into the organism that produces a verifiable neurobiological impact.

- **Objection 2:** It seems that these behaviors are simple problems of lack of discipline or impulsivity, especially in young people, and that they do not present a biological withdrawal syndrome like that of drugs.
- **Objection 3:** It is claimed that the only effective solution to the risk of the digital environment is the total prohibition of technology to avoid the isolation and manipulation that this environment fosters.

■ Foundation or criterion of discernment

Although no ingested chemical substance is involved, these behaviors alter the brain's pleasure and reward centers in a manner similar to drugs. The approach must recognize that the digital environment can expose the person to dependence and to the loss of contact with concrete reality, requiring a re-education of the will.

■ Thesis and argumentative development

It must be said that the treatment of digital addictions requires an integral approach that considers the dynamics of compulsion and the underlying distress, based on the following pillars:

1. Differentiation between impulsivity and compulsivity: Impulsivity is motivated by the search for immediate pleasure, while compulsivity seeks to avoid or reduce negative emotions. Treatment must identify at what point pleasure transforms into a need for evasion.
2. Identification of primary pain: The psychological approach should not stop at the external behavior, but investigate the emotional distress, failure or uncertainty that the individual attempts to anesthetize through the device.
3. Management of secondary pain: Digital evasion generates a new level of suffering marked by guilt, shame and social anxiety. Working on these feelings is essential to break the cycle of digital use.
4. Acceptance and Commitment Therapy (ACT): It is used to help the subject face their internal realities and tolerate distress without seeking the immediate refuge of the screen, strengthening their commitment to real life values.

5. Attention to digital stress and FOMO: The approach must address the constant alertness and Fear of Missing Out, which generate information overload and persistent anxiety for external approval.

■ Response to the objections

- **To the first:** Although there are no external chemicals, the brain processes these experiences through neuroplastic processes. Constant exposure to digital stimuli physically changes brain circuits in a manner similar to the learning of any addictive habit.
- **To the second:** Clinical experience demonstrates that users present mental obsession and physical withdrawal symptoms, such as irritability or discomfort, when they cannot access the network. The design of these platforms specifically seeks to overcome self-control, especially in adolescents with a still-immature prefrontal cortex.
- **To the third:** The objective is not the suppression of technology, but the development of responsible digital citizenship. The aim is for the rational part of the brain to regain command over emotional impulses, transforming technology into a tool for study and human encounter.

Cf. art. 3 (Judge, Substances and the organism, Definition..., Risks...)

8.7 | Accompaniment Skills and Self-Care

This section delves into the art of accompaniment, where active and empathic listening is proposed not merely as a technique, but as the first medicine capable of humanizing the journey of the one who suffers and recognizing their dignity as sacred ground. Fundamental skills are detailed such as paraphrasing, summarizing and affirmation, oriented toward awakening the self-efficacy and protagonism of the person in their own process of transformation. In a complementary and vital manner, the section addresses the urgency of caring for those who care, recognizing the vulnerability of the wounded healer and the pressing need to prevent professional burnout or compassion fatigue in contexts of high complexity. Finally, rest and the establishment of healthy boundaries are reclaimed as essential dimensions of the mission, urging pastoral agents to let themselves be sustained by the community so that service is sustainable and always reflects the tenderness of human encounter.

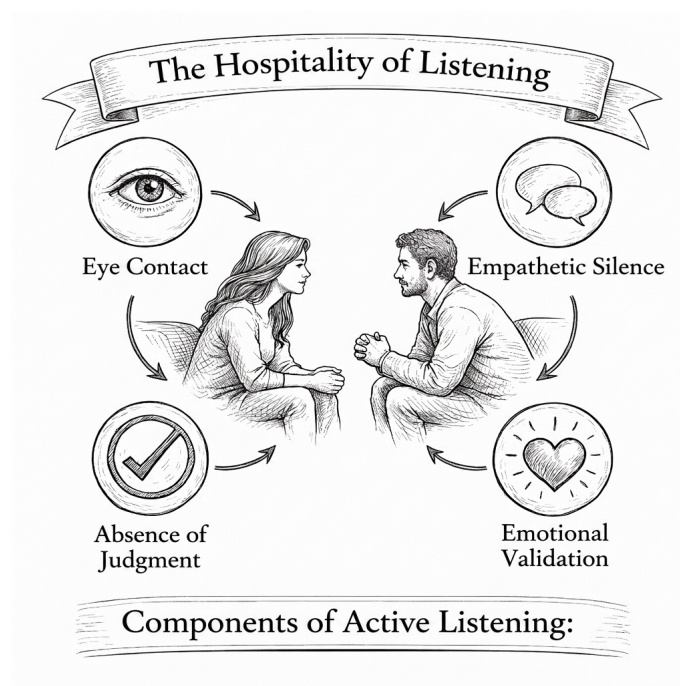


Figure 8.4: Active listening

8.7.1 Article 1: On the nature of active listening and the inner work of the companion

Jas 1, 19 — *Know
this, my beloved
brothers: let every
person be quick
to hear, slow to
speak, slow to anger*

■ Statement of the topic

Active listening is proposed as the first medicine in the recovery process, being a complex skill that transcends simple silence. It requires intense receptivity, concentration and patience to constitute an act of hospitality toward the heart of the other. It is not a mechanical technique, but a spiritual and psychological disposition that seeks to humanize the journey of the one who suffers, recognizing their story as sacred ground that must be treated with the utmost respect.

■ Central question

What are the essential components of active listening and what internal obstacles must the companion work on to achieve a healing bond?

■ Existing positions or objections

- **Objection 1:** It seems that listening is a merely passive process that consists of keeping silent while the other speaks, so no specific training or deliberate attitude would be required.
- **Objection 2:** It seems that the main function of the companion is to be a counselor who must have prepared answers; focusing only on listening could delay the necessary corrective intervention.
- **Objection 3:** It is assumed that the content of communication is solely verbal, so paying attention to physical signals or body language would be secondary to the literalness of words.

■ Foundation or criterion of discernment

Active listening is a fundamental tool designed for the person to feel attended to and considered. It does not seek to impose an external truth, but to allow the life story of the subject to emerge, validating their word as the axis of their own transformation.

■ Thesis and argumentative development

Active listening is grounded in precise technical components and in deep work on the interiority of the companion:

1. Technical components:

- **Active attention:** It involves being concerned with all levels of communication (verbal and non-verbal), communicating presence through eye contact and gestures of encouragement.
 - **Paraphrasing:** It consists of repeating the expressed content using one's own words to verify comprehension and demonstrate that the message has been grasped.
 - **Reflection of feelings:** The companion attempts to perceive and express the emotional state of the other, demonstrating empathy by sharing the understanding of their point of view without judging it.
 - **Summarizing:** It gathers the main points of the conversation to avoid misunderstandings and prepare the subject for the next step in their process.
2. **Internal obstacles of the companion:** The healing bond requires removing barriers such as emotional reactivity, self-referentiality (thinking about one's own response while the other speaks) and prejudices that lead to qualifying the actions of others as vicious.

■ Response to the objections

- **To the first:** Listening is active because it requires dynamic participation of the nervous system and the will to attune to the inner world of the other. It is not the absence of action, but a full and conscious presence.
- **To the second:** The objective is not to be a sage who imparts lessons, but a guide alongside. The person heals when they can symbolize their own pain through the word, recovering their autonomy instead of receiving orders.
- **To the third:** Communication is integral. Non-verbal signals often reveal more about suffering than rationalized discourse; therefore, attention to the corporeal is indispensable for capturing the totality of the message.

8.7.2 Article 2: On self-efficacy, affirmation and social persuasion

■ Statement of the topic

Recovery from addictions requires that the subject recover confidence in their own capacity to generate change. The development of self-efficacy is not a process that occurs in isolation, but one that is constantly nourished by the interaction with the environment and accompaniment. Through affirmation and social persuasion, the companion acts as a mirror that returns to the individual an image of their own strengths, allowing them to move from the paralysis of doubt toward an attitude of protagonism in their life project.

■ Central question

Does the development of self-efficacy, mediated by affirmation and social persuasion, have a determinant influence on the strengthening of the therapeutic process?

■ Existing positions or objections

- **Objection 1:** It seems that self-efficacy is an innate trait of personality or an internal willpower that the subject either possesses or does not, so that external stimuli or the companion's words would not have a real impact on behavior.
- **Objection 2:** It seems that constant affirmation could be counter-productive, since by highlighting positive aspects in someone who has committed serious errors, one risks minimizing the illness or fostering a false confidence that ignores the risks of relapse.
- **Objection 3:** It seems that social persuasion is a superficial resource that does not address the structural modifications in the brain caused by use; without a prior biological repair, no word of encouragement will be able to restore the capacity to decide.

■ Foundation or criterion of discernment

Self-efficacy is a person's belief in their ability to succeed in a particular situation. Receiving verbal encouragement and affirmation from others helps overcome doubts and increases the capacity to take action, transforming motivation from a fluctuating state to a firm commitment to change.

■ Thesis and argumentative development

It must be said that the development of self-efficacy is the motor of change in the therapeutic process, manifesting through the following axes:

1. Affirmation as validation of the being: To affirm implies making sincere and positive statements that validate the person beyond their acts. This practice reinforces small successes, strengthens the therapeutic alliance and demonstrates that the companion recognizes the effort and intrinsic value of the subject.
2. Social persuasion as an antidote to doubt: In contexts of exclusion, the user tends to internalize messages of failure. The companion's word acts as an external force that allows the individual to reconsider their potential, believing in their abilities to succeed even before they themselves can perceive them.
3. Prevention of discouragement: By emphasizing experiences that demonstrate strength, affirmation helps the person move from the feeling of I don't deserve it toward a conviction of I can do it, which is vital for sustaining effort in the initial stages of recovery.
4. Sustainability in critical stages: In both the action and maintenance phases, constant affirmation helps normalize ambivalence and strengthens the capacity to manage new coping strategies without resorting to the substance.

■ Response to the objections

- **To the first:** Although self-efficacy is an internal belief, it is nourished by models and mentors. Internal motivation is often awakened through the social persuasion of someone who trusts the user, providing the necessary impulse for the subject to begin trusting themselves.
- **To the second:** Affirmation does not ignore the reality of the illness, but separates behavior from identity. Transforming irrational thoughts of guilt into affirmations based on strengths is an indispensable requirement for the person to assume responsibility for their own process.

- **To the third:** While the brain is affected, verbal encouragement and community trust act as reinforcers that facilitate the learning of new habits. Neuroplasticity is leveraged so that the rational part of the brain regains command over emotional impulses, thus stabilizing healthy behavior.

Cf. art. 6 (Judge, Very Brief Glossary)

8.7.3 Article 3: On introspection and the emotion journal

■ Statement of the topic

Introspection and the use of tools such as the emotion journal are proposed as instruments for humanizing the journey. They are not mere intellectual exercises, but acts of looking inward to carry out a deep reflection on feelings and behavior. This practice is an essential point for personal growth, allowing the individual to find peace and fulfillment by delving into their own being and the truth of their history.

■ Central question

Do introspection and the use of tools such as the emotion journal have fundamental importance for the self-knowledge and recovery of the patient?

■ Existing positions or objections

- **Objection 1:** It seems that introspection is not advisable for persons with substance use disorders, since having memory networks loaded with trauma, looking inward would only increase their anguish and despair.
- **Objection 2:** It seems that the use of written tools is ineffective or exclusionary, given that many patients in situations of extreme vulnerability have a low level of schooling or cognitive deterioration that prevents them from carrying out written reflections.
- **Objection 3:** It is claimed that what matters most is service and community action under the premise that work heals, so that internal reflection would be a secondary exercise compared to the urgency of social reintegration.

■ Foundation or criterion of discernment

Introspection is the act of internal reflection necessary for personal growth. Self-knowledge helps to delve into one's own being in order to find a transcendent sense of life, transforming the individual from an object of assistance into a subject conscious of their dignity.

■ Thesis and argumentative development

Introspection and emotional recording are fundamental for recovery because they allow addressing the root of suffering under the following pillars:

1. Identification of the internal fracture: It allows the patient to stop seeing the drug as the central problem and begin to understand it as a symptom of a deep pain or prior abandonment. Without this exercise, treatment only touches the surface without healing the cause.
2. Facilitation of awareness: The recording of emotions helps identify negative behaviors and rigid thoughts. This process transforms the subject into a protagonist who assumes responsibility for their own history.
3. Ordering of the internal world: The journal functions as an anchor against the chaos of street life. By naming what they feel, the patient allows the rational part of the brain to regain control over emotional impulses.
4. Connection with transcendence: From the pastoral perspective, introspection is elevated to an examination of conscience, where the person recognizes the presence of God in their daily journey and strengthens their will for change.

■ Response to the objections

- **To the first:** Although looking at trauma is painful, integral healing is only possible through the resignification of those events. The community must provide the safe space so that this introspection is not a solitary act, but an accompanied and contained process.
- **To the second:** The tool must be artisanal and flexible. In cases of low schooling, introspection can be facilitated through empathic dialogue, art or accompaniment by peers who help the subject put into words what they feel.

- **To the third:** There is no opposition between action and introspection, for the human being is a unity of body and soul. Community service takes on its true meaning when it is born from a heart that knows itself and has discovered its dignity before God.

8.7.4 Article 4: On the vital need for self-care for pastoral agents

■ Statement of the topic

Accompanying persons in situations of extreme vulnerability and problematic use entails a high emotional cost that, if not managed adequately, leads to professional burnout, compassion fatigue or existential void. Those who carry out this work find themselves in a scenario of high complexity where frustration can be frequent. Therefore, self-care should not be considered an optional complement, but an intrinsic and vital dimension of the mission that ensures that service is humanizing and sustainable over time.

■ Central question

Is it vital to integrate a self-care module for pastoral agents in order to prevent empathy fatigue, burnout and compassion fatigue?

■ Existing positions or objections

- **Objection 1:** It seems that accompaniment is a total sacrifice that must be assumed as a participation in the cross of Christ, so the agent's tiredness would be a necessary offering that would not require a self-care module.
- **Objection 2:** It seems that resources and time should be focused exclusively on the user, considering that the well-being of pastoral agents is a luxury or a distraction from the urgency of saving lives.
- **Objection 3:** It is claimed that faith and prayer are sufficient to sustain the caregiver, suggesting that exhaustion is due solely to a lack of spiritual life and not to a need for psychological care strategies.

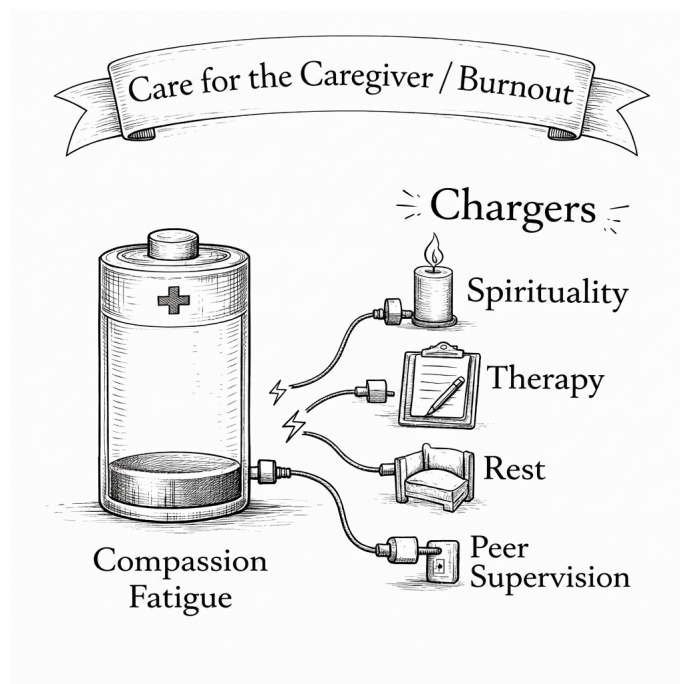


Figure 8.5: Caring for the caregiver

■ Foundation or criterion of discernment

Rest is a human and spiritual need ordained by Christ Himself for those who are at the center of service. Integral accompaniment requires that the agent manage their own life and recognize their limits to prevent the torch of hope from being extinguished, understanding that the right to leisure is an essential dimension of the mission.

■ Thesis and argumentative development

The integration of a self-care module is an act of justice and missionary responsibility grounded in the following pillars:

1. Sustainability of the mission: To care well, it is imperative that the agent preserve their own health. Extreme exhaustion prevents the continuity of the task and makes service unsustainable, affecting the quality of accompaniment in the long term.
2. Prevention of secondary trauma: Caregivers are exposed to post-traumatic stress derived from bearing the pain and wounds of the users. Having protocols for detecting burnout and compassion fatigue allows processing this impact and prevents pastoral agents from somatizing the suffering of others.

3. Identity of the wounded healer: The companion must recognize their own vulnerability and need for tenderness. Accepting one's own wounds allows the pastor to let themselves be cared for by the community, avoiding positioning themselves in a place of superiority that blocks the real bond.
4. Quality of care: An exhausted pastoral agent loses the capacity for active listening and empathy. Self-care allows taking the necessary pauses to ensure that the encounter with the other is always a gesture of love and not a mechanical or bureaucratic burden.
5. Establishment of healthy boundaries: Care involves learning to say no and to step back to the substitute's bench when strength falters, recognizing that no one can do it alone and that the community is the ultimate support of the task.

■ Response to the objections

- **To the first:** Although generous self-giving is valuable, God does not ask for sacrifices that destroy one's own life. Caring for oneself is a way of honoring the gift of life and ensuring that service can continue without the caregiver breaking down.
- **To the second:** Self-care is an indispensable mental health strategy, not a luxury. Investing in the well-being of the team ensures that there are always available hands and clear minds to attend to the social emergency effectively.
- **To the third:** Faith does not annul biology or the laws of the psyche. It is necessary to integrate the spiritual life with healthy habits, exercise and peer support so that the agent's integral health is in optimal condition for the mission.

CHAPTER 9

Substances and the Organism

■ Statement of the topic: Substances and the organism.

The study of the relationship between the human being and chemical substances involves understanding how certain external components interact with the most complex biological structure of man: his nervous system. This interaction is not an isolated event, but a pharmacological and metabolic process that alters the perception and behavior of the individual.

9.1 | Definition and Classification of Substances

A **psychoactive substance (PAS)** is any chemical compound that, when introduced into the organism, **affects the functioning of the central nervous system (CNS)**, modifying behavior, perception, or mood. To act directly on neurons, these substances must be capable of **crossing the blood-brain barrier (BBB)**, a biological frontier that protects the brain and that is impermeable to most chemical compounds.

According to the specific effect they produce when interacting with the brain, they are currently classified into six fundamental groups: **stimulants, depressants, opioids, hallucinogens, dissociatives, and cannabinoids**.

It is essential to recognize that legal substances such as **alcohol, nicotine, and caffeine** are psychoactive substances, since they strictly meet the biological criterion of altering the CNS, regardless of their social acceptance. At present, the health risk has been aggravated by the emergence of **new psychoactive substances (NPS)** and **synthetic opioids such as fentanyl**, whose potency is **up to one hundred times greater** than that of traditional drugs, raising the danger of death by overdose due to their unpredictable dosing and their frequent use as a hidden adulterant.

9.1.1 Article 1: Definition of psychoactive substances (PAS)

■ Statement of the topic: The chemical interaction with the nervous system

The study of the relationship between the human being and substances involves understanding how certain external components manage to interact with the most complex biological structure of man: his nervous system. This interaction is not a random event, but a pharmacological process defined by the capacity of a molecule to alter the perception, mood, and behavior of the individual.

■ Central question

What defines a substance as “psychoactive” and what differentiates its passage through the organism from that of a common medication?

■ Existing positions or objections

1. **It seems that the term refers only to illicit drugs**, associating psychoactivity only with prohibited substances.
2. **It seems that these substances only affect the “mind”**, without having a real repercussion on the rest of the physical organism.
3. **It seems that there is no difference between a PAS and any common medication** (such as an antibiotic), since both are ingested to produce a health effect.
4. **It seems that behavioral addictions are equivalent**, since they alter pleasure without the need for an external chemical.

■ Foundation or criterion of discernment

Against this, the scientific criterion establishes that a PAS is a component that affects the central nervous system (CNS) through a specific pharmacological capacity: that of crossing biological defenses that other components cannot traverse.

■ Thesis and argumentative development

We respond that psychoactive substances are chemical components of **small molecular structure and lipophilic** (fat-soluble). These two characteristics are what grant them the technical *key* to cross the **blood-brain barrier (BBB)**, a protective membrane composed of tightly joined cells that restricts the flow of chemicals toward the brain.

Although lipophilicity and small molecular size constitute the predominant route of access for PAS to brain tissue, pharmacology also recognizes other mechanisms of passage through the BBB, such as active transport and facilitated transport, by which certain molecules are carried by specialized transporter proteins. Likewise, the BBB is not uniformly impermeable in all regions of the brain: certain areas called circumventricular organs have a more permeable barrier, which allows the exchange of chemical signals between the blood and the central nervous system. These clarifications do not alter the general criterion set forth here, but complete the picture for the reader who wishes to delve deeper into the subject.

Having made this clarification, it is worth noting that most common medications are water-soluble (they dissolve in water) and possess large molecules that the BBB effectively blocks. PAS, on the other hand, take advantage of their affinity with the fatty membranes of the barrier to access brain tissue directly. Once inside, they act in the following ways:

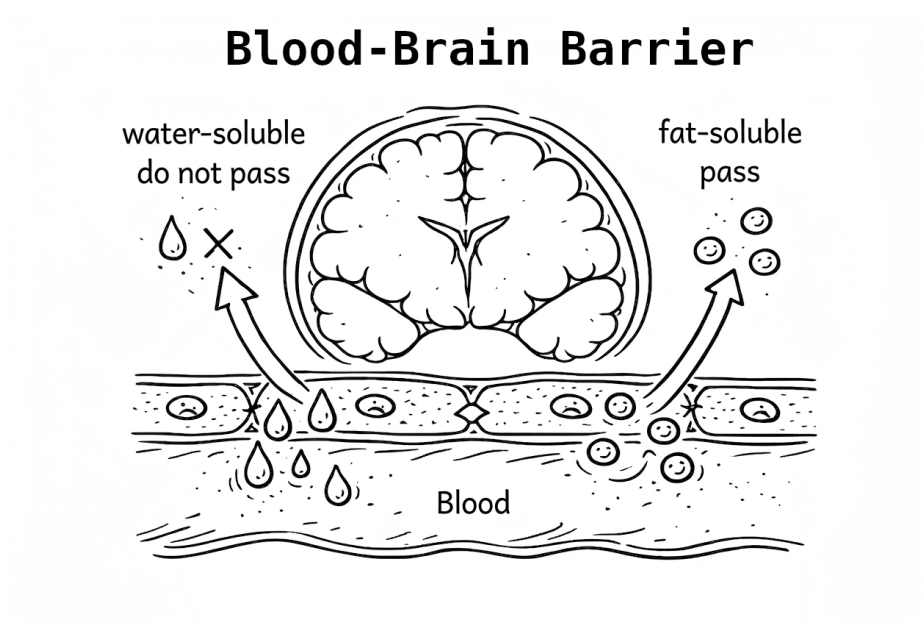


Figure 9.1: Blood-Brain Barrier

Once they cross this barrier, psychoactive substances act in the following ways:

- **Interference in communication:** They alter the way neurons send, receive, and process neurotransmitter signals in the intersynaptic space.
- **Functional classification:** According to their effect, they are divided into **stimulants, depressants, opioids, hallucinogens, dissociatives, and cannabinoids**.
- **Metabolic process:** The body seeks to neutralize them through the liver and kidneys. The impact of a substance is not permanent; its duration is subject to a biological timer called **half-life**, whose technical dynamics are analyzed in depth in the pharmacokinetics chapter.

■ Response to the objections

1. **To the first:** Psychoactivity is a biological criterion, not a legal one. Alcohol, nicotine, and caffeine meet all the requirements of a PAS.

2. **To the second:** Although they act on the brain, PAS are distributed throughout the entire body, causing systemic damage to the liver, kidneys, and immune system, as well as other organs and body systems.
3. **To the third:** The difference is structural. Water-soluble medications (such as many antibiotics) do not cross the BBB, while PAS are lipophilic and access the command center directly.
4. **To the fourth:** The technical definition of PAS necessarily requires the presence of an **external chemical component** that enters the bloodstream, something that does not occur in behavioral addictions.

9.1.2 Article 2: Classification according to the specific effect on the central nervous system

■ Statement of the topic: The functional classification of substances.

The study of psychoactive substances requires a clear taxonomy that allows understanding not only the chemical composition, but the specific reaction they provoke when interacting with the human brain. Given that the central nervous system (CNS) is the center of all human activity, it is fundamental to discern how each group of substances alters the vital functions, mood, and judgment of the individual. However, every classification is a pedagogical tool that simplifies a more complex reality: many substances produce effects that cross the boundaries of a single category, and the concrete experience of use always depends on the interaction between the subject, the substance, and the context (Zinberg's Triad).

Cf. art. 7 (Judge, Very Brief Glossary)

■ Central question: How are psychoactive substances classified according to their effect on the central nervous system?

The aim is to determine whether there is a functional distinction among the various chemical components that, upon crossing the blood-brain barrier, modify the natural operation of neurons and reward circuits, and whether such a distinction can be organized into clear categories.

■ Existing positions or objections

1. **It seems that all substances produce the same *well-being* effect,** so dividing them into categories is unnecessary, since the user always seeks euphoria or escape regardless of the chemical name.

2. **It seems that legal substances, such as alcohol or caffeine, should not be included**, since their social acceptance and everyday commercialization distances them from the category of dangerous *drugs*.
3. **It seems that medications prescribed by doctors lose their psychoactive character**, since their therapeutic purpose (such as relieving pain) would eliminate the risk of being classified as substances of abuse.
4. **It seems that a classification into fixed categories is sufficient to understand the phenomenon**, assuming that each substance belongs unequivocally to a single group and that the boundaries between categories are clear and definitive.

■ Foundation or criterion of discernment

The sources establish that **the way a drug affects a person depends directly on how it alters CNS activity**. This scientific classification is a general guide that allows identifying whether the substance accelerates, inhibits, blocks pain, distorts reality, depersonalizes, or alters the memory and time perception of the person who consumes it. However, given that the person is an indivisible unity and that the experience of use is always situated, the classification should be understood as an orientative map that facilitates discernment, not as a system of watertight compartments.

■ Thesis and argumentative development

We respond that psychoactive substances are classified into seven fundamental groups according to their predominant action on the organism:

Classification	Effects on the CNS	Examples
Stimulants	They have the property of increasing CNS activity . They generate a state of intense alertness, greater energy, and euphoria, simultaneously elevating heart rate and respiration.	Cocaine, amphetamines, nicotine, caffeine
Depressants	They act inversely, as they decrease CNS activity . They induce sensations of relaxation and well-being, but can also cause drowsiness and slowed reflexes.	Alcohol, benzodiazepines, barbiturates

Classification	Effects on the CNS	Examples
Opioids	Their primary action is depressant : they produce a selective inhibition of the CNS oriented toward pain blockade . They are potent analgesics that also generate an intense sensation of euphoria and well-being, which explains their high addictive potential. They can also induce sleep. They are classified in a separate category—distinct from general depressants—because they act on a specific receptor system (the endogenous opioid system) and because their clinical risk profile, especially lethal respiratory depression, requires a differentiated emergency approach.	Morphine, heroin, fentanyl, codeine
Hallucinogens	These are substances that produce profound sensory distortions and alter mood and thought . They cause the person to perceive images or sensations that seem real but are not.	LSD, psilocybin (mushrooms), mescaline (peyote)
Dissociatives	These are substances that produce the sensation of mind-body separation, analgesia, and depersonalization .	Ketamine, PCP
Empathogens	These are substances that intensely enhance emotional empathy, sociability, and the sensation of affective connection with others , combining mild stimulant effects with a significant alteration of emotional perception. Their main mechanism involves a massive release of serotonin.	MDMA (ecstasy), MDA
Cannabinoids	These are substances that produce relaxation, alteration of memory, and time perception .	Cannabis (THC)

Necessary clarifications about the classification. This taxonomy fulfills an indispensable pedagogical function, but must be read with three caveats:

1. **Opioids as a specialized subtype of depressants.** Pharmacologically,

opioids exert a depressant action on the CNS. If they are classified in a separate category, it is not because their mechanism is opposite to that of depressants, but because they act on their own receptor system (mu, kappa, delta) and because the specificity of their clinical risk — particularly the respiratory crisis from overdose— demands differentiated emergency intervention protocols (such as the administration of naloxone). This distinction has direct practical value for territorial teams.

2. **Cannabis as a substance with cross-cutting effects.** Cannabis does not fit neatly into any of the other categories because it simultaneously produces depressant effects (relaxation, drowsiness), mild stimulant effects (initial euphoria, increased appetite), and mildly hallucinogenic effects (alteration of sensory and temporal perception), depending on the variety, the dose, and the context of use. This pharmacological complexity is one of the reasons why it is classified in its own category and is also what makes prevention difficult: its multifaceted profile feeds the erroneous perception that it is a “soft” or controllable substance.
3. **No category is a hermetic compartment.** In clinical and territorial practice, many substances produce effects that cross the boundaries of a single category. Empathogens, for example, combine stimulant properties with perceptual alterations. Some substances change their profile depending on the dose: alcohol in low doses can produce disinhibition (an apparently stimulant effect) before its depressant action predominates. This fluidity reinforces the need to always evaluate the experience of use from Zinberg’s Triad (subject-substance-context) and not solely from the molecule.

■ Response to the objections

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

1. **To the first objection:** Although many substances coincide in activating dopamine, their mechanisms are distinct and sometimes opposite. While a stimulant like cocaine floods the receptors by preventing reuptake, a depressant inhibits the physical response, and an empathogen like MDMA causes a massive release of serotonin that alters emotional perception. Understanding these differences is vital for informed pastoral accompaniment, for identifying risk situations in the territory, and for dialogue with health teams.
2. **To the second objection:** The biological nature of the substance prevails

over its legal status. **Alcohol**, although socially accepted, is a depressant that weakens the immune system and causes high global mortality.

3. **To the third objection:** Psychotropic medications and opioid analgesics are safe under prescription, but they remain psychoactive substances. If consumed in higher doses or in a manner different from what is prescribed, they produce euphoria and generate **Substance Use Disorders (SUD)**, becoming a serious health risk. For this reason, it is important to understand the relationship that the person establishes with substances.
4. **To the fourth objection:** The classification is an orientation tool, not an ontology of substances. Biochemical reality is more fluid than any table. What the pastoral agent and the professional need is not to memorize rigid categories, but to understand that each group indicates a predominant profile of risk and harm that guides the response. A brother who uses a depressant substance faces different dangers than one who uses a stimulant, and that difference has direct practical consequences for accompaniment and for articulation with health services.

9.1.3 Article 3: Risks of new psychoactive substances (NPS) and synthetic opioids

■ Statement of the topic: The challenge of modern chemical synthesis.

The evolution of the substance market has moved from natural components or traditional derivatives to an era of industrial chemical design. The emergence of **new psychoactive substances (NPS)** and the proliferation of **synthetic opioids** represent a rupture in prevention and treatment schemes, as their interaction with the organism does not follow the known patterns of traditional drugs.

■ Central question: What risks do new psychoactive substances (NPS) and synthetic opioids such as fentanyl present compared to traditional drugs?

It is questioned whether these substances are simply variants of those already known or whether their synthetic nature and mode of distribution introduce qualitatively and quantitatively superior dangers to human life.

■ Existing positions or objections

1. **It seems that the risk is equivalent to that of traditional drugs**, since all of them cause dependence and alter the central nervous system (CNS) in a similar manner.
2. **It seems that, since many of them are not under immediate international control, their dangerousness is lower** or at least has not been fully demonstrated by regulatory bodies.
3. **It seems that the problem is limited to the user's will**, who decides to consume a substance regardless of whether it is natural or synthetic, assuming the same type of recreational risk.

■ Foundation or criterion of discernment

However, against this, the sources indicate that the emergence of these substances occurs at an **unprecedented speed (about 500 new ones per year)** and that consumers are unaware of the **dosage and quantity** of the components, which exposes them to extremely serious and often lethal health risks.

■ Thesis and argumentative development

We respond that NPS and synthetic opioids present significantly greater risks than traditional drugs due to three fundamental pillars: their extreme potency, their unpredictable character, and the difficulty of medical response.

- **Disproportionate potency:** Synthetic opioids, specifically **fentanyl**, have a potency that can be up to **one hundred times greater than that of morphine or heroin**. This means that only a **minimal quantity** is required to produce effects, which drastically reduces the margin between the desired effect and the lethal dose.
- **The danger of hidden adulteration:** Unlike traditional drugs, synthetic opioids are often used as a **cheap and potent adulterant** that is added to other drugs such as heroin or cocaine, or they are made into pills that imitate prescribed analgesics. The user consumes these substances without knowing what they are ingesting.

- **Critical impact on vital functions:** Substances such as opioids affect the **brainstem**, which controls basic functions such as heart rate and respiration. This explains why overdoses from these substances substantially reduce breathing until causing **death by asphyxiation** very rapidly.
- **Obstacles for emergency care:** Many pills sold as ecstasy or methamphetamine are actually “**chemical cocktails**”. This means that emergency services find themselves **unable to identify the exact substance**, making it difficult to administer appropriate treatment to save the patient’s life.

■ Response to the objections

1. **To the first objection:** Although all of them affect the CNS, the **speed of action and the intensity of neuroadaptation** are greater in synthetic substances. While a traditional drug has known effects, NPS can cause severe intoxications with doses that the user cannot measure, exponentially increasing the risk of sudden death.
2. **To the second objection:** The term “new” does not mean they are harmless, but that they have recently begun to circulate and their **addictive potential is poorly understood**. The fact that they are not subject to immediate international control is a legal challenge, but it does not diminish their actual toxicity.
3. **To the third objection:** It is not a matter of pure will, since these substances generate a **hyperactivity in the reward circuit** much more violent than natural ones, “teaching” the brain to seek them compulsively and nullifying the capacity of the prefrontal cortex to “brake” the impulse.

9.1.4 Article 4: Cannabis and the low perception of risk

■ Statement of the topic: A substance as widely consumed as it is underestimated.

Cannabis is today the most consumed illicit substance in Latin America, especially among adolescents and young people. Its plant origin, its historical presence in diverse cultures, and the processes of legalization or decriminalization in various countries have installed in broad sectors of the population—including families and pastoral agents—the perception that it is a harmless

substance or one significantly less dangerous than others. This perception constitutes today one of the main obstacles to effective prevention in the territories.

■ Central question: Is cannabis a low-risk substance?

It is questioned whether the scientific evidence supports the dominant social perception that presents it as harmless, or whether on the contrary its effects on the organism —especially on the developing brain— require an informed and serene pastoral response.

■ Existing positions or objections

1. **It seems that cannabis is innocuous because it is natural**, since it comes from a plant and not from a chemical laboratory, which would distinguish it from truly dangerous synthetic drugs.
2. **It seems that it does not generate real dependence**, given that it does not produce a physical withdrawal syndrome comparable to that of alcohol or heroin, which would lead to the conclusion that its use can be stopped at any time by a simple decision of the will.
3. **It seems that its legalization in several countries endorses its harmlessness**, since if States permit it, it is because the scientific evidence does not justify prohibiting it.
4. **It seems that it is less harmful than alcohol**, a legal and socially accepted substance that generates more deaths and deterioration, which would make it inconsistent to worry about cannabis while tolerating the former.
5. **It seems that the medicinal use of cannabis demonstrates that it is a safe substance**, since if medicine uses it for therapeutic purposes, it cannot be considered a dangerous drug.

■ Foundation or criterion of discernment

However, against this, neuroscience establishes that cannabis is a psychoactive substance whose active ingredient, **tetrahydrocannabinol (THC)**, acts directly on the brain, altering cognitive, emotional, and perceptual functions. Its plant origin does not modify its capacity to generate dependence or to produce documented neurological damage, especially in brains that have not

yet completed their development. In the face of this, the pastoral response should not be panic but clear information: just as a parent accompanies their child if they find them consuming alcohol, they should be prepared to accompany them if they find them consuming cannabis, with the same serenity and the same firmness.

■ Thesis and argumentative development

We respond that cannabis presents a real and documented risk profile that social perception underestimates. This profile is articulated in the following points:

- **Real psychological dependence:** Although the physical dependence on cannabis is less intense than that of alcohol or opioids, the psychological dependence is clinically significant. Approximately 9% of users develop a Cannabis Use Disorder, a percentage that rises to 17% in those who begin use in adolescence. The person feels that they cannot relax, sleep, or face daily life without the substance, which seriously hinders the cessation of use without accompaniment.
- **Impact on the adolescent brain:** As developed in section 9.4.1, the brain does not complete its maturation until age 25. Cannabis directly interferes with that process, affecting the circuits of memory, attention, and emotional regulation. Early onset of use is the strongest predictor of severe and lasting dependence, and can generate cognitive deficits that persist beyond the cessation of use.
- **Risk of psychosis in vulnerable individuals:** THC can trigger psychotic episodes in individuals with genetic predisposition —especially family histories of schizophrenia or psychotic disorders— that can become chronic. This risk has been aggravated because current varieties contain THC concentrations up to **ten times higher** than those of previous decades, making comparisons with historical use obsolete.
- **Impact on general mental health:** Regardless of genetic predisposition, regular cannabis use is associated with increased anxiety, depression, and chronic demotivation, especially in adolescents. This phenomenon, known as **amotivational syndrome**, is characterized by a progressive loss of interest in relationships, studies, and life projects.

■ Response to the objections

1. **To the first objection:** The natural origin of a substance does not determine its harmlessness. Cocaine is extracted from the coca leaf and heroin from opium. What defines the risk is the mechanism of action on the organism, not the botanical origin.
2. **To the second objection:** The absence of intense physical dependence does not equate to the absence of dependence. Psychological dependence is clinically real and sufficiently significant to seriously hinder the cessation of use without specialized accompaniment.
3. **To the third objection:** Legislative decisions respond to political, economic, and social criteria, not exclusively health criteria. The legality of a substance is not a scientific endorsement of its harmlessness: alcohol and tobacco are legal and are among the leading causes of preventable mortality in the world.
4. **To the fourth objection:** The comparison with alcohol does not diminish the risk of cannabis; what it demonstrates is that alcohol is also more dangerous than society recognizes, a topic developed in section 9.1.5. The harm of one substance does not neutralize or justify the harm of another.
5. **To the fifth objection:** There is a fundamental technical distinction between the medicinal use and the recreational use of cannabis. Medicine primarily uses **cannabidiol (CBD)**, a component without significant psychoactive effect, under controlled prescription and in precise doses for specific conditions such as refractory epilepsy or chronic pain. Recreational use, on the other hand, seeks the effects of THC in variable and uncontrolled doses. Equating both uses is as inaccurate as equating the medical use of morphine with the street use of heroin.

9.1.5 Article 5: Inclusion of legal substances (alcohol, tobacco, and caffeine) in the PAS category

■ Statement of the topic: The technical nature of psychoactivity versus legality.

In the social sphere, there is often a gap between the popular perception of what a “drug” is and the scientific definition of a psychoactive substance. While prohibited substances carry prejudices and stigmas, those whose commercialization is permitted —such as coffee, tobacco, or alcohol— enjoy an acceptance that often makes their real impact on the biological structure invisible. This legal distinction obscures the fact that **the organism does not differentiate between licit or illicit** when processing chemical components.

■ Central question

Does the category of “psychoactive” respond to a legal convention or is it a biological quality determined by the interaction of the substance with the central nervous system (CNS)?

■ Existing positions or objections

1. It seems that they are not PAS, since their free and regulated sale would indicate that they do not possess the dangerousness of prohibited substances.
2. It seems that alcohol is only a social or liturgical complement, which would distance it from the definition of a substance that modifies behavior.
3. It seems that the use of caffeine and nicotine are mere habits, since they do not produce bizarre intoxications immediately.
4. It seems that including them in the same list as illicit substances dilutes the gravity of social problems such as drug trafficking.

■ Foundation or criterion of discernment

Against this, the univocal technical criterion established in article 1.1 is applied: a substance is psychoactive if it affects the CNS and modifies behavior, perception, or mood. Under this clinical definition, nicotine, caffeine, and alcohol are strictly included in the PAS category, since **pharmacology prevails over legal status**.

■ Thesis and argumentative development

We respond that alcohol, tobacco, and caffeine are psychoactive substances because they possess the capacity to alter cerebral biochemical processes through the mechanisms already described:

- **Cerebral access capacity:** Like the substances analyzed previously, these molecules are small and lipophilic, which allows them to **cross the blood-brain barrier** and act directly on neurons.
- **Functional classification (according to 1.2):** Alcohol acts as a **depressant** of the CNS, reducing heart rate and respiration; while nicotine and caffeine operate as **stimulants**, increasing energy and alertness.
- **Addictive power:** All three substances activate the reward circuits and can generate **dependence and withdrawal syndrome** (tremors, anxiety, and insomnia) when their intake ceases.
- **Impact on public health:** Legality does not reduce their toxicity. Alcohol is responsible for approximately **2.6 million deaths annually** worldwide (4.7% of all deaths), surpassing the health impact of many illicit drugs.

It should be noted that the category “tobacco” no longer designates a single format of consumption. The emergence of electronic cigarettes (*vapers*), heated tobacco devices (such as IQOS), and nicotine pouches (*nicotine pouches*) represents new delivery vectors for the same psychoactive substance —nicotine— with a commercial presentation that is usually associated with less harm and greater social acceptance. This perception of low risk, analogous to that analyzed in article 9.1.4 on cannabis, constitutes in itself a vulnerability factor: accessibility, normalization, and the absence of the traditional cigarette’s characteristic smell facilitate the initiation and invisibilization of consumption, especially in adolescents. From the biological criterion that underpins this manual, it is the same substance and the same addictive mechanism, regardless of the device that delivers it.

■ Response to the objections

1. **To the first:** Legality does not modify pharmacology; the organism metabolizes these substances based on their chemical composition, not on their legal status.

2. **To the second:** Although alcohol enjoys social legitimacy, its abundant consumption weakens the immune system and is a risk factor for serious diseases.
3. **To the third:** Caffeine and nicotine meet the requirements of psychoactivity by effectively altering mood, heart rate, and internal perception. This classification does not imply any moral judgment on the consumption of coffee: anyone who has experienced the discomfort of a day without it understands, on a smaller scale, the same biological mechanism that underlies all dependence. It is precisely that everyday experience that can become a gateway to empathy toward those we accompany.
4. **To the fourth:** Including them allows understanding that the problem is not only the substance, but the **bond that the subject establishes with it** in an attempt to fill “existential voids” or “anesthetize an unbearable life.”

9.2 | Pharmacokinetics: the pathway of the substance in the organism

Pharmacokinetics is the branch of pharmacology that studies the complex chemical processes that the organism performs, from when a substance enters the organism until its elimination. In simple terms, it analyzes “what the body does to the drug” from the moment of its intake, its passage into the bloodstream, its distribution, metabolism, and elimination. A fundamental concept in this study is the **half-life of the substance**, which measures the time needed for the body to eliminate half of the original dose, an essential datum for determining the duration of effects and the time required for complete detoxification.

A mnemonic rule is commonly used to remember the processes that make up pharmacokinetics, and it is the acronym LADME (liberation, absorption, distribution, metabolism, and elimination).

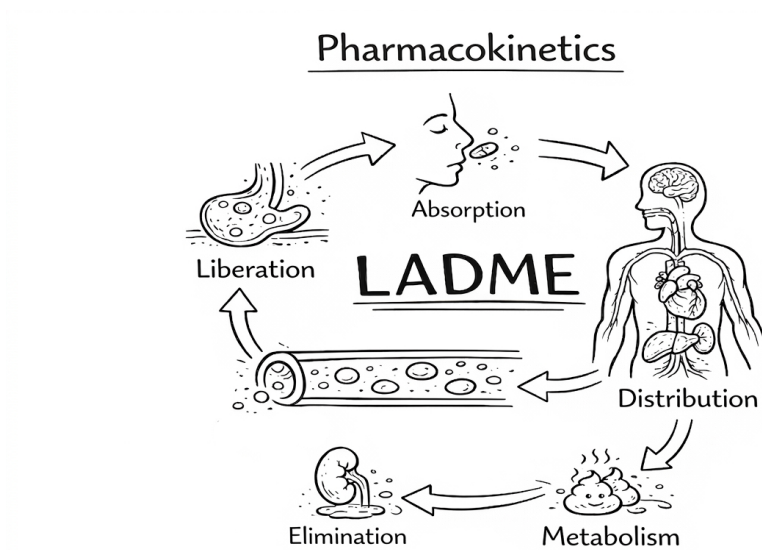


Figure 9.2: Pharmacokinetics (LADME)

9.2.1 Article 1. Routes of administration and speed of action

■ Statement of the topic

The analysis of pharmacokinetics requires specifying how the route of entry of a psychoactive substance (PAS) conditions the latency time and the intensity of its effects on the Central Nervous System (CNS). There is a tendency in preventive outreach to establish linear and absolute comparisons between the inhaled (smoked) route and the intravenous (injected) route, categorically affirming that the former is always faster than the latter. However, contemporary clinical evidence warns that this assertion constitutes an excessive simplification of a phenomenon conditioned by physiological variables and by the kinetics of the plasma peak, a nuance that the manual must incorporate to avoid presenting as firm data what in medical science is an open and complex discussion.

■ Central question

Is it correct to affirm absolutely that the smoked route is faster than intravenous injection, or should the speed of action be interpreted in terms of the kinetics of the plasma peak and the technical variables of administration?

■ Existing positions or objections

- **Objection 1:** It seems that the manual should maintain the chronological primacy of the smoked route (popularly estimated in a range of 7 to 10 seconds) over the intravenous route (estimated at 15 to 30 seconds), since this highlights the dangerousness of immediate combustion substances such as crack or pasta base.
- **Objection 2:** It seems that intravenous injection, by bypassing absorption barriers and entering the bloodstream directly, should be catalogued unequivocally as the fastest route of arrival to the brain in all cases, nesting any equating with the pulmonary route.

■ Foundation or criterion of discernment

Scientific realism and technical precision are indispensable for grounding the authority of the manual in interdisciplinary dialogue. Pharmacokinetics cannot

Cf. art. 7 (Judge,
Very Brief Glossary)

be reduced to a static table of fixed seconds; it must be understood as a dynamic interaction between the biological machinery of the subject and the chemical formulation of the substance (Zinberg's Triad). The clinically relevant distinction does not reside solely in the absolute chronological speed, but in the morphology of the curve of substance concentration in the blood.

■ Thesis and argumentative development

We respond that qualifying the smoked route as unequivocally faster than the intravenous route is an error of simplification, and that both routes must be presented as routes of extreme speed whose effects are differentiated by the kinetics of their plasma peak through three theoretical clarifications:

1. **Variability of the clinical ranges of the intravenous route:** The times habitually assigned to the intravenous route (15-30 seconds) represent the upper range of the estimates analyzed in laboratories. Abundant clinical sources report that the arrival of the substance to the brain via IV injection can occur in a span of 10 to 15 seconds, which effectively equates—and on occasion surpasses—the times of the inhaled route.
2. **Dependence on mechanical and physiological factors in inhalation:** The speed of absorption through the pulmonary capillaries is not a constant value. This dimension depends directly on the user's inhalation technique, their useful lung volume, the depth and retention of the puff of smoke, as well as the combustion temperature of the substance. Therefore, a fixed figure applicable to all subjects cannot be established.
3. **The true distinction: the *onset* or peak plasma concentration:** What science verifies is not that the smoked route “arrives sooner” in terms of absolute time, but that it produces a much more abrupt and vertical *peak plasma concentration* (steeper *onset*). When inhaling, the substance passes directly from the alveoli to the left ventricle of the heart and from there to the brain, bypassing the systemic venous circulation. This generates a concentrated chemical surge that massively impacts the reward circuits, creating a subjective reinforcement (the “rush”) of enormous addictive potency, a morphological mechanism very different from that of venous injection, which is distributed in a more diluted manner in the general blood return before reaching the arterial tree.

■ Response to the objections

1. **To the first:** While it is commendable to alert about the severity and harm of crack or pasta base, using inaccurate chronological data weakens the credibility of the text. The manual is much more rigorous if it explains that the dangerousness of the smoked route lies in the abruptness with which it hijacks the dopaminergic system due to the verticality of its plasma peak, and not in a race of seconds disputed with the injected route.
2. **To the second:** Although IV injection deposits the entirety of the dose in the blood immediately, the venous circulatory circuit imposes a physical route that nuances the speed of arrival to brain tissue. Recognizing that the pulmonary route can compete in speed with the intravenous route due to its direct access to the arterial circulation is a datum that allows understanding with greater precision the extremely high addictive potential of smoked substances and the clinical urgency that their consumption represents.

9.2.2 Article 2: Active action of the organism to manage a psychoactive substance: pharmacokinetics

■ Statement of the topic: The active biological response to a PAS.

The encounter between the human being and a psychoactive substance (PAS) is not a passive reception of altering effects. On the contrary, the human organism possesses a **biological intelligence** that is activated immediately upon the presence of foreign components to attempt to recover its internal equilibrium. This process is not limited to the moment of subjective effect, but encompasses a complex journey that goes from when the substance touches the organism until it is completely eliminated.

■ Central question: What does the organism do with a PAS?

It is questioned whether the body is a passive recipient that only experiences the effects of the substance, or whether on the contrary it deploys a **chemical activity of its own** to manage its entry, transit, and exit.

■ Existing positions or objections

1. **It seems that the organism does nothing actively**, but simply waits for the substance to lose its chemical strength naturally or spontaneously.
2. **It seems that the process is the same for all people**, regardless of their age, physical condition, or history of use.
3. **It seems that the substance is directed only to the brain**, given that it is defined by its psychoactive effect, without affecting other tissues or organs.
4. **It seems that once the effect on the brain ends, the organism has already completed its work**, assuming that the substance has completely disappeared from the system.

■ Foundation or criterion of discernment

Pharmacokinetics is the branch of science that studies precisely this activity: the way in which the body manages the entry, transit, and exit of a substance. It is distinguished from **pharmacodynamics**, which studies the impact of that substance on the organism. From the instant a PAS is ingested, the organism initiates a sequential and irreversible process to process it and expel it, composed of four stages: **liberation, absorption, distribution, and metabolism-elimination**.

■ Thesis and argumentative development

We respond that the organism acts as an **active chemical processor** that seeks to defend its internal equilibrium against any stimulus that alters its physiological processes. This process unfolds in the following stages:

- **Liberation:** This is the initial phase in which the active ingredient of the PAS separates from its physical support (tablet, smoke, powder) to remain in a molecular state that the body can absorb. The speed of this liberation is determinant: instantaneous liberation—as occurs when smoking—generates maximum brain impact and greater addictive potential; slow liberation—such as that of a patch—reduces that reinforcing effect.
- **Absorption:** This is the process by which the active ingredient crosses cellular membranes to enter the bloodstream. The route of administration

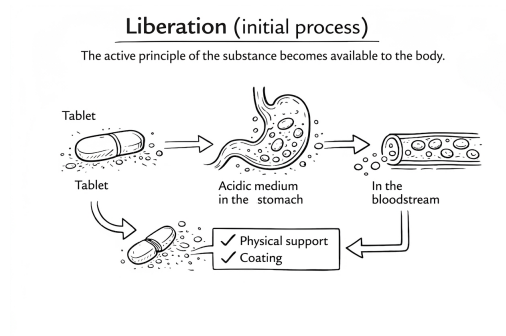


Figure 9.3: Liberation

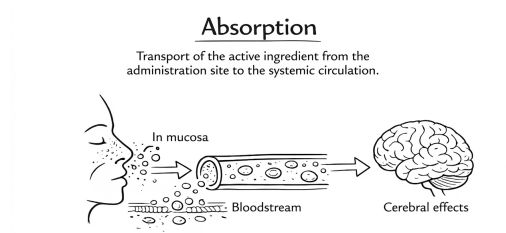


Figure 9.4: Absorption

is the most determinant external factor: smoking allows absorption in 7 to 10 seconds through the pulmonary alveoli, while the oral route can take between 20 and 30 minutes due to digestive transit. Age, history of use, and the chemical properties of the substance also condition the efficacy of this process.

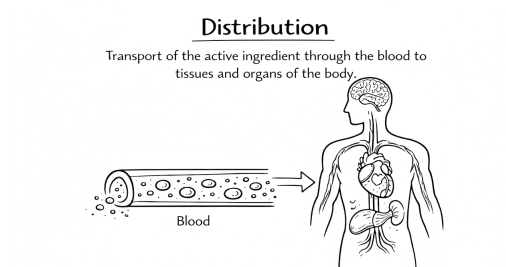


Figure 9.5: Distribution

- **Distribution:** Once in the blood, the substance does not remain static nor is it directed exclusively to the brain. The circulatory system transports it toward various tissues and organs—liver, kidneys, adipose tissue—according to the chemical affinity of each molecule. This systemic action

explains why the consequences of use are not only neurological, but affect the organism as a whole.

- **Blood-brain barrier and access to the brain:** To reach neuronal tissue, the PAS must cross the **blood-brain barrier (BBB)**, a protective membrane of tightly joined cells that selectively filters the components of the bloodstream. Only substances with **small molecules** and **lipophilicity** (fat solubility) can cross it. This is precisely the characteristic that defines PAS: their capacity to cross this biological frontier and directly interfere with communication between neurons. Once inside, they are deposited in adipose tissue, which explains why the organism can remain impregnated with them long after use.
- **Metabolism and elimination:** Once the PAS has completed its journey, the organism initiates the process of neutralizing and expelling it. The **liver** is the main metabolizing organ: it chemically transforms the substance into less active or inactive metabolites that can be eliminated. Final expulsion occurs primarily through the **kidneys** (urine), although sweat, bile, and exhaled air also participate. The speed of this process depends on the chemical nature of the substance, the age of the individual, and the condition of their organs. Repeated use can overload these systems, progressively deteriorating their response capacity.
- **Metabolism and elimination:** Once the PAS has completed its journey, the organism initiates the process of neutralizing and expelling it. The liver is the main metabolizing organ: it chemically transforms the substance into less active or inactive metabolites that can be eliminated. Final expulsion occurs primarily through the kidneys (urine), although sweat, bile, and exhaled air also participate. To measure the time of this process, the concept of **half-life** is used: the period that the organism needs to eliminate half of the original dose, a datum that determines both the duration of effects and the actual detoxification time. This process is not uniform: children and older adults metabolize more slowly, repeated use can overload the liver and kidneys deteriorating their response capacity, and the variable of sex is especially critical, since the greater proportion of adipose tissue in women slows total elimination, requiring longer detoxification processes.

■ Response to the objections

1. **To the first objection:** The organism is not passive. Metabolism is a **complex and constant chemical process** that converts substances into waste to be eliminated through various bodily fluids and pathways. The body works actively from the first moment of contact with the PAS.
2. **To the second objection:** The process varies significantly according to the individual's profile. Factors such as **age** —children and older adults process more slowly—, **history of use**, and **biological vulnerability** determine the efficacy with which the body absorbs, distributes, and eliminates the substance.
3. **To the third objection:** Although the sought effect is cerebral, pharmacology demonstrates that PAS are distributed through multiple organs during their transit, which explains the physical and medical consequences of prolonged use beyond the central nervous system.
4. **To the fourth objection:** The cessation of the mental effect does not imply the total cleansing of the organism. Metabolism and elimination are processes that demand time and depend on the condition of the liver and kidneys. The body can remain **impregnated with the substance** in adipose tissue for a prolonged time, which requires detoxification processes that go far beyond the subjective disappearance of effects.

9.2.3 Article 3: Lipophilicity as a critical factor in drug storage

■ Statement of the topic: Chemical affinity and organic permanence

The study of pharmacokinetics reveals that the impact of a substance depends not only on its potency, but on its capacity to integrate into the host's tissues. The molecular structure of psychoactive substances (PAS) defines whether they simply circulate through the bloodstream or whether they find refuge in the body's lipid reserves, extending their biological presence far beyond the disappearance of the immediate psychic effects.

■ Central question: What does it mean for a substance to be lipophilic and why is it a critical factor in the storage of drugs in the body?

It is questioned whether solubility is a mere technical detail of the laboratory or whether it is the fundamental cause of the difficulty in achieving total detoxification and of the biological differences in recovery processes between men and women.

■ Existing positions or objections

1. **It seems that drugs are completely eliminated from the body in a few days**, since the mental effects of euphoria or sedation usually last only a few hours.
2. **It seems that body fat is an inert tissue** that has no relationship with the addiction process, which is commonly associated only with the brain or the blood.
3. **It seems that the metabolism and storage of substances is identical for all human beings**, without the gender or physical composition of the individual altering the speed of organic cleansing.

■ Foundation or criterion of discernment

However, against this, science teaches that **most psychoactive substances are lipophilic**, which means that they have the property of dissolving easily in fats. This criterion is essential for understanding how PAS cross biological defenses that other drugs cannot breach and how they manage to remain “impregnated” in the organism.

■ Thesis and argumentative development

We respond that **lipophilicity** is the molecular characteristic that allows a substance to cross cellular membranes composed of lipids, being the critical factor in storage for the following biological reasons:

- **Access to the brain:** Being fat-soluble, these substances can cross the **blood-brain barrier**, a protective membrane that blocks water-soluble medications (such as antibiotics) but allows the passage of small and lipophilic molecules, giving them direct access to neurons.

- **Deposit in adipose tissue:** PAS do not remain solely in the blood; due to their chemical affinity, they are deposited in the **adipose tissue (fat)** that surrounds the organs and veins.
- **Differentiation by sex:** The body of the **woman** is surrounded by adipose tissue systemically, while in men it is concentrated primarily in the belly and back. Therefore, substances remain **impregnated longer in women**, making their detoxification and recovery more difficult compared to men.
- **Re-release phenomenon:** Fat acts as a reservoir that keeps the substance stored; in response to stimuli such as **intense heat or fat mobilization**, the body can release these residues back into the bloodstream even months after the last use.

■ Response to the objections

1. **To the first objection:** Although the mental effects disappear, the substance remains present. A detoxification of a few days only cleanses the blood, but does not manage to eliminate the drug accumulated in the adipose system, which requires longer recovery processes.
2. **To the second objection:** Fat is a dynamic actor in addiction. The “dry trip” phenomenon demonstrates that the substance stored in adipose tissue can reappear in the blood months later, causing symptoms of use without having ingested the drug again.
3. **To the third objection:** Storage is unequal. Because PAS are lipophilic, the greater proportion of body fat in women makes them biologically more susceptible to deep and lasting impregnation, which demands treatment strategies with a gender perspective.

9.2.4 Article 4: The lipophilicity of substances and the *dry trip* phenomenon: between biological persistence and psychological conditioning

■ Statement of the topic

The analysis of pharmacokinetics requires specifying how certain psychoactive substances (PAS) are stored in the organism due to their affinity with fatty tissues. It is common to hear in territorial facilities the description of the *dry trip* or *flashback*, popularly defined as the sudden reappearance of psychoactive effects months after having ceased use, attributing it categorically to the release of the substance accumulated in adipose tissue. While lipophilicity is an unquestionable scientific fact, the assertion that its release from fat produces clinically significant effects lacks absolute consensus. It is necessary to judge how to present this phenomenon with due scientific caution, avoiding proposing as firm certainties what in current medicine constitutes a hypothesis under review.

■ Central question

Should the manual present the re-release of substances from adipose tissue as the proven and definitive cause of the *dry trip*, or is it appropriate to situate this phenomenon within a multifactorial model that considers receptor sensitization and psychological conditioning?

■ Existing positions or objections

- **Objection 1:** It seems that the manual should firmly maintain that the *dry trip* is directly caused by accumulated fat that is released months later (for example, during physical exercise or weight loss), since this offers a simple biological explanation with strong pedagogical impact for alerting about the organic persistence of the damage.
- **Objection 2:** It seems that relativizing the biological cause of the *flashback* would reduce the phenomenon to a mere psychological or spiritual suggestion of the subject, dismissing the material basis of the suffering experienced by the brother in recovery.

■ Foundation or criterion of discernment

Intellectual honesty and scientific realism are pastoral virtues that protect the authority of the manual. Presenting with absolute certainty a debated biological mechanism weakens the technical foundation of the text before academia. Discernment invites us to recognize that the fragility of the human being is integral; the traces left by use are not limited to an inert fat deposit, but configure complex memory networks in the nervous system and in the psyche, which dynamically interact with the context.

■ Thesis and argumentative development

We respond that, while lipophilicity and deposit in adipose tissue are firm pharmacological data (especially notable in substances like cannabis), the assertion that re-release from fat generates clinically relevant psychoactive effects months later should be presented with caution, integrating other contemporary mechanisms through three theoretical clarifications:

1. **The subclinical character of lipid re-release:** Current clinical evidence warns that, while during metabolic processes such as lipolysis (weight loss or intense exercise) traces of the substance accumulated in fat are released into the bloodstream, the levels reached are generally subclinical. This means that the resulting concentrations fall well below the threshold necessary to massively reactivate the original psychoactive effects in brain tissue.
2. **Receptor sensitization in the Nervous System:** The phenomenon of *flashbacks* —common in trajectories linked to hallucinogens like LSD and other PAS— finds a much more solid explanation in maladaptive neuroplasticity. Chronic use generates a hypersensitivity or persistent alteration in neuronal receptors. In the face of certain stressful stimuli or extreme fatigue, these receptors can activate anomalously, partially evoking the perception of use without the substance physically circulating in the organism.
3. **The power of psychological and environmental conditioning:** The framework of Zinberg's Triad (subject-substance-context) reminds us that environmental stimuli operate on affective memory. The return to the corners of use, a scent, a song, or a state of existential anguish similar

Cf. art. 6 (Judge, Very Brief Glossary)

Cf. art. 7 (Judge, Very Brief Glossary)

to that which preceded intoxication can trigger a psychophysiological response that simulates the effect of the drug. The mind and heart of the brother, conditioned by past habit, relive the experience due to the depth of the stored learning pattern.

■ Response to the objections

1. **To the first:** The rigor of the manual does not diminish its preventive force. It is much more profound to explain to communities and State agencies that addiction modifies the perception structures and the psychic alert centers of the individual (making them vulnerable to reliving the trip through environmental triggers), than to sustain a purely mechanical theory about body fat that clinical science qualifies as controversial or weak.
2. **To the second:** Attributing the *dry trip* to receptor sensitization and conditioning does not diminish the gravity of the phenomenon nor make it an illusion. On the contrary, it provides neurobiological and psychological grounding for why a brother who has gone months without using can suffer sudden crises when inhabiting the same territory of vulnerability. This justifies the need for a pastoral care that heals orphanhood through rootedness, providing a safe environment and a stable community family where affective memory can begin to heal.

9.3 | Pharmacodynamics. The impact of the substance on the organism

If in the previous section we analyzed pharmacokinetics (the pathway of the substance and the body's reaction to it), pharmacodynamics focuses on the **structural and functional impact** that the chemical component generates when it infiltrates the central nervous system. At this stage, the substance ceases to be a passenger in the bloodstream to become an active agent that alters the most intimate communication of our cells.

9.3.1 Article 1: The reward system and the illusion of desire: beyond the *pleasure molecule*

■ Statement of the topic

The traditional description of the mesolimbic reward circuit usually identifies dopamine almost exclusively as the *pleasure molecule*, reducing the neurobiological mechanism to a mere search for hedonic gratification. However, contemporary neuroscience has significantly surpassed this reductionist reading. Current clinical evidence demonstrates that the dopaminergic system does not mediate the real enjoyment or pleasure of the substance, but rather the mechanisms of anticipation, motivation, and assignment of importance to environmental stimuli. It is indispensable to judge how to present this circuit without falling into conceptual simplifications, allowing the manual to comprehend the true anatomy of disordered desire.

■ Central question

In what way should the mesolimbic dopaminergic circuit be defined: as the system of hedonic pleasure or as the motor of motivational salience and compulsive wanting?

■ Existing positions or objections

- **Objection 1:** It seems that the manual should sustain the popular definition of dopamine as the pleasure molecule, given that this simpli-

fies preventive pedagogy and allows denouncing with greater ease the hedonistic trap proposed by the consumer market.

- **Objection 2:** It seems that the distinction between the chemical mechanisms of desire and those of real enjoyment is an accessory technical detail that does not add substantial value to the pastoral and spiritual discernment of the territorial agent.

■ Foundation or criterion of discernment

Cf. Addiction as
a failed spiritual
search (ch. 7)

Anthropological realism and the Thomistic vision of the passions teach that the human being possesses a concupiscible appetite that can derail, becoming obsessed with the capture of an object (a blind wanting) even when it has ceased to satisfy or bring authentic delight to the soul. This scientific dissociation aligns perfectly with the concept of *chemical slavery* expounded by the Magisterium of the Church, where the will remains chained to the pursuit of an idol that no longer offers consolation but desolation.

■ Thesis and argumentative development

We respond that the mesolimbic circuit should be presented as a system of motivational salience and not as a mere thermometer of pleasure, clearly distinguishing between the force of the impulse to obtain the substance (*wanting*) and the real hedonic enjoyment of its consumption (*liking*), through three theoretical dimensions:

1. **Dopamine as the motor of anticipation:** Current neuroscience verifies that the massive release of dopamine occurs in response to the expectation of use and the preparation of seeking behavior. It is not the substance itself that generates the greatest dopaminergic surge, but the environmental cues that announce its arrival, operating as a motor of attentional fixation.
2. **The dissociation between wanting and liking:** The processes of delight and hedonic enjoyment (*liking*) are mediated in the organism by distinct neurochemical systems, linked to endogenous opioids and endocannabinoids. In substance use disorder (SUD), the enjoyment circuit wears down rapidly through habituation, while the dopaminergic circuit of compulsive wanting (*wanting*) becomes hypertrophied, trapping the subject in a loop of anxious pursuit.

3. **The hijacking of motivational salience:** The mesolimbic circuit originally functions as a relevance assigner that tells the individual which stimuli are vital for survival, such as food, hydration, or social encounter. Chronic use alters this evaluation mechanism, causing the brain to assign maximum and distorted importance to the substance, tragically subordinating the fundamental needs of the social being.

■ Response to the objections

1. **To the first:** Reducing addiction to pleasure weakens the denunciation against consumerism. The market's narrative affirms that consumption equals happiness; explaining that neurobiology dismantles that illusion by demonstrating that addiction is a *wanting without enjoying* unmask the falseness of artificial paradises in a much more powerful way for community prevention.
2. **To the second:** Far from being an empty technicality, this distinction enriches pastoral judgment. It allows the agent to understand that the brother trapped in consumption is not an immoral pleasure seeker, but a person whose internal motivational compass has been hijacked, requiring the scaffolding of responsible love in community to recover their original freedom.

9.3.2 Article 2: Direct interaction of the molecule with the biological machinery

■ Statement of the topic: The action of the substance on biology

. Once the substance has traveled the path of absorption and distribution, we enter the dimension of what the chemical component does to the body. While pharmacokinetics deals with the “transit,” this new field analyzes the direct interaction between the external molecule and the biological machinery of the human being, centering its attention on how the most intimate communication of our cells is altered.

■ Central question: What does a psychoactive substance (PAS) do to the organism?

It is questioned whether the substance is an agent that simply produces passing sensations or whether it possesses the capacity to structurally and functionally intervene in and modify the natural operation of the biological systems and organs of the subject.

■ Existing positions or objections

1. **It seems that the PAS only affects the will or character**, suggesting that the effect is merely behavioral and that the organism remains biologically the same before and after use.
2. **It seems that the effect is limited exclusively to the brain**, ignoring that the body is a unity and that the substance circulates through the entire bloodstream toward other tissues.
3. **It seems that the substance acts in isolation**, as if it did not interact with the natural chemical signals that the body already possesses for its survival.

■ Foundation or criterion of discernment

However, against this, psychoactive substances are components that **affect the functioning of the central nervous system (CNS)** and have the capacity to **alter the biochemical processes of the body's tissues and organs**. This impact is not superficial, but interferes with the way cells communicate and process the information necessary for life.

■ Thesis and argumentative development

We respond that a PAS acts on the organism by interfering with neuronal communication and altering the homeostasis (dynamic equilibrium) of various organ systems. This process develops through three fundamental mechanisms:

- **Chemical imitation (The “impostor”)**: Substances such as cannabinoids or opioids possess a chemical structure similar to that of natural neurotransmitters. Thanks to this **key of action** (structural complementarity), they deceive receptors and adhere to neurons to activate them; however, being “false keys,” they cause the sending of abnormal messages that the brain cannot regulate.

- **Interference in recycling (The “flood”):** Stimulants such as cocaine act on the transporters responsible for **reuptake** (chemical recycling). By blocking this process, they prevent dopamine from returning to its neuron of origin, causing the intersynaptic space to become **flooded** and the receptors to become abnormally saturated, forcing the brain to adapt to unnatural levels of stimulation.
- **Systemic and biochemical impact:** Beyond the brain, pharmacology demonstrates that PAS alter the biochemical processes of other organs. Abundant consumption weakens the **immune system**, making the subject more susceptible to infections and directly affecting liver and kidney functions due to the toxicity of the components and their adulterants.

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

■ Response to the objections

1. **To the first objection:** The action of the substance is not only moral or behavioral; there are **visible biological changes** and physical indicators (signs) such as alteration of heart rate, changes in brain activity captured in diagnostic imaging, and damage to specific tissues.
2. **To the second objection:** Although its name emphasizes “psychoactivity” (brain), the substance is distributed throughout the entire organism. It produces systemic medical consequences that include cardiovascular, respiratory, renal, and hepatic diseases, demonstrating that **the body is a unity** that suffers the impact in an integral manner.
3. **To the third objection:** PAS do not work in a vacuum. They use their **key of action** to infiltrate the body’s natural chemical language and hijack the existing machinery (receptors). By sending abnormal messages through the neuronal network, they destabilize the vital functions that the organism performs autonomously for its survival.

9.3.3 Article 3: On the definition of addiction: between the neurobiological model and the integrity of the subject

■ Statement of the topic

The study of pharmacodynamics and the impact of substances on the organism usually relies predominantly on the model of the National Institute on Drug Abuse (NIDA), which defines addiction as *a chronic, relapsing brain disease*. While this formulation has enjoyed broad institutional support and has been historically influential in countering simplistic moral stigmas, the contemporary neuroscientific and clinical community warns that absolute adherence to this approach is reductionist. It is indispensable to discern how to present the NIDA perspective without ignoring the current debates that enrich understanding of the disorder, safeguarding the agency of the person (their capacity to act independently, make their own decisions, and be the active protagonist of their own story) and maintaining coherence with the integral vision that sustains this text.

■ Central question

Should the manual define addiction exclusively as a *chronic, relapsing brain disease*, or is it appropriate to situate this formulation within the current scientific debate in order to preserve the biopsychosocial-spiritual model?

■ Existing positions or objections

1. **It seems that the manual should adopt the traditional NIDA definition unreservedly**, given that relativizing its character as a *brain disease* could be interpreted as a regression toward moralistic positions that blame the user for their lack of will or control over their behavior.
2. **Addiction should be classified as a medical condition** qualitatively distinct from any other behavioral process, because there is sufficient biological evidence of the alteration in the intersynaptic space, the hijacking of the reward system, and the compromise of prefrontal cortex functions.
3. **It seems that the brain disease terminology must be maintained** because introducing critical nuances or epistemological debates around the term brain disease would weaken the clarity of the manual vis-a-vis State agencies and international public health technical frameworks.

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

■ Foundation or criterion of discernment

In harmony with the effort made in chapter 8 to overcome fragmentary reductionisms, and in fidelity to the anthropology that maintains that the person is an indivisible unity, it is affirmed that social and psychological factors are not mere secondary *companions* of an organic pathology, but co-constitutive elements of the disorder itself. Neurobiology offers a valuable support for understanding the final observable symptom, but the definitive understanding and approach require a holistic perspective that does not subordinate the subjectivity and history of the person to a strictly materialistic determinism.

■ Thesis and argumentative development

It must be said that the definition of addiction as a *brain disease* constitutes a relevant but partial perspective, which must be carefully situated within the contemporary debate through three fundamental dimensions:

- **The moderation of the institutional paradigm itself.** NIDA itself has been nuancing its original formulation. The researchers who most contributed to coining the definition currently recognize that socioeconomic conditions, trauma, chronic stress, and the cultural environment do not operate as external companion variables, but as biographically constitutive forces of the dysregulation of the central nervous system. The emerging scientific consensus indicates that addiction is a phenomenon that occurs at the intersection of biology, biography, and environment, and not exclusively inside the individual's skull.
- **Addiction as a pattern of deep learning.** From within the neurosciences themselves, it has been proposed that addiction is better understood as a deep and persistent learning pattern than as a disease in the strict medical sense. The neuroplastic changes produced by substance use disorder (SUD) are of the same nature as those generated by any intense and absorbing learning. It is not a pathological process qualitatively foreign to the laws of the brain, but an extreme manifestation of its adaptive flexibility. This distinction does not diminish in any way the severity of the suffering nor the reality of the biological damage; what changes is the nature of hope. Because if the brain possesses the capacity to learn addiction through intense repetition, it likewise possesses the potential to unlearn and trace new pathways. Recovery does not then consist of *repairing a broken organ*, but of accompanying a deep relearning, which is precisely what community and bonding are called to offer.

- **The preservation of agency against biological fatalism.** The absolutist use of *brain disease* language carries the paradoxical risk of undermining the subject's agency. By reducing their suffering to a brain irremediably conditioned by organic chronicity, a feeling of fatalism and helplessness can be fostered that weakens the motivation for change and the person's protagonism in their own reintegration process. Pastoral experience in the territories confirms this tension: when a brother is told that their brain is *sick forever*, there is a risk of handing them an identity of chronic patient that nullifies the possibility of spiritual awakening and the life project that this manual seeks to promote.

■ Response to the objections

1. **To the first:** Sustaining a nuanced and complex perspective does not imply leaving the subject unprotected or returning to the moral judgment of delinquency or sin. On the contrary, decentering the exclusive weight of "brain disease" allows focusing the gaze on the functional orphanhood, trauma, and pain of entire communities that pastoral care is called to shelter. The cause of consumption is not the moral weakness of the individual nor a defective brain, but a web of wounds that involves the person, their history, and their environment in an indivisible manner.
2. **To the second:** The indisputable biological alteration of neurotransmitters is the physical correlate of an existential suffering that frequently precedes and sustains it. Neuroplasticity, which the "brain disease" model invokes to explain the damage, is precisely the biological basis of hope for recovery: the same mechanism that allowed the brain to learn addiction is the one that enables the reconstruction of circuits oriented toward meaning and life. Biology does not close the horizon; it opens it.
3. **To the third:** Far from reducing technical clarity, the adoption of an integral vision positions the manual at the forefront of contemporary clinical and institutional discussions, where the scientific community itself is transitioning toward more complex models than the pure brain disease schema. This is fully coherent with a document conceived as continuously updated, capable of engaging in horizontal dialogue with academia and with territorial reality.

Cf. art. 6 (Judge,
Very Brief Glossary)

9.3.4 Article 4: Recovery trajectories: relapse as part of the process

■ Statement of the topic: Chronicity and the phenomenon of relapse.

In the social imaginary, relapse in substance use is usually interpreted as a definitive failure of treatment or as evidence that the person “cannot” recover. This reading generates serious pastoral consequences: the agent who adopts it abandons the accompaniment, and the person who internalizes it abandons hope. The science of *recovery* proposes a radically different reading: recovery is not a single event nor a point of arrival, but a **non-linear trajectory** in which moments of difficulty form part of the process, they do not interrupt it.

■ Central question: Is relapse the end of the recovery process, or does it form an expected part of the healing trajectories in SUD?

It is questioned whether relapse invalidates the path traveled and forces one to start from zero, or whether it can be understood as a clinical event within a process that continues and that, with adequate accompaniment, leads to sustained recovery.

■ Existing positions or objections

1. **It seems that relapse invalidates the entire previous process**, as if the effort and time of previous abstinence did not count and one had to restart from the beginning.
2. **It seems that those who relapse demonstrate insufficient motivation or capacity for change**, which would lead to reducing accompaniment or considering the case as “without solution.”
3. **It seems that there are people who simply “cannot recover,”** because the pattern of repeated relapses is interpreted as evidence of an irremediable condition.

■ Foundation or criterion of discernment

Research on *recovery* trajectories documents that the great majority of people with SUD achieve stable recovery within a five-year horizon, although the paths are substantially different from one another. What the trajectories have in common is not the absence of relapses, but the **general direction toward recovery**. Relapse is a clinical event that signals the need to adjust the accompaniment, not a sign that the process has failed.

■ Thesis and argumentative development

We respond that recovery in SUD is a non-linear process in which relapse is an expected and manageable event, not the end of the road. As the figure illustrates, people with very different trajectories —early and sustained recovery, recovery with one significant relapse, progressive recovery with prolonged difficulties— converge on a common horizon of stability.

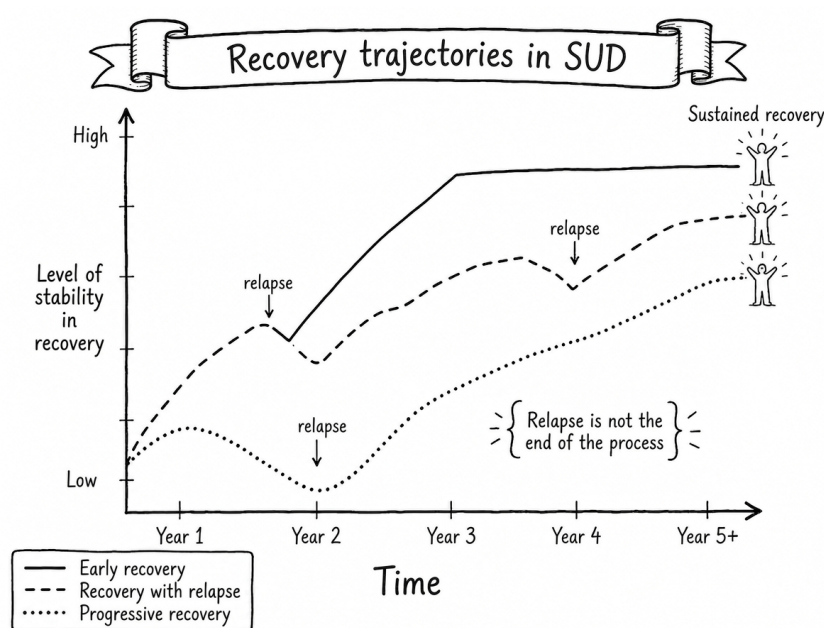


Figure 9.6: Recovery trajectories in Substance Use Disorder (SUD). *Own elaboration based on the chronicity and recovery model of the National Institute on Drug Abuse (NIDA, 2024).*

This understanding has direct pastoral consequences. The companion who understands relapse as part of the process does not abandon the person at the moment of greatest vulnerability —which is precisely when presence is most needed— but rather adjusts the accompaniment to the new situation. Relapse is a **signal, not a sentence**.

■ Response to the objections

1. **To the first objection:** Relapse does not erase what has been learned nor nullify the previous recovery time. The neurobiological modifications, the rebuilt bonds, the acquired tools, and the recovery history remain. Relapse demands an adjustment, not a restart from zero.

2. **To the second objection:** Documented *recovery* trajectories show that relapse also occurs in people with high motivation and real commitment to the process. It is not an indicator of lack of will, but an expression of the biological, psychological, and social complexity of SUD. Reducing accompaniment at that moment is the most costly error a pastoral or clinical agent can make.
3. **To the third objection:** There are no “irrecoverable” people. Long-term research shows that even those who go through multiple relapses over the course of years achieve, in their majority, sustained recovery. What varies is the time and type of accompaniment needed. The pastoral care of hope does not abandon anyone on the way.

9.3.5 Article 5: Structural alteration of neurotransmission in the intersynaptic space

■ **Statement of the topic: The infiltration of the brain’s communication system.**

The human brain functions as an extremely complex biological computer where billions of cells, called neurons, are organized into circuits and networks to control each of our functions. However, this system is not impenetrable; psychoactive substances (PAS) have the capacity to infiltrate this chemical language, distorting the messages that define who we are and how we perceive reality.

■ **Central question: In what way does the PAS alter neurotransmission and the intersynaptic space?**

It is questioned whether the impact of substances is a simple amplification of pleasure or whether it is a structural alteration in the way neurons exchange information in that microscopic space of separation.

■ **Existing positions or objections**

1. **It seems that drugs simply add new sensations**, without modifying the “language” or the natural processes with which the brain already functions.
2. **It seems that all substances act under the same mechanism in the synapse**, suggesting that there is no difference between how a substance depresses or stimulates the system.

3. **It seems that the chemical message is transmitted normally**, assuming that the drug only increases the volume of the signal, but not its content.

■ Foundation or criterion of discernment

However, the brain communicates through neurotransmitters that travel through the **intersynaptic space** to adhere to receptors, functioning like a **key in a lock**. PAS achieve their effect precisely because they **interfere with the way neurons send, receive, and process these signals**.

■ Thesis and argumentative development

We respond that the alteration in the intersynaptic space interrupts normal communication, since the chemical signal cannot be canceled or limited. When saturated by the ‘flood’ or deceived by the ‘impostor,’ the receptors force the brain into a **neuroadaptation**: a defensive response where the neuron reduces its number of locks (receptors) to attempt to protect itself from the excess of stimulation, which initiates the process of tolerance.

■ Response to the objections

1. **To the first objection:** The PAS does not only add sensations, but alters the basic communication process. By interfering with transporters or imitating neurotransmitters, the substance **hijacks the existing machinery** to send distorted signals.
2. **To the second objection:** There are differentiated mechanisms. While some substances **activate neurons by imitation** (such as opioids), others force them to **release excessive quantities** of natural chemicals by preventing their clearance at the synapse (such as stimulants).
3. **To the third objection:** The message is not the same. Substances that imitate natural neurotransmitters activate networks in a vitiated or erratic manner, producing a communication that the brain cannot regulate on its own and that ends up ‘breaking’ the equilibrium of survival circuits.

9.3.6 Article 6: The paradox of the captive will: compulsive wanting without hedonic enjoyment

■ Statement of the topic

Territorial chronicles constantly collect the heartbreaking testimony of brothers in situations of chronic use who express with lucidity: *I no longer enjoy the substance, I abhor it, but I cannot stop seeking it*. Faced with the condemnatory social gaze that assumes that the person in a situation of dependence continues using out of pure delight or hedonistic persistence, it becomes necessary to discern how the alteration of the motivational salience system consummates the slavery of the subject. The manual must integrate this phenomenon to provide scientific and pastoral realism to the approach to the most severe phases of dependence.

■ Central question

Should persistence in chronic use be interpreted as a continuous search for pleasure or as the manifestation of a compulsive wanting disorder dissociated from real enjoyment?

■ Existing positions or objections

- **Objection 1:** It seems that if an individual exposes their health, their bonds, and their dignity in the search for a substance, it is because the physical pleasure obtained continues to be superior to any other stimulus, which would situate the problem exclusively in the weakness of the will before bodily delight.
- **Objection 2:** It seems that maintaining that a person acts driven by a compulsive wanting that no longer produces enjoyment blurs their moral responsibility, reducing the sin of consumption to a biological automatism foreign to free will.

■ Foundation or criterion of discernment

This painful scenario finds its theological illumination in the Pauline description of the internal contradiction of the human being: *I do not do the good I want to do, but the evil I do not want to do* (Rom 7:19). The current ecclesial

magisterium takes up this intuition by defining severe addiction as a loss of original freedom, where disordered passions and neurobiological hijacking annul the intentionality of the subject, leaving them trapped in a materialistic inertia that empties their existence of all vital purpose.

■ Thesis and argumentative development

We respond that severe addiction is fundamentally a disorder of compulsive wanting (*wanting*) and not of hedonic enjoyment (*liking*), which represents the consummation of chemical slavery through three clinical and pastoral clarifications:

1. **The validation of the brother's suffering:** Contemporary scientific evidence validates the truth of the territorial testimony. Due to the mechanisms of organic tolerance, the pleasure that the substance produced in the initial stages diminishes drastically until it disappears; however, the dopaminergic motivational impulse becomes independent of enjoyment, compelling the subject to execute the seeking behavior despite the suffering and secondary pain it generates.
2. **The tyranny of hijacked attention:** The derailed mesolimbic circuit saturates the individual's attention. Although the reason and heart of the brother recognize the destruction of their life project, the incentive salience mechanically assigned to the substance operates as a blind force that clouds the prefrontal cortex, the biological brake of impulses, preventing conscious deliberation.
3. **The devitalization of original demands:** When the reward system remains trapped in this chemical monologue of compulsive wanting, the search for meaning, the life project, and openness to the transcendent become anesthetized. The subject no longer decides in freedom; it is the inertia of the damaged circuit that manages their vital energy, confirming that addiction is not a hedonistic party, but the tomb of human agency.

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

■ Response to the objections

1. **To the first:** The idea that someone who suffers from a chronic SUD uses for pleasure is an unfounded belief that neurobiology itself disproves

and that social stigma uses to justify discarding. Science demonstrates that what sustains the behavior is the tyranny of the hypertrophied dopaminergic circuit of anticipation, coexisting with an absolute void of physical delight, which transforms the experience into a chronic existential torment.

2. **To the second:** Recognizing the fracture of the will does not nullify responsibility, but rather grounds the urgent need for a liberating grace and a network of community care. The person retains their ontological dignity intact, but their freedom is crippled; therefore, the organized community acts as the indispensable external affective scaffolding to restore their capacity to decide and return to them the protagonism of their story through a pedagogy of tenderness.

9.3.7 Article 7: Compromise of vital functions in the brainstem, amygdala, and prefrontal cortex

■ Statement of the topic: The architecture of will and survival

The human brain is not a uniform mass, but a system of interconnected circuits that regulate everything from heartbeats to the most complex decisions. Psychoactive substances (PAS) do not impact the nervous system at random, but rather alter specific areas responsible for maintaining life and allowing the autonomy of the individual.

■ Central question

What vital functions are compromised when drugs affect the brainstem, the amygdala, or the prefrontal cortex? It is questioned whether the impact is a passing alteration or whether it represents a degradation of the biological mechanisms essential for survival.

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

■ Existing positions or objections

1. **It seems that brain damage is limited to memory**, assuming that automatic physical functions are protected.
2. **It seems that the inability to stop using is a moral failure**, ignoring that the brain undergoes physical changes that biologically nullify the capacity to brake impulses.

3. **It seems that overdoses are accidental events**, without understanding that they originate from the chemical depression of the vital control centers.

■ Foundation or criterion of discernment

However, science confirms that addiction is a brain disease because substances change its structure and functioning in a lasting manner. Use alters areas necessary for life and drives compulsive use that escapes voluntary control.

■ Thesis and argumentative development

We respond that the compromise of these three brain areas puts at risk the physical integrity and freedom of the individual due to the alteration of specific circuits:

- **Brainstem (The regulator of life):** It controls automatic functions such as heart rate, respiration, and sleep. Substances such as **opioids** affect this sector, which explains why an overdose can stop breathing and cause death.
- **Extended amygdala (The stress center):** It manages anxiety and irritability. Under chronic use, this circuit becomes hypersensitive; when the drug is absent, the distress is so profound that the person no longer uses for pleasure, but to relieve an unbearable state of stress.
- **Prefrontal cortex (The “brake” of the brain):** It is the area responsible for thinking, planning, and making decisions. When damaged, the person loses control of their impulses and prioritizes use above any family or work responsibility.

■ Response to the objections

1. **To the first objection:** The compromise of the brainstem demonstrates that drugs affect the basic mechanics of life (respiration and pulse), not just memory.
2. **To the second objection:** What is interpreted as “lack of will” is a physical alteration in the prefrontal cortex. Since this area completes its maturation around **age 25**, the individual (especially the young person) lacks the complete biological equipment to evaluate risks.

3. **To the third objection:** Overdose is the ultimate evidence of the impact on the brainstem, where vital functions are “shut down” by flooding the brain’s receptors.

9.4 | Differences according to stage in the life cycle, by sex, and by context

Cf. art. 9.4.3 (Judge, Substances and the Organism, Differences according to..., The differentiated physiological response...)

This section explores how biological and social vulnerability is not a uniform phenomenon, recognizing that the impact of psychoactive substances (PAS) varies profoundly according to the life cycle, sex, and context of the individual. The singularity of women is analyzed, as they present a greater physiological sensitivity due to the telescoping effect and their distribution of adipose tissue. Likewise, the critical fragility of children and adolescents is addressed, whose neuronal development—specifically of the prefrontal cortex—culminates only around age 25, as well as the invisibilized reality of late-onset use in older adults. Finally, the study is situated in the territorial context, evaluating the impact of drug trafficking, homelessness, and structural exclusion, factors that compel transcending a merely clinical approach toward an integral, humanized accompaniment situated in the reality of the most discarded.

9.4.1 Article 1: Increased biological vulnerability in adolescents and young people

■ Statement of the topic: The immaturity of the command center.

Adolescence and youth are not merely stages of social transition; they are periods of a profound biological metamorphosis. During these years, the brain undergoes a process of structural refinement that determines how the individual will process pleasure, risk, and self-control. When a PAS interferes with this design “under construction,” the impact is more severe and lasting than in an adult.

■ Central question: Why are adolescents and young people biologically more vulnerable to developing a substance use disorder (SUD)?

It is questioned whether this fragility responds to a lack of discipline or will, or whether there are specific physiological reasons that explain why the transition toward dependence is much faster in them.

■ Existing positions or objections

1. **It seems that use is only a matter of will**, assuming that a young person has the same rational capacity as an adult to evaluate risks and say “no.”
2. **It seems that an 18- or 20-year-old already possesses sufficient maturity** to discern the risks of use, since they are already legally considered an adult in most societies.
3. **It seems that the precocity of use does not influence its severity**, believing that trying drugs at early ages is merely an anecdote and not a factor that permanently alters the neuronal structure.
4. **It seems that the social environment is the sole culprit**, assuming that the structure of the brain does not play a relevant role in the speed at which dependence develops.

■ Foundation or criterion of discernment

However, against this, neuroscience establishes that the brain continues developing until age **25**. The **prefrontal cortex** —responsible for evaluating situations, making reasoned decisions, and controlling impulses— is the last area to mature. Early use of PAS therefore occurs in an organ that has not yet finished installing its control mechanisms, which generates a critical gap between the capacity to feel and the capacity to decide.

Cf. Macro influences on parenting capacities (Ch. 3) Judge, Substances and the Organism, Definition..., Risks...)

■ Thesis and argumentative development

We respond that the vulnerability of young people rests on three critical neurobiological pillars that the pastoral companion must know:

- **Immaturity of the prefrontal cortex (the biological “brake”):** This area is the last to mature, completing its development around age 25. As it is not yet completely connected with the emotions, the adolescent lacks an **effective biological brake** that allows them to measure long-term consequences, remaining dominated by impulse and the search for immediate gratification. There exists here a critical gap between the law and biology: although the legal age of majority is set at 18, the neurological center for risk evaluation is not consolidated until approximately age 25.

Cf. art. 6 (Judge, Very Brief Glossary)

- **High neuroplasticity and anomalous learning:** The young brain is extremely plastic to facilitate learning. Because PAS use the same processes as memory, the young brain “learns” to be addicted with a speed and force that do not occur in the mature brain. Use before age 25 can also leave **permanent deficiencies** in the neuronal structure that had not yet finished consolidating.
- **Hyperreactivity of the reward circuit:** In a brain thirsty for novelties, the massive surges of dopamine caused by PAS —up to ten times greater than natural levels— “teach” the organism to prioritize the substance above any other healthy learning, installing dependence with disproportionate speed.

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

■ Response to the objections

1. **To the first objection:** It is not only will. The immaturity of the cerebral “brake” generates an organic incapacity for inhibition; the young person’s physical system simply does not respond to the desire to stop in the face of the massive stimulus of the substance.
2. **To the second objection:** There is a critical gap between the law and biology. Treating a young person as a biologically mature adult is a technical error: neuroscience demonstrates that the risk evaluation center is not consolidated until age 25, regardless of what the legislation establishes.
3. **To the third objection:** Precocity is determinant. Addictive learning before age 18 is engraved in the brain’s architecture with disproportionate force, making dependence more severe, more lasting, and potentially generating permanent structural damage.
4. **To the fourth objection:** The environment is crucial, but **biological vulnerability potentiates environmental risks**. A developing brain exposed to an environment of drug supply is incomparably more prone to suffer neuroadaptation than a mature brain under the same circumstances.

9.4.2 Article 2: Influence of neuroplasticity on the speed of addictive learning

■ Statement of the topic: Biological malleability as a risk factor.

The human brain is not born as a rigid structure, but as an organ in constant remodeling that adapts to the experiences of the environment. This capacity, fundamental for survival and the acquisition of knowledge, reaches its peak during childhood and adolescence. However, in the context of psychoactive substances (PAS), this biological flexibility transforms into a critical vulnerability, allowing the addictive circuit to become installed with a speed and depth that does not occur in the adult brain.

■ Central question: What role does neuroplasticity play in the speed with which the young brain learns addictive behavior?

Cf. art. 6 (Judge, Very Brief Glossary)

It is questioned whether the speed with which a young person develops a substance use disorder (SUD) is simply a lack of behavioral maturity or whether it responds to a physical property of the brain that accelerates the learning of the addictive habit above other healthy learning.

■ Existing positions or objections

1. **It seems that the learning of a negative habit takes the same time for everyone**, assuming that the repetition of a behavior generates addiction with the same speed in an adolescent as in a 40-year-old adult.
2. **It seems that neuroplasticity is a process exclusive to positive learning**, such as languages or music, and that it does not intervene in the formation of pathologies such as addiction.
3. **It seems that addiction is only a voluntary choice**, ignoring that there are tangible physical changes in the neuronal structure caused by the stimulus of the drug.

■ Foundation or criterion of discernment

However, the sources define **neuroplasticity** as the brain's ability to physically change based on the stimuli to which it is subjected. Prevention science indicates that substance use disorder is considered a **phenomenon parallel to learning processes**, which means that the brain "learns" to be addicted using the same mechanisms it uses to memorize information.

■ Thesis and argumentative development

We respond that **neuroplasticity is the factor that accelerates the transition toward dependence** in the young brain, functioning as a biological accelerator of the disease for the following reasons:

- **Addiction as anomalous learning:** The brain learns to be addicted using the same mechanisms it uses to memorize information, but at a much greater speed. Because PAS release surges of dopamine much greater than natural ones, the young brain—which is extremely plastic—physically adapts to the drug in a much shorter period than that of an adult.
- **Persistence of early learning:** What the brain assimilates before age 17 through the formation of new connections tends to remain much longer. Therefore, the “learning” of addiction in youth is engraved with disproportionate force in the brain architecture that is being consolidated.
- **Substitution of healthy circuits:** The massive surge of dopamine changes the connectivity of neurons, facilitating the young person’s automatic repetition of use. This displaces the learning of social and emotional skills necessary for adult life, hijacking the individual’s capacity for growth.

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

■ Response to the objections

1. **To the first objection:** The adolescent brain is “programmed” to change intensely in response to stimuli; therefore, the exposure period necessary to become dependent is **much shorter** compared to an adult.
2. **To the second objection:** Neuroplasticity is a **neutral biological mechanism**. The brain does not have the capacity to distinguish whether a stimulus is ‘good’ (like learning a language) or ‘bad’ (like the use of PAS); it simply adapts physically to the most potent stimulus. In this case, the chemical intensity of the drug wins the race against natural stimuli.
3. **To the third objection:** Although the beginning may be a decision, neuroplasticity converts that behavior into a **permanent structural change**. Since the cerebral ‘brake’ (prefrontal cortex) has not yet finished

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

maturing by **age 25**, the young person is left without the physical tools to stop a habit that their brain has already learned at a deep biological level.

9.4.3 Article 3: The differentiated physiological response and the effect according to biological sex

■ Statement of the topic

Historically, studies on addiction and the toxicokinetics of psychoactive substances (PAS) have focused predominantly on male subjects, which has generated a profound knowledge gap about how use affects women differently. However, human physiology is not neutral; biological sex determines critical and incontrovertible variables in the absorption, metabolism, distribution, permanence, and elimination of substances in the organism.

■ Central question

What differences linked to the sexual condition exist in the physiological response to PAS, and why does the female organism present greater structural and metabolic vulnerability to systemic damage and dependence? It is questioned whether the organic impact of drugs is uniform between sexes or whether it responds to specific anatomical mechanisms that accelerate the chronicity of the disorder in women.

■ Existing positions or objections

1. **It seems that the response to drugs depends exclusively on dose and body weight**, assuming that a man and a woman of equal size will react in the same way and that the organic impact is uniform if physical dimensions are adjusted.
2. **It seems that adipose tissue is a passive and irrelevant component in addiction**, believing that drugs only act while circulating in the bloodstream and that, once the blood is cleansed in a few days, the body is completely free of the substance.
3. **It seems that the speed with which dependence develops or the greater sensitivity of women is a purely behavioral or psychological matter**, ignoring the existence of demonstrated metabolic and anatomical factors that accelerate the process of deterioration.

■ Foundation or criterion of discernment

However, scientific evidence and clinical practice confirm that biological variables radically alter the pharmacokinetics of PAS according to sex. Most psychoactive substances possess high lipophilicity, which means they dissolve and deposit easily in fatty tissues. This technical criterion, combined with differences in water composition and metabolism, grounds what is scientifically defined as the *telescoping effect*: the demonstrated tendency of women to progress much more rapidly than men from initial use to the development of a Substance Use Disorder (SUD) and the appearance of serious medical consequences.

■ Thesis and argumentative development

We respond that the sexual differences in physiological response are profound, persistent, and rest on four fundamental biological pillars:

- **Body water levels and plasma concentration:** Women have, proportionally, less water in the body than men. Having less blood and less water to dissolve the substance, with equal doses of PAS, it reaches **higher levels of toxicity** in women's blood, drastically elevating the risk of premature organ damage such as hepatic cirrhosis.
- **Systemic distribution of adipose tissue as a biological magnet:** While men concentrate fat primarily in localized areas (belly and back), the body of women possesses adipose tissue distributed systemically throughout the entire organism. Since PAS are lipophilic, the drug molecules are magnetically attracted by this tissue, transforming the female anatomy into a large, dynamic biological reservoir.
- **Prolonged impregnation and difficulty in detoxification:** This generalized accumulation in fat deposits causes the chemical load to remain impregnated in the woman's organism for much longer than in the man's. The toxicity persists in a latent form and is not eliminated by a simple blood cleansing of a few days, which slows and significantly complicates the natural process of biological detoxification.
- **The telescoping effect and the speed of structural damage:** As a direct consequence of the convergence between greater immediate water-based concentration and prolonged lipid retention, the transition toward severe dependence and structural deterioration of organs occurs in a

notably shorter period in women, consolidating a metabolic vulnerability that conditions the entire clinical approach.

■ Response to the objections

1. **To the first objection:** It is not enough to evaluate body weight; the internal proportion of water and fat varies structurally by sex, which radically alters the pharmacokinetics, elevating the concentration of the substance in the woman's bloodstream and accelerating the progression toward physical damage.
2. **To the second objection:** Adipose tissue is not passive; it functions as a **dynamic reservoir**. The clinical phenomenon of the “**dry trip**” demonstrates that the body can release substances that remained accumulated in fats back into the bloodstream even months after the last use, confirming that the apparent initial blood cleansing does not equate to total detoxification.
3. **To the third objection:** The speed of deterioration or female sensitivity has a demonstrated organic and anatomophysiological basis through the telescoping effect. The speed of chronicity of the disorder does not respond to isolated psychological or behavioral factors, but to objective metabolic variables that accelerate the destruction of tissues and fix the biological dependence.

9.4.4 Article 4: Biological risks in pregnancy

■ Statement of the topic: The vulnerability of the beginning of life.

The use of psychoactive substances (PAS) during pregnancy does not represent only a risk for maternal health, but constitutes a **chemical intrusion** into an organism in formation that lacks its own defense mechanisms. This issue marks the physical and cognitive development of the child before they have the opportunity to be born in a healthy environment.

■ Central question

What specific risks does pregnancy present and what consequences does PAS use have for the newborn? It is questioned whether the damage is limited to the moment of delivery or whether it generates permanent sequelae in the brain structure and quality of life of the infant.

■ Existing positions or objections

1. **It seems that the placenta acts as an infallible filter**, suggesting that the fetus is protected from external toxins.
2. **It seems that “legal” substances (tobacco or alcohol) are less harmful** than illegal ones, minimizing the impact of occasional use.
3. **It seems that withdrawal syndrome only affects adults**, ignoring that a baby can be born with severe physical dependence.

■ Foundation or criterion of discernment

Cf. Differentiated approaches for women (ch. 6) and Spirituality in women (ch. 7)

However, technical sources establish that PAS cross directly through the bloodstream to the fetus. Being substances that are mostly **lipophilic**, they easily pass through the membranes of the placenta and reach the developing brain and organs directly.

■ Thesis and argumentative development

We respond that the use of PAS during pregnancy generates critical and differentiated risks with direct consequences for the newborn:

- **General risks:** Restriction of fetal growth, low birth weight, and high probability of developing **cognitive deficits** and long-term behavioral problems.
- **Alcohol:** It is toxic during all nine months; the baby can be born with **fetal alcohol spectrum disorder (FASD)**, which includes facial anomalies and permanent brain dysfunctions.
- **Cocaine:** It can cause placental abruption, severe hemorrhaging, and cardiac malformations in the fetus.

- **Tobacco:** It exposes the fetus to 7,000 toxic substances, causing malformations such as cleft lip and permanently altering lung growth.
- **Heroin and Opioids:** Babies are born with **physical dependence** and can die from withdrawal syndrome if they do not receive immediate specialized treatment.

■ Response to the objections

1. **To the first objection:** The placenta does not filter PAS; their lipophilic nature allows them to cross this barrier with the same ease with which they cross the blood-brain barrier of the adult.
2. **To the second objection:** Alcohol and tobacco are extremely harmful. Alcohol is toxic throughout the entire pregnancy and tobacco drastically reduces fetal oxygenation.
3. **To the third objection:** **Neonatal abstinence syndrome** is a serious clinical reality; babies are born with tremors and seizures, and their lives are at imminent risk in the first days after birth.

9.4.5 Article 5: Consequences of alcohol use in neonates (NAS and FASD)

■ Statement of the topic: The chemical imprint at the beginning of life

The impact of psychoactive substances (PAS) during pregnancy weakens the biological development of the fetus from its earliest stage. Because PAS cross the **placental barrier** and reach the fetal bloodstream directly, the baby can be born with complications that mark their physical structure and neurological functioning for life.

■ Central question

What is neonatal abstinence syndrome (NAS) and fetal alcohol spectrum disorder (FASD)? It is questioned whether these conditions are temporary difficulties or whether they represent chronic pathologies derived from irreversible structural damage caused by the toxicity of substances.

■ Existing positions or objections

1. **It seems that the baby's withdrawal is only temporary irritability** that disappears within a few days after birth without leaving sequelae.
2. **It seems that only illegal drugs cause these disorders**, assuming that legal substances such as alcohol or tobacco have minimal effects on the newborn.
3. **It seems that alcohol damage only occurs in the last trimester**, suggesting that early consumption is less risky for fetal development.

■ Foundation or criterion of discernment

However, clinical records demonstrate that alcohol is toxic during all **nine months of pregnancy** and that substances such as heroin generate real physical dependence in the baby. The newborn lacks the **metabolic maturity** necessary to process chemical residues autonomously, so these conditions require immediate specialized interventions.

■ Thesis and argumentative development

We respond that NAS and FASD are the most severe manifestations of prenatal exposure to substances, with direct consequences for the neonate:

- **Neonatal Abstinence Syndrome (NAS):** It is a set of symptoms that occur when a baby is born with physical dependence. It manifests with **autonomic hyperactivity**, extreme irritability, tremors, and sleep problems. Unlike adults, newborns can die from withdrawal if they do not receive specialized treatment in intensive care.
- **Fetal Alcohol Spectrum Disorder (FASD):** It encompasses the permanent damage caused by alcohol intake at any stage of pregnancy. It produces **irreversible intellectual disability**, growth delays, and characteristic facial anomalies that limit the child's life expectations and future social integration.

■ Response to the objections

1. **To the first objection:** Neonatal withdrawal is not a minor discomfort, but a severe biological crisis that can include seizures and cardiac malformations, requiring intensive care to stabilize the infant's nervous system.
2. **To the second objection:** Tobacco and alcohol are extremely harmful. Tobacco smoke reduces fetal oxygen and causes malformations such as cleft lip, while alcohol is the leading cause of preventable cognitive disabilities.
3. **To the third objection:** There is no safe level of alcohol consumption. Being toxic throughout the entire gestational process, even early consumption interferes with the formation of critical organs and the development of motor skills.

9.4.6 Article 6: Greater biological vulnerability in poverty and chronic stress

■ Statement of the topic: The biological scar of exclusion

Vulnerability to addictions does not depend solely on genetics or an individual choice; it is profoundly linked to the environment. In contexts of exclusion, the subject's biology does not remain unscathed; on the contrary, the environment of deprivation writes a “**chemical biography**” in the brain, altering the natural mechanisms of pleasure and reward long before the first contact with a substance.

■ Central question

In what way do extreme poverty and chronic stress biologically affect dopamine receptors (D2), increasing susceptibility to addiction? It is questioned whether scarcity and the tension of survival are passing external factors or whether they have the capacity to modify the density of neuroreceptors, creating a fertile physiological terrain for the disorder.

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

■ Existing positions or objections

1. **It seems that poverty is only a social factor**, without real impact on the chemical architecture of neurons.

2. **It seems that stress does not alter the reward system permanently**, suggesting that the brain recovers its equilibrium immediately if the environment improves.
3. **It seems that susceptibility to addiction is equal for everyone**, assuming that the biology of pleasure functions the same in a safe environment as in one of extreme deprivation.

■ Foundation or criterion of discernment

However, from a pastoral perspective we define addiction as the symptom of an internal fracture or a deep pain that the individual attempts to compensate. There is a direct relationship between traumatic experiences in impoverished homes and the physical alteration of specific neuroreceptors such as **D2**.

■ Thesis and argumentative development

We respond that extreme poverty and chronic stress act as disruptive agents of the brain's chemical homeostasis through the following mechanisms:

- **Decrease in D2 receptors:** The constant stress of survival biologically causes a decrease in the density of D2 receptors. This generates a “**biological void**” where the reward system is incapable of processing pleasure from natural stimuli.
- **The drug as self-therapeutic compensation:** Faced with this pleasure deficit, PAS appear as a way to anesthetize bitterness and anxiety.
- **Activation of the alert system:** Chronic stress keeps the individual in a state of nervous hypervigilance, pushing the brain to desperately seek an escape route or anesthesia in the drug.

■ Response to the objections

1. **To the first objection:** Poverty translates into a visible organic alteration. Abuse and the unmet basic needs influence gene expression and weaken the soundness of personality.
2. **To the second objection:** Prolonged stress in childhood affects the maturation of the **prefrontal cortex** until **age 25**, leaving structural deficiencies that hinder the capacity to say “no” to the impulse.

3. **To the third objection:** There is no biological equality in the face of risk. The “**recovery capital**” of a person in poverty is lower, and their nervous system is already conditioned by a hostile environment that accelerates the passage toward severe dependence.

9.5 | Comorbidity and Integral Health

Cf. art. 8.2
(Judge, The Psy-
che, Trauma...)

This section, titled **Comorbidity and Integral Health**, delves into the complexity of subjects who simultaneously face addiction and other critical conditions, such as **dual pathology** and infectious diseases associated with poverty. Dual pathology is defined as the coexistence of a baseline psychiatric disorder (psychosis, neurosis, or borderline personality) with problematic use, where the substance usually functions as a **self-therapeutic attempt** to anesthetize deep traumas and a reality experienced as unbearable. Likewise, the manual addresses the impact of **tuberculosis (TB) and HIV**, conditions that act as markers of vulnerability and that, when not adequately attended by a fragmented health system, result in shameful and entirely preventable deaths. The central axis of this section is **integral biopsychosocial and spiritual health**.

9.5.1 Article 1: Dual pathology

■ Statement of the topic: The intersection between the mind and addiction

The approach to addictions has evolved toward a clinical understanding that recognizes the complexity of human mental health. In most cases, substance use does not present in isolation, but is intertwined with preexisting or substance-triggered psychiatric conditions.

■ Central question

Cf. art. 8.2
(Judge, The Psy-
che, Trauma...)

What is dual pathology and why do 50% of people with Substance Use Disorder (SUD) also present a co-occurring mental disorder? It is questioned whether addiction and mental disorders are independent events or whether there is a common root —biological, psychological, and social— that explains this high coincidence.

■ Existing positions or objections

1. **It seems that addiction is the only real problem**, and that the mental symptoms are passing effects of intoxication that will disappear upon leaving the drug.
2. **It seems that they should be treated separately**, in different institutions and with specialists who do not communicate with each other.

3. It seems that the coincidence is merely “bad genetic luck,” ignoring the role of the individual’s life history and traumas.

■ Foundation or criterion of discernment

However, from a pastoral perspective we define addiction not only as a disease, but also as the symptom of an “**internal fracture**” or a deep pain that the individual attempts to compensate. Research confirms that approximately **50% of people with SUD** suffer from at least one mental disorder, which necessitates an integral biopsychosocial and spiritual approach.

■ Thesis and argumentative development

We respond that **dual pathology** is the coexistence of two clinical conditions: a baseline psychiatric disorder (such as psychosis, neurosis, or borderline personality) and problematic use of PAS. This co-occurrence is grounded in the following pillars:

- **Self-therapeutic attempt:** The substance fulfills the function of **anesthetizing an intolerable, painful, or threatening life** due to prior traumas. Use is an immediate way to reduce anguish and emotional dysregulation.
- **Shared vulnerabilities:** Use and mental health problems affect the **same areas of the brain**, so a psychiatric predisposition increases the biological propensity to dependence.
- **Maladaptive memory networks:** Poorly processed traumatic experiences activate fight-or-flight responses; the drug appears as a “**flight**” tool in the face of a world perceived as hostile.
- **Vicious circle of disconnection:** SUD causes a spiritual and personal disconnection that generates an inner void, aggravating the initial psychiatric condition.
- **Explanatory models of the relationship between both disorders:** Clinical research has identified four models that explain how dual pathology is articulated.
 1. The **common factors model** holds that both disorders share genetic, neurobiological, and social roots —such as early onset of use or unfavorable socioeconomic conditions— that predispose the individual to develop both conditions simultaneously.

2. The **secondary SUD model** posits that a primary mental disorder triples the risk of developing an addiction, since the person uses the substance to palliate their psychic suffering.
3. The **secondary mental disorder model** reverses the relationship: it is sustained use that generates neuroadaptive changes that trigger the mental pathology.
4. The **bidirectional model** integrates the previous ones, recognizing that both disorders mutually potentiate each other, aggravating the patient's condition and complicating any intervention.

■ Response to the objections

1. **To the first objection:** Problematic use is rarely the problem in itself; it is an attempt to cope with a decompensated baseline condition. Ignoring the underlying mental pathology makes treatment inefficient and inappropriate.
2. **To the second objection:** Fragmented care is a technical error. Dual patients require a strategy where the health system and the community work as a network, humanizing the healing journey through affectionate accompaniment.
3. **To the third objection:** Although genetic factors exist (40-60%), interaction with the environment is determinant. **Structural poverty** and insecure attachment bonds weaken personality, creating the “existential crack” where dual pathology becomes established.

9.5.2 Article 2: The impact on the immune system

■ Statement of the topic: Organic fragility and social vulnerability

The use of psychoactive substances (PAS) is not only a cerebral phenomenon; it represents a systemic aggression that weakens the organism's defenses. This issue places the individual at an intersection where physical health is compromised both by the direct chemical action and by the conditions of marginality and exclusion that usually accompany problematic use.

■ Central question

How does PAS use affect the immune system and what is its relationship with infectious diseases such as HIV, tuberculosis, and hepatitis? It is questioned whether the prevalence of these infections is an inevitable biological consequence or whether it responds to a complex dynamic where use alters decision-making and the body's capacity to defend itself.

■ Existing positions or objections

1. **It seems that HIV and hepatitis are risks exclusive to those who inject drugs**, minimizing the risk for other routes of use.
2. **It seems that tuberculosis is a disease linked only to overcrowding**, without an intrinsic relationship with the impact of substances.
3. **It seems that the lack of medications is the only cause of death**, assuming that the formal health system is sufficient on its own without considering treatment abandonment.

■ Foundation or criterion of discernment

However, science confirms that PAS use weakens the immune system, making the person significantly more susceptible to serious diseases. HIV and tuberculosis (TB) act as markers of vulnerability that are not only linked to poverty, but perpetuate it.

■ Thesis and argumentative development

We respond that PAS use impacts immunological health through three critical levels of vulnerability:

- **Direct Biological Impact:** Chronic use weakens the immune response, facilitating the proliferation of pathogens such as the TB bacillus. In injectable drugs, the risk is extreme: it is estimated that 12.6% of users live with HIV and more than half with hepatitis C.
- **Alteration of Risk Behavior:** The decrease in inhibition and the negative cognitive effects lead to an increase in risk behaviors (such as unprotected sexual intercourse), multiplying sexually transmitted infections.

- **Systemic Barriers and Abandonment:** The greatest danger is not the infection itself, but that substance use disorder (SUD) leads to abandoning treatments (ART or TB regimens). The formal system often fails to address the complexity of those living on the street, resulting in absolutely preventable deaths.

■ Response to the objections

1. **To the first objection:** The risk of HIV in people with SUD is **four times greater** than in the general population, even without injection, due to the emotional and behavioral dysregulation caused by use.
2. **To the second objection:** There is a close relationship; use generates such physical and neurological deterioration that the individual loses the notion of self-care, allowing TB to progress as a co-infection alongside HIV.
3. **To the third objection:** Medication does not guarantee health without a **community care network**. As we will see later in the chapter on the social dimension, and in the proposals of Part 4 (Act), peer accompaniment and differentiated care facilities achieve therapeutic success rates exceeding **92%**, surpassing the rigidity of the traditional hospital system.

9.5.3 Article 3: Impact of psychoactive substance use on general health

■ Statement of the topic: The systemic degradation of the organism

Chronic use of psychoactive substances (PAS) not only alters brain chemistry, but subjects the body to a constant aggression that degrades vital organs and systems. When this use occurs in contexts of marginality and homelessness, the biological damage is exponentially potentiated: the lack of housing, malnutrition, and the absence of care networks transform treatable diseases into mortal conditions.

■ Central question

What are the collateral consequences on physical health (oral, gastric, respiratory) derived from marginality and chronic substance use? It is questioned whether this damage constitutes minor side effects or whether it constitutes a systemic pathology that requires an integral approach, given that exclusion fragments the subject's capacity to care for their own life.

■ Existing positions or objections

1. **It seems that physical damage is caused solely by the toxicity of the drug**, ignoring that factors such as cold, lack of hygiene, and hunger are determinant in the appearance of these diseases.
2. **It seems that oral or gastric problems are superficial**, assuming that the only focus of attention should be the central nervous system and neurological detoxification.
3. **It seems that the traditional health system is sufficient to treat them**, without considering that bureaucracy and stigma act as barriers that prevent completing treatments.

■ Foundation or criterion of discernment

However, territorial data indicate that marginality and chronic use generate “**catastrophic expenditures**” in health and drastically reduce life expectancy. The lack of stable housing exacerbates problems ranging from skin diseases to severe respiratory and gastric crises.

■ Thesis and argumentative development

We respond that the physical consequences in these populations are profound and manifest in three critical areas that the companion must monitor:

- **Oral and Dental Health:** The chemical impact of PAS and extreme neglect cause sores, gum diseases, and severe cavities. During abstinence, dental pain is exacerbated, becoming a trigger for use to “anesthetize” the pain.

- **Gastric and Metabolic Health:** Poor nutrition and chronic use lead to gastrointestinal ulcers and liver diseases. The digestive system loses the capacity to absorb essential nutrients, which delays any attempt at neurological recovery.
- **Respiratory Health and TB:** Smoked use (crack, pasta base) causes direct damage to lung tissue. Immunological vulnerability facilitates the proliferation of **tuberculosis (TB)**, which usually presents as a co-infection alongside HIV in street contexts.

■ Response to the objections

1. **To the first objection:** The substance initiates the damage, but homelessness prevents the body from recovering. Factors such as exposure to the elements cause a common respiratory infection to become fatal pneumonia in people with low defenses.
2. **To the second objection:** These problems are not minor; poor oral and gastric health prevents adequate nutrition, which makes it impossible to repair the damaged brain circuits. They are visible signs of a disease that affects the entire being.
3. **To the third objection:** The formal system has a “ceiling” because it only medicates, but does not offer the necessary care network to ensure that someone on the street completes a treatment. Only **community accompaniment** can “stitch together” these fragmented responses to save the subject’s life.

9.5.4 Article 4: Behavioral addictions (Gambling, technology, and pornography)

■ Statement of the topic: The expansion of the concept of addiction.

Historically, the concept of addiction was limited to the use of external chemical substances. However, modern science and pastoral practice have revealed that the human brain can develop addictive bonds with certain behaviors —such as gambling, pornography, or excessive use of technologies— in an astonishingly similar manner to traditional drugs. This reality compels looking beyond the substance and understanding the vulnerability of our own brain architecture to digitally or behaviorally designed stimuli.

■ Central question

Why do behavioral addictions activate the same neurobiological circuits as chemical substances? It is questioned whether it is possible to speak of a “disease” when there is no ingestion of an external chemical, or whether the brain is capable of generating its own “internal drug” in response to specific stimuli, replicating the cycle of dependence.

■ Existing positions or objections

1. **It seems that these behaviors are simple pastimes or lack of discipline**, since there is no chemical that crosses the blood-brain barrier to alter neurons.
2. **It seems that one cannot speak of real addiction if there is no physical withdrawal syndrome**, such as that which occurs with alcohol or heroin.
3. **It seems that “technology addiction” is an exaggerated term**, since these tools are fundamental for modern life and cannot be compared with the damage of drugs.

■ Foundation or criterion of discernment

However, the human brain is “wired” to repeat pleasurable activities through the reward system. Specialized manuals such as the DSM-5 already classify pathological gambling within addictive disorders, recognizing that behaviors can generate clinical and functional impairments identical to those of substances.

■ Thesis and argumentative development

We respond that behavioral addictions activate the same circuits because they hijack the brain’s natural machinery of pleasure and learning:

- **Activation of the Reward Circuit:** Like drugs, behaviors such as online betting or video games generate hyperactivity in the basal ganglia. Although there is no external substance, these activities alter pleasure centers through intense psychological stimuli that trigger internal dopamine.

Cf. art. 9.3.1 (Judge, Substances and the Organism, Pharmacodynamics..., Art. 1...)

Cf. art. 3 (Judge, Substances and the Organism, Definition..., Risks...)

- **From Impulsivity to Compulsivity:** These behaviors usually begin as a search for pleasure, but over time they become compulsive, driven by the need to avoid negative emotions such as stress or anxiety, which is identical to the cycle of chemical addiction.
- **Failure of the Cerebral “Brake”:** The persistent use of these technologies or games weakens the capacity of the prefrontal cortex to control impulses. This explains why the person loses autonomy and cannot stop the behavior despite the negative consequences in their life.

■ Response to the objections

1. **To the first objection:** Although no external chemical enters, the visual or interactive stimulus triggers a cascade of natural neurotransmitters that alter neuronal communication as powerfully as a drug.
2. **To the second objection:** Clinical experience shows that there is a **behavioral withdrawal syndrome** characterized by irritability, anxiety, and obsessive thoughts when access to the game or device is interrupted.
3. **To the third objection:** It is not about the tool, but the use. The design of many digital platforms expressly seeks to “hook” the user, taking advantage of the **neuroplasticity** of the brain —especially that of young people— to install rapid and severe dependence circuits.

Cf. art. 6 (Judge, Very Brief Glossary)

CHAPTER 10

Paths of Integration

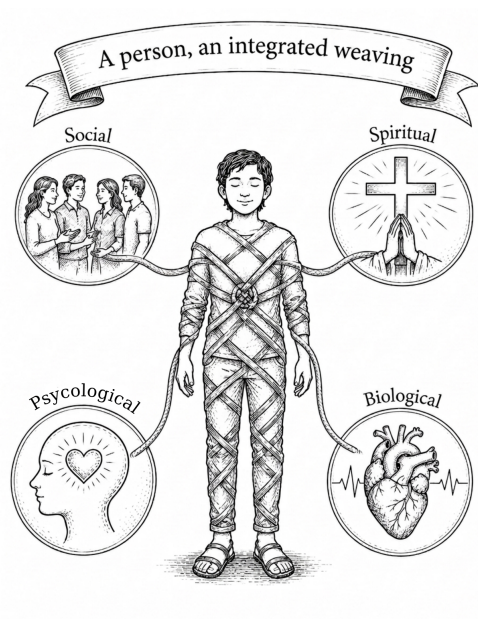


Figure 10.1: The four dimensions of the integral fabric

Throughout the preceding chapters, we offered elements for discernment deployed across four major dimensions: the social being, the human spirit, the psyche, and substances and the organism. Each dimension illuminated an essential aspect of the person suffering from a substance use disorder, and each generated its own questions, its own tensions, and its own response criteria. But the person is not the sum of their dimensions. They are a living unity, and the suffering of addiction cuts through them entirely.

This chapter does not add one more dimension to the map: it traverses the

map in its entirety to show how the dimensions connect. Its function is integrative. The tables that follow cross-reference the fundamental themes of accompaniment with each of the four dimensions, allowing the pastoral agent to locate themselves with precision when facing a concrete situation: what they are looking at, from what angle they are looking at it, and what other perspectives might enrich their response. The articles that accompany them offer criteria of discernment for the tensions that no table can resolve on its own.

This chapter is also the threshold between Judging and Acting. Whoever has gone through this discernment does not come out with a protocol, but with a way of seeing. And that way of seeing is what makes the Act meaningful.

One of the most important tensions running through the preceding chapters deserves to be named before moving forward. The chapter dedicated to the psyche holds that a substance use disorder is not a closed personality structure but a phenomenon that is added to the singular identity of the subject; their dignity and their potential for change are prior to and superior to the disorder. The chapter dedicated to substances and the organism recognizes that chronic use produces persistent neurobiological modifications that condition behavior and hinder recovery. How can something “be added” to identity without defining it if at the same time it durably alters the subject’s biology? The answer lies in the anthropology that vertebrates this manual: the person is an indivisible unity of body, soul, and spirit, but that unity is not an equivalence. What happens in the body is real and cannot be ignored, but the person is not reducible to their body. Addiction modifies the brain — that is a biological fact — but the person who inhabits that brain retains an identity, a dignity, and a vocation that transcend the organic modification. Just as a scar is added to the body without becoming the body, the disorder is added to the biography without becoming the identity. The scar is real, it hurts, it conditions, but it does not define who bears it. And the same neuroplasticity that allowed the brain to learn addiction is what allows it to trace new paths: not because the damage is erased as if it had never existed, but because the human brain is designed to keep learning as long as it lives. That is the biological basis of the hope this manual proposes.

Cf. art. 6 (Judging,
Briefest Glossary)

10.1 | Anthropological foundations

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Human Dignity	Human rights; the right to be called by one's own name in the face of stigma. (§6.1.2)	Inalienable ontological dignity for being the image of God; superior to any sin. (§7.1.3)	Self-efficacy and recognition of the person as a subject and not as an object of assistance. (§8.1.1)	Physical and cognitive deterioration that compromises general health but not the value of the being. (§9.5.3)
Freedom	The street as false freedom; real freedom requires minimum conditions of social justice. (§6.6.1)	Inalienable potentiality; addiction is a "chemical slavery" that obscures but does not erase original freedom. (§7.2.4)	Recovery of autonomy and the capacity to decide in the face of the impulsivity of use. (§8.4.3)	Hijacking of the reward system; the prefrontal cortex (biological brake) is damaged. (§9.3.6)
Identity	Popular and solidarity economy as drivers of identity and labor dignity. (§6.6.4)	Essence of being; inalienable sacred mark. (§7.1.1)	Person First: the disorder is not the identity, it is an added condition. (§8.1.1)	Neuroplasticity that allows "reprogramming" identity toward health. (§9.4.3)
Trascendence	Social charity: familial affection that opens itself to serving the people. (§6.7.1)	Radical capacity to go beyond oneself toward God and neighbor. (§7.3.1)	Meaning of life that allows tolerating distress without chemical evasion. (§8.4.4)	The healing brain does not close in on itself: neuroplasticity opens it toward new bonds. (§9.4.3)

Cf. art. 6 (Judging, Briefest Glossary)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Meaning of Life	Belonging to a people; social protagonism as an antidote to being discarded. (§6.3.2)	Vital purpose as the driving force of identity. (§7.1.2)	Logotherapy: discovery of values in the face of the weariness of existing. (§8.4.4)	Homeostasis: chemical balance that allows the subject to be at peace. (§9.3.3)
Existential Void	Social invisibility and lack of horizons among the “NEETs” (young people who neither study nor work). (§6.2.6)	Pathology of the spirit born from the lack of values and vital purpose. (§7.3.4)	Drugs as a failed suture for a life perceived as unbearable. (§8.4.6)	Decrease of D2 receptors in contexts of chronic stress, creating a “biological void.” (§9.3.6)

10.2 | Biological basis

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Psychoactive Substance	Cultural contexts that ritualize or profane the use of substances. (§8.1.7)	Attempt to fill a thirst for the infinite with material answers. (§7.3.2)	Modification of perception, mood, and behavior. (§8.1.6)	Chemical component that crosses the blood-brain barrier and alters the CNS. (§9.1.1)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Legal Substances	The consumption of alcohol and tobacco is deeply ritualized in social and family contexts. (§6.1.7)	Normalization of alcohol and tobacco as a “gospel of well-being.” (§7.3.5)	The legal/illegal distinction does not determine the level of harm; what matters is the subject’s relationship. (§8.1.6)	Alcohol and tobacco act on the CNS with the same mechanisms of dependence. (§9.1.4)
Reward System	Digital territory (video games, gambling) that activates the same circuits as drugs. (§6.1.4)	Consumerism that saturates the desire for plenitude with immediate pleasures. (§7.3.5)	From impulsivity to compulsivity; adaptation through desensitization. (§8.3.1)	Hyperactivated basal ganglia; massive bursts of dopamine. (§9.3.6)
Prefrontal cortex	Recruitment of children (child soldiers) exploiting the biological immaturity of minors. (§4.5)	Capacity for spiritual discernment to choose good over evil. (§7.2.4)	Executive functions: planning, risk assessment, and impulse control. (§8.1.2)	Late maturation until age 25; it is the biological brake of decisions. (§9.4.2)
Neuroplasticity	Healthy bonds that act as new stimuli for the plastic brain. (§6.2.1)	Possibility of biological “resurrection”; the brain can learn to heal. (§7.4.3)	Unlearning harmful behaviors; creation of new adaptive networks. (§8.4.2)	Every genuine encounter leaves a physical imprint: it is the biology of hope. (§9.4.3)

Cf. art. 9.3.1 (Judging, Substances and the organism, Pharmacodynamics..., Art. 1...)

Cf. art. 3 (Judging, Substances and the organism, Definition..., Risks...)

10.3 | Psychological dynamics

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Trauma	Social exclusion and structural poverty as settings of complex trauma and lack of protection. (§6.6.1)	Trauma as a veil that hides the image of God and generates spiritual orphanhood. (§7.2.2)	Use functions as a self-therapeutic attempt to anesthetize pain. (§8.2.3)	Maladaptive memory networks that dysregulate the autonomic system (cortisol). (§9.5.1)
Memory	Community memory of the neighborhood as a tool for empowerment. (§6.5.4)	Therapeutic memory: recognizing the roots in order to project the future. (§7.4.1)	Reprocessing of traumatic experiences; stitching together the broken story. (§8.2.3)	Maladaptive memory networks stored in the limbic system. (§9.2.8)
Emotions	Emotions born in the bond with the other; Trinitarian relationality. (§8.1.5)	The heart as a unifying center of reason and feeling; search for plenitude. (§7.2.3)	Emotional regulation; use of an emotions journal for introspection. (§8.7.3)	Triggered by the amygdala and stress circuits in the face of negative memory networks. (§9.3.7)
Fear and Anxiety	Terror imposed by drug trafficking; invisible borders in the neighborhood. (§4.13)	Existential desolation that clouds the vision of a hopeful future. (§7.3.3)	Trauma: perception of the world as a constant threat. (§8.2.3)	Hypersensitivity of the amygdala in the absence of the substance. (§9.3.7)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Mental Health	Fragmented health system that expels complex patients. (§4.8)	Fracture of transcendence; deep emotional orphanhood. (§7.3.1)	Coexistence of SUD with psychiatric disorders (psychosis, neurosis, borderline). (§8.2.2)	Dysregulation of the central nervous system; genetic vulnerability. (§9.5.1)
Discernment	Political action: discerning which structures harm the common good. (§6.7.1)	Spiritual wisdom to distinguish false solutions of the market. (§7.7.5)	Process of change: moving from ambivalence to intentional decision. (§8.3.3)	Recovery of the rational part (prefrontal cortex) to assess risks. (§9.3.7)

10.4 | Bonds and community

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Primary Bonds	The family as a school of fraternity and an antidote to individualism. (§6.2.2)	Necessary human mediation to recognize oneself as loved by God. (§7.2.1)	Repair of maladaptive memory networks caused by neglect. (§8.2.3)	Secure attachment that biologically regulates cortisol levels. (§9.4.9)
Family	School of fraternity; support against macroeconomic influences. (§6.2.2)	Domestic church; first place for the transmission of values and meaning. (§7.2.1)	Systemic approach: the family organizes itself around the symptom. (§8.4.5)	Hereditary biological factors of vulnerability. (§9.4.1)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Community Environment	The neighborhood as a community family; community child-rearing against individualism. (§6.2.4)	Impossibility of isolated spiritual experience; mystique of encounter. (§7.9.2)	Family recovery capital; the role of foster families. (§8.5.3)	Chronic environmental stress that conditions gene expression. (§9.4.9)
Culture of Encounter	Antidote against individualism; reoccupation of democratic spaces. (§6.1.1)	Spontaneity of reconnection in the encounter with brothers and sisters. (§7.4.1)	Secure attachment bond in neighborhood centers and parishes. (§8.5.3)	Reduction of biological stress through affective hospitality. (§9.4.9)
Accompaniment	Nonspecific accompaniment in the territory (street, prison, hospital). (§6.7.3)	Road to Emmaus; accompanying without judging to restore hope. (§7.5.1)	Active listening, empathy, and emotional validation. (§8.7.1)	Technical-professional approach necessary to stabilize damaged biochemistry. (§9.5.3)
Active Listening	Hospitality of listening in the face of the coldness of bureaucratic systems. (§6.1.1)	Value of the word and testimony in generating filial trust. (§7.5.4)	Paraphrasing and mirroring techniques so the subject can symbolize their pain. (§8.7.1)	Regulation of the nervous system through the secure presence of the other. (§9.3.7)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Professional vs. Territorial Knowledge	The territorialized pastoral agent possesses a capital of knowledge that is rendered invisible. (§6.5.5)	The spiritual knowledge of the neighborhood companion has its own authority. (§7.5.4)	Tension between the clinical model and community knowledge; management of parity. (§8.5.4)	Technical-clinical knowledge is necessary to understand biochemical processes. (§9.5.3)

10.5 | Social structures

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Poverty	Structural exclusion; lack of land, shelter, and work (the 3 T's). (§6.3.2)	Spiritual desolation due to lack of belonging and roots in a "people." (§7.3.4)	Chronic stress that decreases dopamine receptors, facilitating addiction. (§9.4.9)	Malnutrition and weakening of the immune system from toxic psychoactive substances. (§9.4.9)
Social Justice	Denunciation of structures of sin (drug trafficking) that enslave the people. (§6.7.1)	Political charity: defense of the rights of the most broken. (§7.9.5)	Overcoming social invisibility that generates existential void. (§8.1.3)	Equitable access to neonatal health to prevent disabilities. (§9.4.7)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Drug Trafficking	Narcopolitics and institutional corruption; the narco as neighborhood organizer. (§4.13)	Culture of death; merchants of death who profit from pain. (§5.8.1)	Terror and fear that fragment subjectivity and territory. (§8.2.1)	Production of NPS and fentanyl; toxic adulteration of traditional substances. (§9.1.3)
Stigma	Social labeling that expels the young person from the educational system. (§6.2.6)	Moral disqualification that makes the subject feel unworthy of God. (§7.1.3)	Internalized identity of “addict” that sabotages self-efficacy. (§8.1.3)	Health segregation in hospitals that prevents medical treatment. (§9.5.3)
Digital Territory	New risk setting; digital citizenship and family disconnection. (§6.1.4)	Spiritual disconnection through virtualization and deep loneliness. (§7.3.5)	FOMO; anxiety from constant external approval. (§8.6.3)	Online gambling addiction; alteration of pleasure circuits by notifications. (§9.5.4)
Human Mobility	Interculturality demands that pastoral work adapt its languages and methodologies. (§6.6.5)	The migrant’s uprooting generates spiritual orphanhood. (§7.3.4)	Unresolved migratory grief constitutes a specific risk factor. (§8.2.3)	Disruptions of the biological habitat and vulnerability. (§9.4.9)

10.6 | Specific populations

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Childhood	Functional orphans; recruitment by criminal gangs (child soldiers). (§4.5)	Impact of the lack of home love; wounded spiritual seed. (§7.2.2)	Lack of protective figures; accelerated addictive learning due to plasticity. (§8.6.2)	Average age of first use at 9 years; vulnerable brain under construction. (§9.4.2)
Women and Use	Feminization of poverty; women as weavers of care in the neighborhood. (§6.6.2)	Restoration of the image of God after gender-based trauma. (§7.8.3)	Double condemnation and maternal guilt; specific barriers to treatment access. (§8.6.1)	Telescoping effect ; greater adipose tissue and differentiated metabolism. (§9.4.4)
Maternity	Protection of the family against the threat of custody loss. (§6.6.3)	Community mothers; mystique of maternal hospitality. (§7.8.4)	Repair of the maternal bond after trauma and use. (§8.6.1)	Biological risks in pregnancy; neonatal abstinence syndrome. (§9.4.7)
Travesti-Trans Population	Systemic exclusion; prostitution linked to survival-related use. (§4.11)	Fragile essence; refuge in alternative beliefs due to religious rejection. (§7.1.3)	Identity conflicts and gap between mental image and physical reality. (§8.6.1)	Accelerated physical damage due to extreme street conditions and violence. (§4.10)

Cf. art. 9.4.3 (Judging, Substances and the Organism, Differences according to..., The physiological response...)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Prisons	Extension of the neighborhood's vulnerability; drugs as currency of exchange. (§4.12)	The "abyss of freedom" after release; need for redemption. (§7.4.4)	Fear of psychiatric diagnosis for fear of longer sentences. (§8.2.2)	Overcrowding and poor physical health that aggravate neurological disorders. (§9.5.3)

10.7 | Pastoral and spiritual responses

Amoris Laetitia No. 291

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Mercy	Political charity: advocacy in structures of justice. (§6.7.1)	Sacraments as remedy for the wounded. (§7.6.1)	Unconditional acceptance that allows healing self-esteem. (§8.7.1)	Field hospital: urgent physical care before asking questions. (§9.5.3)
Shared Table	The neighborhood center as a home for families who eat together. (§6.5.1)	Eucharist: food for the weak; sign of fraternity. (§7.6.2)	Heals the internal fracture of being discarded by feeling invited and valued. (§8.5.1)	Recovery of basic physical nutrition in community. (§9.5.2)
Calling by Name	Bond in the face of administrative dehumanization. (§6.1.2)	Recognition of unique and unrepeatable ontological dignity. (§7.1.3)	Emerging from anonymity; overcoming the identity of "addict." (§8.1.3)	Recognition of the singular biological subject, not standardized. (§9.3.3)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Incarnate Faith	A Church that goes out to encounter the excluded in the territory. (§6.7.3)	Spirituality is measured by its incarnation in concrete bonds. (§7.5.6)	Coherence between values and actions as a factor of psychic health. (§8.7.2)	Faith verified in service regulates the companion's stress. (§9.4.9)

10.8 | The ethics of care as a cross-cutting criterion

10.8.1 Article 1: Abstentionism or Harm reduction?

■ Statement of the topic

In concrete pastoral practice, agents who accompany persons with substance use disorders often find themselves facing a dilemma that is perceived as inevitable: opting for the abstentionist model—which orients the entire process toward total cessation of use as a condition for recovery—or for the harm reduction approach—which prioritizes the reduction of risks associated with use without requiring abstinence as a prerequisite for access to accompaniment. This tension, far from being merely technical, has profound pastoral consequences, since it defines who is accompanied and under what conditions. The challenge consists in discerning whether this tension constitutes a true contradiction that forces a choice, or whether there exists a higher criterion capable of integrating it without dissolving either of the two poles.

Lk 10:33–34 — *But a Samaritan who was traveling came to where he was, and when he saw him, he was moved with compassion. He went to him and bandaged his wounds, pouring on oil and wine*

■ Central question

Must pastoral agents choose between the abstentionist model and the harm reduction approach, or does a criterion of discernment exist that can orient action without forcing that choice?

■ Existing positions or objections

- **Objection 1:** It seems that the harm reduction approach implies an abandonment of the person, since by not orienting the process toward total abstinence it renounces the aspiration for their full recovery. Accepting use as a permanent datum would be settling for less than what the

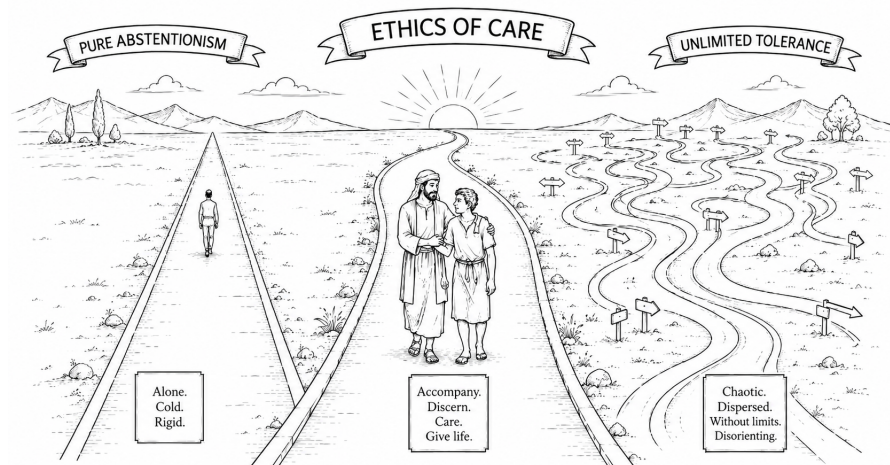


Figure 10.2: The ethics of care between abstentionism and harm reduction

brother or sister deserves, depriving them of the possibility of reaching their maximum dignity and autonomy.

- **Objection 2:** It seems that the abstentionist model equally abandons the person, since by conditioning accompaniment on the achievement of abstinence, it ends up letting go of those who do not achieve it. The one who relapses, the one who cannot or does not want to stop using, is left without a safety net. The demand for results becomes, in practice, a covert form of exclusion.
- **Objection 3:** It seems that both logics are incompatible with each other, and that pastoral work cannot sustain itself in ambiguity. Maintaining both approaches simultaneously would generate confusion in teams, incoherence in programs, and distrust among those being accompanied. It would be necessary, therefore, to clearly opt for one paradigm or the other with institutional clarity.

■ Foundation or criterion of discernment

The fundamental error in all three objections is the same: assuming that the primary criterion of pastoral accompaniment is the clinical result —abstinence achieved or harm reduced— when in reality the primary criterion is the dignity of the person. The **ethics of care** is not a midpoint between two technical models, but a paradigm of a different order: it affirms that access to accompaniment cannot be conditioned by any prior result, but solely by the condition of being a wounded human being who needs to be accompanied.

This criterion is not a pastoral novelty, but the operative translation of what this manual has proposed from the beginning: the image of the Isenheim Altarpiece, where the patients of the monastery of Saint Anthony were not received once healthy nor once willing to heal, but in the rawness of their open wound. The Church as a *field hospital*, in the expression of Pope Francis, does not ask for merits to open the door; it heals first, and accompanies the process without anticipating its outcome. Francis says: *the evangelizing community gets involved by word and deed in people's daily lives, bridges distances, is willing to abase itself if necessary, and embraces human life, touching the suffering flesh of Christ in the people.*

Evangelii Gaudium
No. 24

From this criterion, abstinence is a **desirable and legitimate horizon**, not a condition for inclusion. And harm reduction is a **valid tool in certain stretches of the process**, not a capitulation before the phenomenon. Both approaches are instruments at the service of care, and pastoral discernment consists in knowing when and how to deploy each one, without absolutizing either.

The ethics of care is cross-cutting because it does not belong to any exclusive dimension of the approach—it is not only social, nor only clinical, nor only spiritual—but operates as the ground from which all responses are articulated. The one who cares does not choose between aspiring to the best for the other and accompanying them where they are: they do both things at the same time, in the order that the concrete situation demands.

Responses to the objections:

- **To the first:** The harm reduction approach does not abandon the person when it is oriented by the ethics of care; rather, it sustains them in the stretch of the process where abstinence is not yet possible. To abandon would be to withdraw. To reduce harm is to remain at their side. The aspiration for full recovery is not denied; it is sustained even when the path is longer and more tortuous than expected.
- **To the second:** The abstentionist model does not abandon the person when it does not confuse the horizon with the requirement. Abstinence as a goal orients the process; abstinence as a condition closes it. A pastoral approach that lets go of the brother or sister who relapses is not being faithful to the ideal of recovery, but betraying it: structured mercy—as developed in this manual—knows that the bond is not broken in the face of fragility, but is strengthened precisely there.
- **To the third:** The apparent incompatibility between both models

dissolves when one understands that neither of them is the paradigm, but tools within a greater paradigm. There is no contradiction between upholding abstinence as a horizon and accompanying those who cannot yet reach it. The ambiguity that must be avoided is not that of using different tools according to the moment, but that of not having a clear criterion about why they are used. That criterion is the care of the concrete person, in their singular history, without abandoning them at any stretch of the journey.

10.8.2 Article 2: On the accompaniment of those who do not recognize their problem

Lk 15:20 — *While he was still a long way off, his father saw him and was filled with compassion; he ran to meet him, embraced him and kissed him*

The Father saw him and was moved
He who does not recognize the problem...



Figure 10.3: The Merciful Father

■ Statement of the topic

In concrete pastoral practice, one of the most difficult moments is not that of the brother or sister who asks for help, but that of the one who does not ask. The person who uses without recognizing the harm, who rejects accompaniment, or who simply has no awareness of needing it, places the pastoral agent before a question that admits no easy answer: does it make sense to sustain a bond when the other does not recognize it as such? Is it legitimate to approach someone who has shown no signs of wanting to be accompanied? Or must the agent wait until the subject expresses their need before acting? Pastoral discernment requires clarity about what the foundation of the bond is and at what moment the desire for change is born.

■ Central question

Can the pastoral agent sustain a meaningful accompaniment with someone who does not recognize their problem nor expresses a desire for change, or must they wait for that motivation to emerge before initiating the process?

■ Existing positions or objections

- **Objection 1:** It seems that one cannot accompany someone who does not ask for help, since any unsolicited intervention violates the person's autonomy. Imposing oneself on someone who does not recognize their situation as problematic would be a form of paternalism that disregards their capacity to decide about their own life, reproducing the very logic of control that pastoral work aims to overcome.
- **Objection 2:** It seems that sustaining a bond with someone who uses without recognizing the problem is equivalent to enabling that use. If the agent remains alongside without demanding any change, they could be sending the implicit message that the situation is tolerable, inadvertently becoming an accomplice to a process that destroys the brother or sister.
- **Objection 3:** It seems that without motivation no process is possible. The Transtheoretical Model of Change teaches that the subject in the precontemplation stage is not ready to modify their behavior; therefore, all effort by the companion would be premature and futile, a waste of energy that produces no result and that can end up exhausting the agent and frustrating the person being accompanied.

■ Foundation or criterion of discernment

The error shared by all three objections is the assumption that the bond comes after motivation, when in reality it occurs exactly the other way around: **meaningful presence is the condition of possibility for the desire to change**. No one can desire what they have never experienced even as a possibility. And the possibility of a different life does not emerge from an abstract decision, but from the concrete encounter with someone who sees you, calls you by your name, and remains at your side without conditions.

This principle is not a pastoral novelty: it is what the Isenheim Altarpiece has depicted since the sixteenth century. John and the Magdalene were not at the foot of the cross because the crucified Christ had asked them to stay. They

remained because their love did not need to be solicited in order to sustain itself. That presence which does not demand immediate reciprocity is precisely the model of pastoral accompaniment in the moments of greatest darkness.

From the psychology of attachment, science confirms what faith already knew: the regulated presence of a significant other creates the neurobiological conditions for desire to emerge. The brain damaged by use and abandonment cannot generate motivation in a vacuum; it needs first to experience that there is someone who does not leave, who does not judge, who calls by name. That bond sustained over time acts as scaffolding upon which the person gradually begins to speak, to name what they suffer, and to recognize in that presence the first sign that something better is possible.

The pastoral agent who approaches without waiting for the other to ask does not violate their autonomy: they **build** it. Because autonomy is not a prior datum that must be respected from outside, but a capacity that develops in the bond. A subject who has been subjectively ravaged by use, abandonment, and stigma does not have full autonomy in the abstract sense of the term; they have, however, the possibility of recovering it if someone remains close enough and long enough for desire and autonomy to take place.

Responses to the objections:

- **To the first:** Meaningful presence does not impose or intervene upon the other; it offers a bond. There is no violation of autonomy in staying alongside, in calling by name, in not abandoning. The autonomy invoked as an argument for not approaching is frequently indifference disguised as respect. The pastoral agent does not wait for the other to ask before approaching, because they know that asking requires having previously experienced that someone can respond.
- **To the second:** Sustaining the bond is not approving use. Meaningful presence does not say “what you are doing is fine,” but “I will not let go of you even though what you are doing destroys you.” That distinction is what separates complicity from accompaniment. The Isenheim Altarpiece does not depict John and the Magdalene approving the crucifixion; it depicts them refusing to abandon the crucified one. Remaining at the side of the one who suffers is an act of denunciation of suffering, not acceptance of its causes.
- **To the third:** The Transtheoretical Model of Change does not say that the subject in precontemplation cannot advance; it says they cannot

advance alone. The precontemplation stage is not a wall; it is a threshold. And thresholds are crossed when there is someone on the other side. Motivation does not precede the bond: **it is born from it**. The agent who remains in that apparently sterile stretch is not wasting energy; they are sowing in the only soil where the desire for change can germinate.

10.9 | Practical responses

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Prevention	Promotional spaces (sports/art) to “arrive before” the drug trafficker does. (§6.5.3)	Education in values and the capacity to say “no” to what dehumanizes. (§7.5.2)	Strengthening self-efficacy and refusal skills. (§8.7.2)	Early intervention to protect the child’s brain. (§9.4.2)
Relapse	Support network so as not to abandon the brother or sister who falls. (§6.4.3) and (§8.5.3)	Mercy as the strength to rise again; it is not a moral failure. (§7.7.4)	Pedagogical opportunity within the cycle of change. (§8.3.4)	Cellular memory and “dry trip” from substances in fatty tissue. (§9.2.8)
Healthy Boundary	The boundary set from the bond, not from control; the community norm as a protective embrace. (§6.3.3)	God’s gratuitousness is not disorder; the boundary expresses a love that cares by preventing self-destruction. (§6.3.3)	The healthy boundary reduces anxiety and trains the will through gradual and predictable goals. (§8.3.1)	The predictable structure regulates the autonomic nervous system and decreases cortisol from chronic stress. (§9.4.9)

Continues...

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Substitution Therapies	Rejection of liberalization as a solution; abstinence as a horizon, not as a condition for access to care. (§5.9.2) and (§10.8.1)	Full freedom as the vocation of the spirit; accompaniment does not renounce that horizon even when the path is gradual. (§7.4.4)	Harm reduction as a valid tool in the stretch where abstinence is not yet possible; autonomy as the goal of the process. (§8.3.2) and (§10.8.1)	Pharmacological intervention aimed at preserving life and stabilizing the subject so that the integral process can be sustained. (§9.3.3)
Work	Cooperativism against the easy money of drug trafficking. (§6.3.1)	Work as participation in God's creative work. (§7.4.4)	Development of vocational skills; overcoming the role of being assisted. (§8.7.2)	Recovery of circadian rhythms and physical energy through trades. (§9.5.3)
Self-care	Sustainability of the community network; caring for the caregivers. (§6.7.2)	Theology of rest; the right to leisure that glorifies God. (§7.7.3)	Management of burnout and compassion fatigue. (§8.7.4)	Prevention of biological exhaustion of the companion. (§9.5.3)
Gratitude	Culture of encounter celebrated in the grateful community. (§6.1.1)	Engine of deep healing; recognition of daily miracles. (§7.7.4)	Reduction of anxiety; focus on strengths. (§8.7.3)	Reduction of cortisol levels and immune improvement. (§9.5.2)

10.10 | Dimensions of the process

Topic	The social dimension	The human spirit	The psyche	Substances and the organism
Logic of Time	Artisanal processes versus the logic of institutional franchises. (§6.5.2)	Friendship with time; respect for the sacred history of the other. (§7.7.2)	Stages of the process of change; maturation cannot be forced. (§8.3.1)	Biological chronometer: half-life of elimination and slow processes. (§9.2.10)
Immediacy	Throwaway culture that prioritizes immediate consumption. (§5.6)	False absolute of the market that offers instant magical happiness. (§7.3.5)	Digital impulsivity that erodes the capacity to wait. (§8.6.3)	Speed of action: smoked substances reach the brain in 7 seconds. (§9.2.1)
Comorbidity	Bureaucratic barriers that prevent access to public health. (§4.7)	Anointing of the Sick in critical health situations. (§7.6.5)	Somatization of suffering; treatment abandonment due to desolation. (§8.2.1)	Marker diseases: TB, HIV, oral and dental damage. (§9.5.1)

Discernment is not an abstract exercise. It has a concrete destination: the person on the other side, with their singular history, their open wound, and their desire not yet fully awakened. Everything that has been illuminated in this part of the manual —dignity, freedom, the bond, trauma, biology, the spirit— converges in a single pastoral gesture: that of staying alongside without letting go.

The Act that follows is not the mechanical application of what was learned in the Judging. It is its verification in the flesh of real history. There, in the parish, in the school, in the prison, in the street, the agent will discover that the criteria learned need to be incarnated anew each time, in each person, at each moment. That is not a weakness of the method: it is its greatest virtue. A manual that could tell the agent exactly what to do in each situation would not be forming them; it would be replacing them.

What this manual offers is something more valuable than a protocol: a way of

seeing capable of seeing the other as a complete being, broken but not dead, lost but not without a destination. With that way of seeing, we offer proposals for our Act.

PART IV

Act

The Pastoral Response

When Marcelo came to the chapel for the first time, nobody knew much about him. Some had seen him wandering around the neighborhood for months. He slept wherever he could: sometimes at a friend's house, other times in a doorway, other times right at the train station. He was in his mid-thirties, though his body looked considerably older. He walked fast, always with his head down and a gray jacket on even when it was hot.

He came in on a rainy afternoon. In the parish hall they were finishing catechesis and preparing the afternoon snack for the children. Marcelo stood near the door, uncomfortable, as if he were ready to leave at any moment. A woman who was serving the cocoa milk looked at him and simply asked:

—Do you want something to eat?

Marcelo nodded without saying much. He ate quickly. Then he sat alone, watching how the children ran from one side to the other while a catechist scolded them because they were playing soccer inside.

Nobody asked him right away what he was using. Nobody asked him for explanations. Nobody talked to him about treatment.

First there was a chair. Then a plate of food. Then someone who began to remember his name.

Over time he started showing up more and more often. Sometimes he helped move tables before the afternoon snack. Other times he disappeared for days on end. When he came back, his body carried the weariness of the street, his eyes lost and the mixed smell of smoke, wine, and sleepless nights. The relapses were constant. There were weeks when he seemed to be doing better and then suddenly he would lose himself again. More than once he stole small things to pay for his use. He also lied many times. Some in the community grew tired. Others were suspicious. Some wondered if it was really worth continuing to insist.

But the parish priest kept repeating something simple: — People are more important than their worst moments. Marcelo had started using very young. First alcohol. Then cocaine. Then bazuco or crack. He had gone through temporary jobs, family fights, nights in police stations, and periods on the street. His mother had died years ago. He barely had a relationship with his daughter. For a long time he had lived feeling like he was a nuisance everywhere.

One Saturday, while they were preparing the community soup kitchen, an elderly woman asked him for help carrying some bags of vegetables. Marcelo accompanied her to the kitchen and she, without knowing much about his story, said to him:

—Thank you, son, thank goodness you came because I couldn't do it alone.

That phrase kept echoing in him for days.

“Son.”

It had been a very long time since anyone had called him that.

The community slowly began to become part of his life. Not in a perfect way. Not like in tidy stories. There were conflicts, exhaustion, arguments, and very hard moments. One night he arrived beaten up after a fight. Another time they had to take him to the hospital because he could barely breathe. Later he showed up crying because a friend from the neighborhood had died while using.

And the parish stayed there. Sometimes with words. Sometimes not knowing what to say. Sometimes just being present.

Marcelo began to participate in some celebrations. At first he stayed in the back, near the door. Then he dared to read a prayer intention at Mass. Later he helped arrange chairs after the gatherings. One summer he began to accompany the children at the parish camp. It was not a linear recovery. They never are. There were still bad days. There was still the fear of falling again. He still lived with deep wounds.

But something had begun to change.

He was no longer alone.

And in that simple experience—an open chapel, a community that knows his name, a shared table, someone who waits for him when he disappears, someone who goes looking for him again when he falls—Marcelo slowly began to recover something he had believed lost for years: the feeling that his life was worth living.

Some time later, during a meeting, someone asked him what had been the most important thing for him throughout that whole process.

Marcelo sat thinking for a long while before answering. Then he said slowly:

—I came because I was hungry. . . but I ended up staying because here I felt that if one day I didn't show up, someone would come out looking for me.

Marcelo's story is not a clinical success story. It is a story of bond. Nobody applied a protocol to him. Nobody designed a therapeutic itinerary for him from the first day. Someone asked him if he wanted to eat, and then remembered his name. That was everything — and it was enough for something to start moving.

The proposals that follow in this part of the manual are born from that same logic. They are not recipes or closed models. They are paths that different communities have walked, from the parish to the school, from the neighborhood to the prison, animated by a common conviction: that the first pastoral gesture is not technical but human, and that the ethics of care is not an abstract principle but a concrete decision taken every time someone arrives, every time someone falls, every time someone returns.

The agent who goes through these pages will find tools, criteria, and experiences. But the question that orients everything remains the same one that was asked on that rainy afternoon: *do you want something to eat?*

CHAPTER 11

Pastoral Proposals by Area

This first part gathers guidelines and concrete proposals that any community can put into practice in the different areas where pastoral life unfolds. They are not closed models or fixed protocols. They are proven paths that each community will need to inculturate in its own territory.

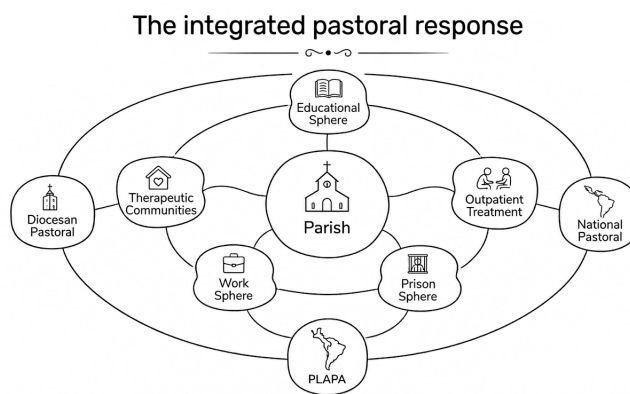


Figure 11.1: The rings of pastoral response

11.1 | Parish setting

If the diagnosis of our time reveals to us a crisis of bonds and a profound sense of orphanhood, the parish's response cannot be limited solely to worship, program management, or the opening of technical programs. The parish, before being an institution that provides services, is called to be a community that generates life. Pastoral action in the world of addictions consists, essentially, in

offering filiation and belonging there where use has left isolation and emptiness.

This mission becomes concrete when the parish manages to constitute itself as a true home. The first gesture of this transformation is the disposition of going out, which is manifested at the entrance door and in street work. A community that does not wait for the suffering person to knock on its door, but goes out to seek them in the margins, on the street corners, and in the corridors where life hurts. This closeness is translated into gestures of radical simplicity: walking the territory, sharing a piece of peace, and receiving life as it comes, without questions, without conditions, and without prior judgments.

Once the bond is established, initial hospitality finds its channel in the creation of groups and shared spaces. We start from the certainty that no one is saved alone; in a world that tends toward fragmentation, the parish offers the circle and the encounter as settings where the word has a place again. This process is sustained through personal accompaniment, a bond of fidelity and patience that consists of walking alongside each unique life, holding the hand in the moments of greatest fragility and accompanying with patience the timing of each process.

Recovery also passes through the everyday and the simple. Community life — sharing the table, organizing the tasks of the day, celebrating bonds— gives back to the person the sense of dignity and of belonging to something greater than their own problems. In this framework, workshops and prevention activities (sports, art, trades) are not entertainment, but tools so that each person can develop their abilities and once again project a future. Spirituality permeates this entire movement, not as an imposition, but as an offer of meaning that invites one to discover a God who walks in simplicity and who is a source of hope.

We understand that recovery and integration processes are long-haul journeys, marked by advances and setbacks. For this reason, parish action implies not letting go of the hand and being willing to start over as many times as necessary. This care necessarily extends to families, who suffer the wear and tear of pain and need to be sheltered in their anguish. Finally, the parish recognizes that it is not an island; it knows itself to be part of a community network and seeks to coordinate efforts with clubs, health centers, and neighborhood organizations, understanding that the territory is cared for by everyone together. When the community manages to be that space of welcome and care, it becomes a sign that life, despite everything, can always sprout again.

We understand that there are some actions that are usually part of the pastoral response of our parishes. It is important that these spaces understand how to

accompany those who suffer from these problems.

11.1.1 Spaces for listening and spiritual accompaniment:

Each life is unique and needs a close bond to sustain it. To accompany is to walk alongside, with patience and fidelity.

Some concrete gestures may include:

- Personal meetings
- Visits
- Being attentive
- Accompanying in paperwork or difficult moments.

11.1.2 Groups, workshops, and life-giving activities:

Doing helps heal and prevent. Learning, creating, moving, discovering abilities opens new paths.

Some concrete gestures may include:

- Trade workshops
- Sports
- Music
- Art
- Tutoring
- Spaces where each person can develop their talents

11.1.3 Work with families:

Families also suffer and need to be accompanied. Caring for them is strengthening the heart of every process.

Some concrete gestures may include:

- Parent meetings
- Listening spaces

- Guidance
- Being close in moments of crisis

11.1.4 The liturgy:

The liturgy is the great moment of encounter for parish communities, in which faith and its understanding are expressed. For this reason it is important that these problems of our people begin to enter into dialogue with our communal prayer and celebration.

Some concrete gestures may include:

- Incorporating these topics in homilies
- Penitential services
- Eucharistic adoration

11.1.5 Spiritual retreats:

Many of our parishes offer what are called impact retreats (Cenacle, Emmaus, etc.) supported by life testimonies that generate identification. It is important that these retreats have room to receive the broken life of the person who uses substances or their family members.

Some concrete gestures may include:

- Incorporating testimonies of people who went through these problems and overcame them.
- Planning group accompaniment opportunities for those who, after making the retreat, want to rethink their life.
- Proposing concrete service actions for retreat participants with people experiencing homelessness or severe social exclusion.

11.1.6 Street work:

The Church goes out to encounter; it does not wait. It goes to seek, makes itself close, gets involved in the life of the neighborhood, and opens its doors so that everyone has a place.

Some concrete gestures may include:

- Street routes
- Mission in the neighborhood
- Being on the street corners
- Opening the parish with some food or drink to share
- Receiving without questions or conditions.

11.1.7 Neighborhood Centers

An open door in the neighborhood

Problematic use of substances is not only an individual health problem: it is, above all, a symptom of exclusion. Behind every person who uses there is almost always a story of affective orphanhood, of violated rights, of broken bonds. Therefore, a response that limits itself to the clinical or the spiritual without rooting itself in the territory where that person lives, works, and suffers, always arrives late and always arrives from outside.

The parish has an advantage that no other actor in the system possesses: it is already in the neighborhood. It does not arrive at the territory; it lives in it. It knows the families, knows the history, knows the names. That prior insertion is the most valuable resource it has to build a pastoral response to problematic use, and it is the foundation upon which a neighborhood center can be built.

A neighborhood center is not a health center, nor a therapeutic community, nor a soup kitchen. It is something different and more basic: a space of welcome and bond from which everything else is articulated. It is, to use an image from the language of sports, the midfield: the ball passes through there. From there one reaches the resources of the system and from there one returns. Without that territorial node, interventions remain fragmented and people are left alone in the journey between one program and another.

Three axes: closeness, management, and accompaniment

The methodology of the neighborhood center is sustained on three axes that are not stages but permanent and simultaneous attitudes.

Closeness. The first gesture is not technical but human: making room. Receiving life as it comes, without conditioning access to any prior requirement. The person who arrives —or the one who is sought out— does not need to be

ready to change, nor to have made a decision, nor to have their basic problems resolved. They arrive as they are, with their open wounds, with their entire history. The neighborhood center receives them that way, and starts from there.

This closeness is built with concrete gestures: a plate of food, a remembered name, a home visit, accompaniment to a medical appointment. These are not auxiliary gestures to accompaniment: they are accompaniment itself in its earliest forms. Real inclusion, not discursive, is always body to body. Every person is sacred; no life is surplus.

A key element of closeness is the **integral gaze**. The neighborhood center does not attend to one part of the person —their use, their health, their legal case— but to their complete history. It seeks to know their family, their housing, their bonds, the support network they have or lack. This comprehensive view is possible precisely because the center is in the neighborhood and can see what no external specialist can see.

Management. The second axis is network coordination. The neighborhood center does not replace the health system, the school, judicial bodies, or state programs: it connects them with the person. Many times what fails is not the existence of resources but access to them. Bureaucracy expels; schedules exclude; forms intimidate. The neighborhood center acts as an interface between the person and the system, accompanying them through every procedure, every referral, every admission, every discharge.

This function as a node in the network is irreplaceable. Without it, a person who leaves a therapeutic community is left alone. With it, they have a place to return to, someone who waits for them, a network that sustains them while they rebuild their life.

Accompaniment. The third axis is the continuity of the bond over time. The processes of recovery from problematic use are long, nonlinear, marked by relapses and setbacks. The formal health system works by episodes; the neighborhood center works by stories. It sustains the bond before the problem, during treatment, and after discharge. There is no moment when accompaniment ends; there are moments when it becomes more or less intense according to what the person needs.

Who sustains the center

The neighborhood center does not require a team of professionals to function. Its strength lies in **volunteers with territorial roots** — people from the

neighborhood itself who know the territory because they live in it — and in **peer companions**: people who have themselves gone through situations of use and exclusion, and who for that reason have a credibility and a closeness that no outside technician can match.

The peer companion does not accompany from theory but from the experience of pain, falling, and the real possibility of starting over. Their presence says what no discourse can say: that change is possible because it has already happened in someone of flesh and blood, from that neighborhood, with that history.

The role of the pastoral agent or ecclesial leader is to sustain the mystique of the whole, to ensure that the center does not lose its identity of unconditional welcome, and to coordinate with broader networks — parish, diocesan, institutional.

The center as a spiritual space

Problematic use is, among other things, a spiritual illness. Not in the moralistic sense of the term, but in the deepest sense: the person who uses has frequently lost the conviction that their life is worth living. They have lost meaning, joy, the passion for existing.

For this reason the neighborhood center is not just a social program: it is a space where meaning is engendered. Where someone calls you by your name and that alone is already a spiritual act. Where the community says with its presence that no life is surplus. Where, little by little and without hurry, the passion for living is rekindled.

The parish that opens a neighborhood center is not offering an additional service: it is being what it has always been called to be. A place where the excluded find a place. A big family that receives life as it comes.

11.1.8 How to begin

It is not necessary to have everything figured out to start. What is needed is a physical space — it can be a room in the parish hall — a small group of people willing to welcome, and the decision not to judge whoever arrives. The rest is built along the way.

Some concrete steps for getting started:

- **Map the territory:** Who are the people in situations of use in the

Cf. Gen 4:9
— *Where is
your brother?*

neighborhood? Where are they? What resources already exist in the area — health centers, municipal programs, community organizations?

- **Identify leaders:** Are there people in the community with recovery experience who could accompany as peers? Are there volunteers rooted in the neighborhood willing to be trained?
- **Open the space:** A fixed schedule, a known location, a door that is always open. Regularity generates trust; trust generates bond; bond generates process.
- **Coordinate with the network:** Know the programs available in the territory — health centers, therapeutic communities, employment programs, ombudsman offices — and build concrete relationships with their leaders. The neighborhood center cannot do everything alone; its strength lies in being the node of a network that can.
- **Get trained:** Accompaniment of persons with problematic use requires tools. The training of agents is not a luxury but a condition for sustainability. Without it, burnout causes volunteers to leave and the center to close.

11.1.9 The embrace of childhood

In some realities where the average age of first use is 9 years, the parish cannot wait for the problem to manifest in adolescence; it must *arrive before* through promotional spaces that strengthen the construction of the social being.

Parish action with children is grounded in the paradigm of *community child-rearing*. This model understands that when families are very dysfunctional or very broken, child-rearing is not a task confined exclusively to the sphere of biological family intimacy, but rather a responsibility shared by the entire community. The parish must constitute itself as a *big family* that offers shelter and belonging where primary bonds are fragile.

Criteria and actions for parish work

For this accompaniment to be effective and transformative, the following lines of action are proposed:

- **Prioritize the basics:** Before any deep pedagogical or spiritual approach, the community must ensure the right to food, hygiene, and warmth. The

bath, the shared table, and the embrace are the first medicines that restore dignity to the child.

- **Specific listening spaces:** It is necessary that within the parish there be places where children have their own voice and specific teams that attend to them. The child's companion should not be the same one who accompanies the mother or father, to avoid biases and to ensure that the child feels like the protagonist of their own process.
- **The pedagogy of tenderness:** The healthy boundary in the accompaniment of children is tenderness. One must act with infinite patience, recognizing that a child who has been violated is *being born again* and needs models of authority that are not based on punishment but on example and forgiveness.

Fundamental roles in the territory

The community deploys its healing strength through key figures that the parish must identify and empower. These are the **Support families**. In this proposal, some families of the community open themselves to collaborate with the school, with therapy, or even to temporarily house children in crisis situations, adding arms and affection to the child-rearing network.

Finally, the parish must always work toward the strengthening of the family bond of origin, avoiding over-intervention that fragments the child or forced separation that deepens the damage. The goal is to accompany the adults in charge so that they can recover their capacity for care, while the Church acts as the support fabric that leaves no one alone in the task of raising children.

11.1.10 The preventive proposal of the “3 C’s”

In the face of the pain and suffering that so many neighborhoods endure, prevention cannot be reduced solely to informational campaigns or sporadic interventions. Prevention is, above all, the decision to arrive before, to *take the first step*. It is going out to encounter before suffering becomes deeper and proposals of death occupy the place that the community left empty. It is going to seek the lost sheep, and working so that the others do not get lost.

The parish, understood as the Church among the houses, is called to look at the neighborhood with eyes of mercy and with the heart of a family. There where life takes place —on the street, in the plaza, on the corner, at the school, on the playing field— the Christian community also discovers its place of mission.

The neighborhood is the parish, and the parish is called to organize itself to care for life.

On this path, many communities have been discovering that prevention requires generating concrete spaces of belonging, identity, and care. It is not enough merely to denounce the advance of drug trafficking or warn about the risks of use. It is necessary to build real proposals for life, capable of accompanying children and adolescents on a daily basis.

That is why the *3 C's of Life* were born: Chapel, College, and Club. Three dimensions profoundly united among themselves, which express a community that organizes itself to receive life as it comes and to accompany it in all its stages.

The 3 C's of Life: The three “C's” express a single pastoral intuition: to build healthy and joyful spaces where children and adolescents can grow accompanied, develop their potential, and discover that their lives have value.

The Chapel offers community and meaning. The College opens horizons and opportunities. The Club generates belonging, identity, and daily care. The three together form a community fabric that accompanies life integrally.

That is why the “3 C's of Life” are presented as a concrete response to the “3 C's of death”: the Street, the Prison, and the Cemetery. There where the throwaway culture proposes abandonment and hopelessness, the Christian community responds by organizing hope and building a culture of encounter.

The three “C's” are not isolated programs or independent structures. They are expressions of a Church that wants to become a family in the midst of the neighborhood, a Church that receives life as it comes and organizes itself so that no young person is lost.

11.1.11 Self-Help Groups

What is a self-help group

A self-help group is defined as a meeting point where people facing a similar problem—whether grief, addictions, marital separation, or chronic diseases—share their challenges, difficulties, and coping strategies. These spaces are characterized by horizontality and reciprocity among their members; all are considered equals and possess a unique authority based on lived experience. Unlike a therapy led by experts, the group focuses on mutual accompaniment and peer support.

Advantages of a self-help group

Participation in these groups offers significant benefits for the person's integral well-being:

- **Reduction of isolation:** By connecting with people in similar situations, the person stops feeling stigmatized or alone in their pain.
- **Emotional management:** It helps reduce anxiety, improves self-esteem, and fosters hope by seeing the progress of others who act as models.
- **Empowerment:** It strengthens the members' capacity to solve their own problems and share updated information about their condition.
- **Low cost and high efficacy:** It is an accessible model of social intervention that requires little investment and generates a high community impact.

Why a self-help group in the parish

The parish is an ideal place for these groups because it embodies the Church's mission as a field hospital and a center of integral healing. From a theological perspective, these groups live synodality, understood as the path that members of the People of God walk together. Implementing these groups in the parish allows:

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- Leveraging the institutional trust and closeness of the Church with its members.
- De-stigmatizing mental health, treating it as a medical condition requiring care and not as a weakness of character.
- Transforming pain into an opportunity for encounter with Christ and growth in community.

What types of self-help groups exist

There are various recovery communities based primarily on the twelve-step model, classified according to the area of intervention:

- **For the person with addiction or compulsive behavior:**

- **AA (Alcoholics Anonymous):** The pioneering group focused on recovery from alcoholism.
- **NA (Narcotics Anonymous):** For those seeking freedom from dependence on any type of drug.
- **Gamblers Anonymous:** Focused on gambling and betting addiction.
- **Sex Addicts Anonymous:** For recovery from compulsive sexual behaviors.
- **For family and friends:**
 - **Al-Anon:** Groups for adults affected by a loved one's alcoholism.
 - **Alateen:** Specific spaces for adolescents who live with alcoholic family members.
 - **Nar-Anon:** For family members of people with drug addiction.
- **Other mutual support groups:** Such as the Resurrection Group for people in grief.

The 12-step program

The 12-step program is a mutual help model among peers designed to overcome addictive and dysfunctional behaviors. It is based on a set of guiding principles that seek a spiritual awakening and an integral life change through the following steps:

1. *We admitted we were powerless over our addiction — that our lives had become unmanageable.*
2. *We came to believe that a Power greater than ourselves could restore us to sanity.*
3. *We made a decision to turn our will and our lives over to the care of God as we understood Him.*
4. *We made a searching and fearless moral inventory of ourselves.*
5. *We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.*
6. *We were entirely ready to have God remove all these defects of character.*

7. *We humbly asked Him to remove our shortcomings.*
8. *We made a list of all persons we had harmed, and became willing to make amends to them all.*
9. *We made direct amends to such people wherever possible, except when to do so would injure them or others.*
10. *We continued to take personal inventory and when we were wrong promptly admitted it.*
11. *We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and to practice these principles in all our affairs.*

11.1.12 Catechesis

In practically all parishes, chapels, and organizations linked to our Catholic Church, there is some process of catechesis. It involves an enormous number of people who entrust their faith to God, who open themselves to the inspiration of the Holy Spirit, and prepare to walk with Christ in their daily lives.

What better opportunity for all these people and groups to question their relationship with the use of psychoactive substances, and the way they see people with substance use problems in order to minimize processes of stigmatization. From a pedagogy of trust, affection, and family and community co-responsibility, specific topics related to drugs can be addressed.

Illuminated by the Word of God, in catechesis processes the prevention of drug use is related to Christian identity. Education is provided in interior freedom, in the promotion of healthy bonds capable of resisting those personal and social dynamics that lead to various forms of slavery.

The topics to be developed, adapted to each age, group process, and particularities, are:

- The love of God.
- Gratitude for and care of the body as a gift from God and love toward oneself.

- Understanding and caring for emotions.
- Building and managing healthy relationships in couples, families, and friendships.
- The influence of social and peer pressure toward drug use.
- The Christian understanding of freedom and possible forms of slavery, including drug use and related problems.
- Discernment in the face of temptations, specifically in relation to psychoactive substance use.
- The love of God as mercy and inspiration to change when we make mistakes.
- The love of God in processes of forgiveness when we have been harmed by our own actions and those of others.
- The mission to care for ourselves and care for others on their path of salvation.

For the activities to be feasible in practice, it is important to offer simple, participatory, and adaptable pastoral materials for diverse ecclesial settings. The itinerary format helps provide suggestions that can then be adapted to the reality of each group. It can generate a process in itself, or be interspersed with other catechetical itineraries.

The suggested methodology and approach is as follows:

- Reinforce Christian identity and the capacity to say “no” to evil with interior freedom.
- Highly visual and participatory gatherings.
- An atmosphere of trust and affection.
- Positive, simple, and concrete vocabulary.
- Illuminate with the Word of God.
- Adapt to the different stages of life: childhood, adolescence, youth, and adulthood.
- In groups of children and adolescents, integrate parents or adult reference figures in some sessions.

- Adapt the topics, materials, and pedagogical dynamics to the differences that may exist between men and women in situations related to drug use. This may include different dimensions, such as the impact on the body, cognitive and emotional processing, identity construction, and the social contexts that affect each person in their being male or female.

11.1.13 The parish club: a community that generates belonging

In many neighborhoods, the street corner appears as one of the main spaces of identity and belonging for adolescents and young people. But many times that belonging is shot through with proposals of violence, use, crime, or hopelessness. In response, parish clubs emerge as a concrete response from the organized community to care for life.

Parish clubs are often born in a simple way: a game on the neighborhood field, a youth soccer school, a boxing class, a dance workshop in the parish hall, or a recreational activity organized by young people of the community. But when the community sustains those small gestures over time, they begin to transform into true spaces of encounter, care, and belonging.

A parish club is a community that uses sports, play, art, and shared life as tools to accompany and care for the lives of children and adolescents in the neighborhood.

Over time, those small spaces grow and consolidate. Weekly trainings appear, teams by age groups, tournaments, trips, camps, celebrations, jerseys, banners, and colors that express a shared identity and strengthen the sense of belonging.

But the central thing is not the activity itself. The most important thing is the bond that is generated around it. The coaches, teachers, and leaders are not merely those who teach a sport: they are significant adults who listen, accompany, provide support, and help others grow.

The parish club is not born to select the best or to train high-performance athletes. It is born so that no child is left out. So that everyone has a place where they are expected, recognized, and accompanied.

That is why its rules tend to be different from those of many traditional clubs: free fees, flexible enrollment, inclusive proposals, and a logic where no one is left out for not performing or for not being “good” at sports.

The jersey, the crest, the banner, the colors, the trips, the tournaments, and the celebrations generate something much deeper: the feeling of being part of

a family.

There where many children were alone, without activities, without adults who looked at them or accompanied them, the club becomes a daily presence. A place where someone asks how they are doing, sets boundaries, listens, advises, and embraces.

In many contexts permeated by drug trafficking, it is not enough to offer isolated activities or only on weekends. Criminal organizations dispute every day the heart, the time, and the sense of life of our young people. That is why prevention needs sustained presence, spaces open during the week, and community processes that accompany daily life.

The club then appears as a concrete response to isolation and the throwaway culture. While the logic of drug trafficking organizes death, violence, and exclusion, the organized community proposes encounter, play, friendship, care, and belonging.

The training sessions cease to be simply sports practices to become spaces of accompaniment. Preseasons, trips, and camps become times of fellowship and community. Competition ceases to focus solely on winning and comes to express other values: playing together, not leaving anyone out, learning to share, and celebrating even in the midst of difficulties.

Through sports, art, and culture, clubs also become true schools of positive leadership. Many young people who grew up participating in these spaces later take on tasks of accompaniment, coordination, or training of other children from the neighborhood, themselves becoming community leaders.

Thus, the parish club becomes much more than a recreational space. It is a pastoral and community strategy to reach those who were being left alone. A concrete way of organizing hope and contesting the territory from tenderness, presence, and the care of life.

The importance of Volunteering

The Addiction Pastoral Ministry in diocesan and parish settings does not sustain its fruitfulness through the mere hiring of professional services, but through the vocation and commitment of its volunteers. The volunteer is not a secondary collaborator or an emergency assistance resource; they constitute the foundational mission and the very heart of the Pastoral Ministry in all Instances of Ecclesial Communion.

Assuming the centrality of volunteering means recognizing that the Samaritan

witness of the Church is incarnated in men and women of the community itself who offer their time and their lives to embrace the most vulnerable. It is this network of gratuitous closeness that sustains the day-to-day of the neighborhood centers, shaping the mystique of the “home” and the “extended family” before structuring the specific mechanisms of support, supervision, and institutional care for the operating teams.

11.1.14 Caring for the caregivers

Foundation and Meaning

Caring for pastoral agents is a central element of service. It is where the quality of the accompaniment provided in the mission is determined.

Principles from the Magisterium and Humanity

The care proposal is sustained on five fundamental principles that allow the task to be humanized and prevent emotional exhaustion or *burnout*:

- **Culture of encounter:** Recognizing one’s own vulnerability and that of the other through a tender gaze that genuinely asks about the companion’s wellbeing.
- **Tenderness as strength:** Understanding that tenderness is the language of the smallest ones and a transformative tool in contexts of pain.
- **Recognition of one’s own wound:** Accepting that the caregiver is also a vulnerable person who is psycho-spiritually *broken*, which allows for more horizontal and human accompaniment.
- **Rest as part of the mission:** Following the command of Mark 6:31 (“Come away by yourselves and rest a while”), rest is not an interruption of the task, but a necessary condition to be able to sustain it over time.
- **Managing boundaries and guilt:** Learning to draw healthy boundaries and let go of what does not depend on oneself, working through the guilt generated by stopping. In this regard, the Serenity Prayer is an important guide:

*Lord,
grant me the Serenity
to accept the things
I cannot change
courage,
to change the things I can
and wisdom
to know the difference*

Parish Action Strategies

For care to be effective, the parish must institutionalize concrete spaces and protocols:

- **Fraternal Gatherings (“Stop to Keep Going”):** Hold monthly team meetings to share life, pray, and process the frustrations inherent to the territory, reinforcing awareness of working in a network.
- **Apostolate of Time:** Create a network of lay volunteers who temporarily fill in for the primary caregiver in administrative tasks or basic accompaniment, allowing them to take brief rests or attend to personal matters.
- **Emergency Protocols (ABC Guides):** Establish clear action guides for crises so that the agent knows how to act without receiving the entire emotional impact in a disorganized way.
- **Supervision and Continuing Education:** Offer listening spaces with professionals or experienced peers to supervise the work, orient the vocation, and prevent the suffering of those assisted from being personally carried home.
- **Spiritual and Recreational Resources:** Foster the use of specific spirituality materials (prayers, music), as well as experiences of connection with nature or recreational activities that offer a “breath of fresh air for the soul.”

Conclusion

Caring for the caregivers from the parish means moving from an attention centered solely on the success of treatment to an integral gaze that values the physical, mental, and spiritual health of its servants. Only through a community that cares for itself as a network is it possible to sustain hope in the places where being discarded and suffering seem to prevail.

11.1.15 Grief accompaniment: remaining when death arrives

In the pastoral ministry of addictions, death is not a distant possibility: it is a frequent companion. Brothers and sisters who die from overdose on a street corner. Young people murdered over debts with the drug trade. Mothers who find their children lifeless in a room. People experiencing homelessness whose death never makes the newspapers. The territorial experience confirms that many pastoral agents and families live with a succession of losses that rarely find a space for processing and consolation.

However, grief over the death of a person with addiction possesses characteristics that distinguish it from other forms of grief and that the parish community needs to understand in order to accompany:

- **A stigmatized grief.** The family that loses a child to overdose or violence associated with use carries a double pain: the loss and the shame. Society tends to issue an implicit judgment —“they must have done something wrong,” “he brought it on himself”— that isolates the bereaved and denies them the right to the public consolation naturally granted in the face of other deaths. This loneliness of grief is one of the cruelest forms of being discarded.
- **An anticipated and prolonged grief.** Many families begin grieving long before physical death. The progressive deterioration of the brother or sister, the disappearances, the admissions, the successive relapses gradually generate a loss of the person they knew. When death arrives, it is sometimes experienced as a relief that immediately generates guilt. Other times it arrives as the confirmation of a pain that had been carried in silence for years.
- **A grief without closure.** In contexts of territorial violence, many families do not recover the body, do not know exactly what happened, or the death goes unpunished. The impossibility of closing the cycle aggravates the suffering and can make it chronic.

- **A grief that reaches the pastoral team.** Agents who accompany people with problematic use lose brothers and sisters with whom they have walked for months or years. Those deaths leave deep marks that, if not processed, accumulate until they produce an emotional exhaustion that can lead to abandoning the task.

The theology of grief that this manual proposes has been depicted since the sixteenth century in the Isenheim Altarpiece. The scene of the burial of Jesus, described in chapter 3, shows the Church that remains when efficacy has been silenced. Mary, John, and the Magdalene do not try to resurrect the crucified one; they hold him, weep for him, and prepare his body with reverence. That is the image of a community that does not abandon its dead or those who mourn them. As the manual says: *the Church is a mother who does not let go of her children's hand, not even when the world has already buried them.*

Some concrete gestures may include:

- **Memorial liturgies.** Periodic celebrations —at least once a year— where the parish community names and remembers the people who died from causes linked to substance use in the territory. These liturgical spaces fulfill a double function: they honor the memory of the deceased and break the isolation of families by making public and communal a pain that is usually lived in the secrecy of shame.
- **Accompaniment groups for bereaved families.** Regular spaces where mothers, fathers, siblings, and partners who lost someone to addiction can share their experience with others going through the same reality. These groups do not require specialized professional leadership, although coordination with a mental health professional for cases of complicated grief is recommended. What they do require is a leader trained in active listening and a commitment to confidentiality and non-judgment.
- **Personalized accompaniment at the time of death.** When the community learns of the death of a brother or sister in a situation of substance use, the most important pastoral gesture is to be present: to go, to accompany the family through the procedures, to offer the celebration of funeral rites without conditions and without judgment. In many cases, the family fears that the Church will reject or judge them; unconditional presence at that moment can be the beginning of a bond of trust that sustains the subsequent grief process.
- **Memorials of remembrance.** Some neighborhood centers and communities in the region have created physical spaces —a wall, an altar, a

corner— where the names or photos of those who are no longer here are placed. These memorials function as a community gesture that says: this person existed, was loved, and their life had a value that death does not erase.

- **Processing spaces for the pastoral team.** Agents who lose brothers and sisters need their own space to process those deaths. This is not resolved with a quick prayer at the end of a meeting; it requires dedicated moments where the team can name those they lost, express what they feel, and receive the support of their peers. This dimension connects directly with what was developed in the previous subsection on caring for the caregivers.

Grief accompaniment is not a minor addition to the pastoral ministry of addictions. It is the litmus test of the ethics of care: if the Church accompanies only while there is hope of recovery and withdraws when death arrives, then its presence was conditioned on the result and not on the dignity of the person. Remaining at the side of the family that lost their child —without easy explanations, without moralisms, without the temptation to find an immediate meaning in the meaningless— is the most naked and most truthful pastoral act that a community can offer. It is what Mary, John, and the Magdalene do in the predella (lower part) of the Altarpiece: they stay.

11.2 | Educational setting

11.2.1 School prevention

Speaking of prevention in the school setting requires, first and foremost, broadening the perspective. If we reduce prevention to the transmission of information about substances or to sporadic interventions in response to emergencies —such as “workshops on addictions”— we run the risk of staying on the surface of the problem. Accumulated experience and reflection invite us to understand that problematic use does not constitute an isolated phenomenon, but is often the expression of a deeper crisis: fragility in bonds, weakening of the community fabric, and, in many cases, a void of meaning in people’s lives.

In this framework, the school occupies a privileged place. Not because it must solve such a complex problem by itself, but because it is one of the privileged spaces where habits, bonds, perspectives on life, and future projects are shaped. When a school does what is proper to it well, it becomes profoundly preventive.

Now then, when does a school do what is proper to it well? We could say, synthetically, that it does so when it contains, accompanies, and enables life planning. Let us briefly dwell on each of these essential dimensions of the educational task.

Containment and accompaniment

Prevention in the school begins, before anything else, with an attitude: that of presence, closeness, and bond. Being there, listening, sustaining, enabling the word. Many times, the first preventive gesture is not a structured intervention, but the ability of a significant adult to generate trust and recognition.

From there, prevention unfolds as the construction of a true institutional culture of care. It is not simply about adding isolated activities, but about reviewing practices, climates, and daily dynamics: How do we relate to one another? What place do we give to the students' voice? How do we address conflicts? What experiences of belonging do we offer?

In line with what has been developed in this manual, we know that addictions often have their roots in a deep affective orphanhood, in the weakening of bonds, and in the difficulty of finding meaning. It is not just about “not knowing some things,” but about an existential disposition: the person experiences a void that ends up crystallizing in the perception of a hostile or uninhabitable world. Then use appears as an illusory way out, a form of evasion.

In the face of this negative experience of the world, the school can become an inhabitable place, a space that invites being present. And this happens, above all, through everyday bonds. It is especially the reference adults —teachers and non-teaching staff— who can generate an atmosphere of kindness and recognition, where students can be present with their stories, often marked by pain and anguish.

The school often functions as a true “field hospital”. There arrive children, adolescents, and also adults with deep wounds. But for those wounds to be sheltered and accompanied, it is necessary that the adults do not pass by, that they do not become entrenched solely in functional or bureaucratic matters that end up generating distance and indifference.

In contexts of social fragmentation, this presence acquires decisive importance. Many children and adolescents today grow up in environments where reference adults have ceased to be protective figures to become invisible or absent. Added to this is the fact that, in many vulnerable contexts, drug trafficking advances seeking to recruit children and young people. There the task of containment

and protection that schools carry out becomes urgent. Something similar occurs with the risks associated with the “digital territory,” including new forms of addiction linked to the problematic use of screens and devices. In many cases, schools are becoming one of the few settings capable of helping regulate these forms of use.

A boy or girl spends a large part of their life in school. That is why it is important that during that time they can be present with their story and their reality; that they can explore their interiority and do so from an experience of kind coexistence with others. Ultimately, it is others who make the world inhabitable. Every person needs to feel recognized and valued for who they are—and not only for what they might become. There trust is strengthened, and it constitutes the firm ground upon which the life trajectory unfolds. In contrast with “addiction”—understood here as that which blocks or silences—the school must be a space for “diction”: a place where each student can find and express their own voice.

On the contrary, when someone goes through the school experience as an anonymous person, as someone unrecognized, the school not only ceases to prevent but can become a setting that predisposes to evasion. Moreover, when relationships in the school environment become hostile (through violence or bullying, indifference, excessive competition, etc.), all this is likely a breeding ground for addictive behaviors: thus the school generates the tendency toward evasion, toward not wanting to inhabit and be present.

When the school truly manages to constitute itself as an Educational Community, bonds form a powerful network of containment and care. Trust then prevails over the mere logic of control. In this framework, the school transforms itself into a promoter of an authentic Culture of Care. This demands, of course, an intelligent coordination among the different instances of accompaniment: from the person at the reception desk to teachers, tutors, and guidance teams. Prevention is never an individual task; it is always a collective construction.

And although many times we do not have all the answers, we can build them together with others. That is why it is fundamental to understand that prevention is not exhausted within the school. The coordination with families, community organizations, and other actors in the territory extends the reach of actions and strengthens care networks. The school thus becomes a node within a broader fabric capable of sustaining people in their multiple dimensions.

Life planning

The other great element that makes the school preventive is its capacity to collaborate in the life planning of students: that is, in the way a person imagines, orients, and organizes their life toward the future.

Life planning has to do with the meaning each person gives to their existence, with the horizons toward which they want to walk, and with what they consider valuable. It is not limited solely to concrete goals —“I want to study a certain career” or “I want to have a certain job”— but includes much deeper questions: what kind of person do I want to become, what bonds do I want to build, what values do I want to embody, what mark would I like to leave, how do I imagine a full and meaningful life.

The school is, in this sense, a privileged place for developing a true “pedagogy of hope.” Perhaps this is one of its greatest challenges today. Horizons for planning often appear weakened or outright canceled. On one hand, we live bombarded by painful situations and social narratives permeated by disenchantment. On the other, reality often presents itself as closed upon itself, without transcendence or promise.

But the school needs hope as an essential input. We educate because we hope; and we hope for something good from people and from the future. The school is called to be an antidote to the lack of horizons.

There is here a subtle yet profoundly significant matter: when the educational proposal appears void of meaning, colorless, unhealthy, or even “indigestible,” it too can cause harm. Besides fostering, in many cases, school dropout, it generates skepticism regarding the very possibility of planning one’s life. There where someone should find inspiration and meaning, they find something that numbs and discourages them.

That is why one of the essential functions of the school consists in opening horizons, daring to ask about ends and not only about means. Education cannot be reduced to providing tools or skills for survival; it must also offer meanings that allow one to aspire to a full life.

Students need to be able to recognize themselves as protagonists of their own life project. A project that reaches its fullness when it is thought from the perspective of service, communion, and openness to others. Only thus can each person bear “fruit in abundance.”

Concrete actions and guidelines

We share here some concrete actions and guidelines that are already practiced in many of our schools and that have a preventive character.

Create listening spaces in the school: Listening at the right time can change a story. The school must be a place where someone can speak and be received. **Some concrete gestures may include:**

- Tutoring sessions
- Dialogue spaces
- Availability of teachers
- Providing accessible places to approach

Commit to the educational community A school that cares generates belonging. When someone feels they are part of something, life is better protected. **Some concrete gestures may include:**

- Integration activities among students, parents, teachers, non-teaching staff, administrators
- Participation spaces
- Caring for the climate among all.

Youth protagonism: Young people are not just recipients; they are protagonists. They can care for each other and be part of the response.

Some concrete gestures may include:

- Peer groups
- Youth leaders
- Student-driven projects

Work with families: The school and the family need each other. Together they can better support the children.

Some concrete gestures may include:

- Meetings with parents
- Dialogue spaces
- Accompaniment

Teacher training: The educator is key. They need tools, but also support for their task.

Some concrete gestures may include:

- Training sessions
- Reflection spaces
- Institutional support

Coordination with the territory: The school is not alone. It is part of a broader care network. **Some concrete gestures may include:**

- Links with parishes
- Neighborhood centers
- Accompanied referrals.

Without a doubt, in this and other matters, the school can and often does encounter its limits. And this obliges it both to critically examine itself and to avoid shutting itself behind walls that, although they claim to protect it, end up suffocating it.

In a context marked by multiple fragilities, the school is called to be a sign and space of care. Not from a logic of surveillance or control, but from a proposal that humanizes, bonds, and gives meaning.

Wherever there exists a true educational community, there also exists a profoundly preventive setting.

11.2.2 Universities

When we speak of a University we recall its three principal roles:

Teaching: it is the transmission of knowledge.

Research: it is the production of knowledge.

Extension: it is the relationship with the Territory.

Although we habitually focus more on Teaching, it is urgent to remember that all three must be coordinated. When the University distances itself from the territories, its research does not serve their needs and its teaching ends up repeating the same knowledge, often decontextualized. On the contrary, when these three roles are well integrated and complement each other, the University contributes to Integral Human Development in a much fuller way. For that reason, we will attempt to account for each of these roles in their relationship with our topic.

The University cannot remain indifferent to the drug problem or to the realities of poverty, because it is one of the most complex problems of the contemporary social fabric. That is why university intervention is fundamental through education, social commitment, interdisciplinary research, and extension.

The institutional vision must assume the approach to substance use from a public health and human rights perspective, rejecting criminalization and promoting the integration of the subject into the community through knowledge and accompaniment. It must understand and convey that the person who uses substances is a subject of rights, and what the consequences of that are. Likewise, this action aligns directly with the global commitments of the Sustainable Development Goals (SDGs), which are part of the global action plan adopted by the member countries of the United Nations (UN), directly impacting the Eradication of Poverty (SDG 1), Health and Well-being (SDG 3), Gender Equality (SDG 5), Innovation and Infrastructure (SDG 9), Reduction of Inequalities (SDG 10), and the building of Peace, Justice, and Effective Institutions (SDG 16).

When the University includes these topics in its academic offerings, the number of leaders who respond to the problem is multiplied. Therefore, if the diagnosis made by our communities in the territory reveals a great disproportion between the problem and the responses, it is necessary to influence the Universities so that they incorporate these topics across their academic agenda. Another important task is the contribution of evidence-based inputs for public debate and for understanding the legal framework of each country. Grassroots actors, entirely devoted to the urgencies of the territory, do not have the institutional time for continuing education. It is important for the university to bridge that

distance, transferring the knowledge and scientific tools that strengthen and give confidence to the valuable work they already do in their communities.

Teaching

The university must not only train territorial leaders but also the professionals who will become specialists. Traditionally this role has been envisioned for physicians, psychologists, social workers, lawyers, or nurses. However, given the complexity of addictions and social vulnerabilities, all university programs and courses must actively commit to this challenge, training professionals who are sensitive and technically prepared. In this way, the institution assumes this cross-cutting commitment as a direct contribution to the global fulfillment of the Sustainable Development Goals (SDGs).

The academic offering must expand through the cross-cutting nature of the different fields of knowledge. Below, let us see some examples:

- **Education and Teaching Degree Programs:** They have the potential to design and deliver educational and pedagogical workshops (such as teaching the mother tongue, foreign languages, literature, culture, among others) adapted for people undergoing treatment.
- **Engineering and Technical Programs:** They can promote practical workshops (such as mechanics, computer science, or electricity, among others) aimed at training and qualifying the workforce, opening paths for job placement.
- **Business and Administration Programs:** They have the capacity to offer entrepreneurship and personal finance workshops, training participants in the creation of cooperatives and micro-enterprises that ensure their economic autonomy.
- **Arts, Design, and Communication Programs:** They can implement art therapy, music, and design workshops as tools for emotional expression, as well as collaborate in the design of stigma-free community prevention campaigns.
- **All areas of knowledge:** They have the capacity to develop courses and projects that promote dynamics to strengthen low self-esteem, motivate the continuation of studies, and encourage access to higher education.

University study must provide protocols so that prevention is more successful and treatments are safer, with scientific rigor. The University must teach future

professionals that the approach is not the same in a school, in a factory, or in a courtroom, but that one must be trained with specific tools that adapt to the reality of each person and each context.

Finally, university knowledge is the best defense against punishment. A trained professional knows that substance use is a health matter and not a crime. This ensures that programs treat people with dignity, respect their privacy, and seek their recovery, always complying with the laws in force in each territory.

Research

It is urgent to develop a methodological proposal that designs the foundations for an applied research line linking territorial programs with academia and public agencies, aimed at generating scientific data capable of effectively influencing current drug policies.

- **Epistemological Shift:** It is necessary to reduce the current disproportionate emphasis on reductionist neuroscientific approaches that isolate the phenomenon in the individual brain. That knowledge is important, but not the only one needed.
- **Strategic Objectives:**
 1. *Policy Influence:* It arises from the articulation of two complementary streams: the construction of community power from the grassroots and the mastery of the technical-institutional language of evidence-based public policies.
 2. *Arriving Before:* It is urgent to develop research with a preventive approach to identify early warning signs in the trajectories of children and youth.
 3. *Responses to Substance Use:* It is necessary to diagnose, map, and document the actual dynamics and patterns of use in peripheral neighborhoods.
- **Methodological Complementarity:** It is urgent to promote a horizontal dialogue between the university and the territory through a mixed methodology:
 - *Quantitative Research:* Production of rigorous statistical data, fundamental for demonstrating the scale of the problem and competing for state budgets.

- *Qualitative Research (Grounded Theory)*: Adoption of the *Grounded Theory* approach under the methodological premise of “going bare to listen” to the territory, allowing analytical and therapeutic categories to emerge directly from the voice of coordinators and neighborhood protagonists.

Based on this approach, the discussion and evaluation of results obtained in territorial classrooms and workshops allows understanding how education acts as a fundamental pillar for the reconstruction of lives. The direct interaction and exchange of scientific-cultural academic experiences generate a valuable data bank for future research, fostering the development of science and reflection on the role of the education system as a real instrument of social inclusion.

- **Co-construction of Community Indicators:** This consists of the joint development of dynamic evaluation metrics for auditing community processes. This indicator overcomes the static state bias (centered solely on abstinence or clinical discharge) to measure processes of real inclusion: document regularization, restoration of family bonds, health check-ups, school re-engagement, and development of labor autonomy in cooperatives.

University Extension

The University’s relationship with the territory must not be assistentialist, but based on the transfer of knowledge and direct action in the diverse environments of society. Therefore, extension projects can and should be implemented in any community space, prioritizing those with the highest rates of social exclusion, such as public schools, community centers, soup kitchens, informal settlements, and spaces of critical vulnerability. Coordination is carried out both with the actors already operating in the territory (community leaders, neighborhood leaders, and NGOs) and directly with the inhabitants of these areas.

The idea is to train these leaders and communities through the delivery of statistical data, field studies, and updated reports, enabling the design of strategic, intelligent, evidence-based interventions adapted to the most neglected realities.

The territorial organizations should be provided with methodological tools so that they can carry out their own surveys, enabling early detection of new use trends or emerging risks in specific areas. It is important to translate university research into practical guides and simple action protocols that serve as technical

support so that the neighborhood leader knows how to act, whom to turn to, and how to sustain accompaniment in contexts of high vulnerability.

Through this extension engagement, lives are given new meaning through university extension, achieving fundamental results based on five essential pillars:

1. **Raising self-esteem and reducing the feeling of marginalization:** It shows participants (as occurs, for example, with women in situations of vulnerability and addiction) their true potential and personal value, combating stigmas and prejudices.
2. **Increasing commitment to one's own recovery process:** Continuous learning awakens interest in new education and employment opportunities.
3. **Promoting social interaction and the exchange of knowledge:** It creates an environment of mutual support through coexistence and horizontal dialogue between communities and the volunteer university team.
4. **Training participants:** It offers practical and technical knowledge to ensure a much more autonomous social and economic reintegration into society.
5. **Contributing to a more sensitive and humane teacher education:** It allows academics and future teachers to develop empathic skills and pedagogical tools designed specifically for complex teaching environments.

11.3 | The labor setting

At the heart of our communities and pastoral proposals, work is understood as a necessity. Work constitutes the fundamental axis upon which the recognition of human dignity is rebuilt and the social fabric damaged by profound exclusion is mended. “*Embracing life as it comes*” means receiving each brother and sister in their total reality, assuming the commitment to accompany them integrally from their first arrival in a situation of homelessness or problematic use, to achieving their full social and labor inclusion.

Work, besides being indispensable for dignity, *helps to weave relationships of exchange and mutual aid, allows one to feel a collaborator of God in caring for and developing this world, and makes one feel useful to society and supportive of their loved ones.* For those who have inhabited the margins of being discarded

and vulnerability, survival mode consumes all their daily energy; formal or community work interrupts that destructive logic, restoring the certainty of being a protagonist of their own story.

Therefore, it is necessary to develop strategies aimed at effectively guaranteeing access to the sacred right of **Work**, integrating it as a therapeutic and pedagogical tool within the recovery itinerary. These are not activities parallel to pastoral work, but pastoral work itself incarnated in the table, the workshop, the cooperative, and solidarity finances, promoting a social economy centered on life, that cares for the Common Home and respects the processes of the community.

11.4 | Diocesan Pastoral Ministry

The problem of addictions does not recognize parish boundaries. It affects families throughout the diocese, exceeds the response capacity of any single community, and demands a perspective that can encompass the territory as a whole. For this reason, the organization of pastoral ministry at the diocesan level is not an administrative option but a pastoral necessity.

A diocesan response allows, in the first place, a more precise knowledge of the territory's reality: identifying the most affected areas, the resources that already exist, and the gaps that remain unaddressed. Without that map, each parish acts in isolation, duplicating efforts or leaving without care those who need it most.

In the second place, the diocesan dimension makes it possible to coordinate a network of accompaniment that no single parish could sustain on its own. Therapeutic communities, family groups, training teams, and prevention programs in schools can be coordinated and complement each other when there is an entity that convenes and sustains them.

Finally, the particular Church —the diocese— is the proper place of ecclesial communion. It is there where the bishop, as pastor, can promote a unified response that reflects the option of the entire local Church for the most vulnerable. A diocesan pastoral ministry of addictions is, in this sense, a concrete expression of synodality: walking together toward those who need it most.

11.4.1 Mission

That the Church care for its children:

The pastoral ministry of addictions reflects the Church's call to care for each

one of its children, embracing especially those who need it most, and developing preventive strategies so that the youngest do not compromise their lives on paths that harm them. This integral care is not limited only to spiritual support, but extends to the physical, emotional, and social dimensions of each person, each family, and community. Through this pastoral ministry the Church strives to protect and heal those who have fallen into the abyss of addiction, offering tools for their recovery, constant accompaniment, and hope in a new life, while implementing adequate prevention measures to keep more people from suffering these forms of slavery.

That the Church be the family of the most broken:

The pastoral ministry of addictions must be the welcoming face of a Samaritan Church that does not fear to embrace those most wounded by life. Like a mother who receives her most fragile children, the Church is called to be refuge and consolation for those who, through diverse circumstances, have fallen into the slavery of addictions. This pastoral ministry thus becomes a concrete expression of the unconditional love of God, building a spiritual family where the most broken are seen, heard, accompanied, and integrated into the community, in their process of healing and redemption. In this sense, Pope Benedict XVI said: *The Church is God's family in the world.*

Benedict XVI, *Deus Caritas Est* (2005).

That the Church deepen its option for the Gospel of Life:

The pastoral ministry of addictions must be a living testimony of the Church's option for the Gospel of Life, proclaiming with strength that every life is sacred and worthy of being loved, defended, and restored. In a world that often tends to marginalize and exclude the most vulnerable, this pastoral ministry reaffirms the Church's commitment to the defense of all human life, from its beginning to its natural end. To deepen this option means to promote life in its fullness, combating not only addictions but also the structures of sin and exclusion that feed them.

11.4.2 Vision

The vision of the pastoral ministry of addictions is grounded in the identity of the Church as a community of faith, hope, and love, which responds to the realities of the world from its own mission. Although the ecclesial proposal does not resemble that of health centers, which address addictions from a clinical and care-based approach, the Church does not disavow the importance of these institutions and perspectives. Instead, it understands that its work is complementary to theirs, offering spiritual accompaniment and contributing its integral and community perspective. The Church promotes human dignity and

respect for life in all its stages, presenting in its pastoral action the way of love of Jesus. This is manifested both in prevention, which seeks to reach children and young people before it is too late, and in the accompaniment of people who already walk the paths of addiction, inviting them to return to God and to the Church. Thus, the Church becomes a beacon of hope for those who suffer from addictions, creating a community that promotes inclusion, solidarity, and mutual care in the healing process.

ministry:

The pastoral ministry of addictions must be understood as an integral and cross-cutting effort that transcends the borders of traditional ministries and extends to all areas of the life of the Church. This means that, beyond the direct actions it may carry out, this pastoral ministry must place itself at the service of catechesis, schools, youth groups, and families, offering support and resources to address the problem of addictions and their prevention in an integral manner. The cross-cutting nature of this pastoral ministry is reflected in the collaboration with different groups and ministries, creating a support network that allows addictions to be addressed from multiple angles. Thus, the Church becomes a testimony of synodality, where each one contributes according to their gifts and vocations to the service of the common good and the care of the most vulnerable.

11.4.3 Objectives

1. Raise awareness in ecclesial communities about the problem and the response offered by the Church.
2. Promote preventive and care responses in parishes, schools, and ecclesial institutions.
3. Identify the different institutions and actors in the dioceses that are responding to this issue.
4. Weave networks among those institutions and actors who are responding to each other, and with the other pastoral spaces of the diocese.
5. Develop care or preventive responses where they are needed.
6. Produce a Catholic and diocesan reflection on this problem and its paths of solution that enriches the perspective.
7. Proclaim the Gospel of Life, in the historical moment we are living, and in the ecclesial contexts in which our diocese develops.

8. Influence public policies and general opinion from a human perspective based on the Gospel.
9. Gather all the care, preventive, accompaniment, and social reintegration responses that are given in the parishes, schools, communities, and institutions of the diocese.
10. Train and accompany the pastoral agents of the diocese so that they have adequate tools.

11.4.4 Activities

1. Organize meetings for raising awareness in society, organizing preventive and care responses, and integrating pastoral networks.
2. Place oneself at the service of other pastoral ministries, offering information about the problems of use and addiction to alcohol, drugs, gambling, pornography, and other behavioral addictions, as well as their prevention and treatment.
3. Make the resources of the Church and of civil society accessible and available to the diocesan community.
4. Hold conferences of discernment, analysis, and reflection aimed at developing one's own perspective, expressed in one's own religious language.
5. Develop a social and political dialogue aimed at influencing public policies.
6. Organize continuing education opportunities for the diocesan pastoral agents, including courses, meetings, and materials adapted to the local context.
7. Create regular spaces for accompaniment and review for the teams working in this pastoral ministry, caring for the integral health of those who accompany.

11.5 | The incarceration setting

Prison pastoral ministry serves in what is called the world of incarceration, which encompasses not only the person deprived of their liberty, but their entire environment: family, judiciary, correctional and security personnel, as well as the technical areas of education, health, social services, work, and legal affairs. The relationship with this surrounding world has the purpose of accompanying

people in an integral manner; therefore it also accompanies them in overcoming addictions within the prison and guides them on the path toward freedom.

The prison pastoral team is composed of pastoral agents and catechists with specific formation in the context of confinement, together with the presence of professionals such as therapeutic companions. This composition facilitates dialogue and collaborative work with correctional staff and families, enabling an integral approach that, among other things, seeks to prevent the overmedication of incarcerated persons.

The approach to this reality is carried out through various initiatives:

- Workshops with job-training outcomes are conducted within the framework of work therapy. These spaces respond to the concerns of those about to regain their freedom regarding their future employment possibilities. The workshops function as spaces of trust where the incarcerated are listened to and bonds are established that serve as bridges between them and the staff. The work is artisanal, with small groups of ten to twelve people to ensure proper attention to each individual.
- Likewise, therapeutic lunches are organized in the prison, in which incarcerated persons participate together with correctional staff, specialized psychologists, and the pastoral team. This activity fosters a climate of greater trust and improves daily treatment within the prison. The pastoral work is a missionary service open to all without distinction, carrying a message of hope and closeness.
- Work with families is considered one of the fundamental keys. It is common for bonds to fragment due to exhaustion or other reasons, which profoundly affects the process of the person deprived of liberty. By communicating with families, it helps to reestablish those broken ties and to enable them to support their loved ones in treatment. In this regard, the participation of support groups for family members of people with addictions is very significant.

The pastoral task seeks to show each person the love of God in every action undertaken. To that end, spiritual experiences adapted to the context of confinement are offered, such as kerygmatic evangelization retreats, which offer a proposal of meaning and an opportunity for a new life.

Finally, the goal is the construction of a solidarity chain through coordination with external networks, which include various care programs. This network is vital for ensuring continuity of treatment and accompaniment when a person is

released from prison or must continue their sentence in a community setting. It is an integral response that puts the person first, receiving life as it comes.

11.6 | Therapeutic Communities

The therapeutic community is a residential care model directed at persons with substance use disorders that seeks to understand the person not solely from the perspective of their use, but from the totality of their history, their emotions, their family bonds, their social environment, their physical health, and their spiritual dimension. Within the framework of this manual, the therapeutic community is understood as a concrete expression of the community family developed in chapter 6: a safe, structured, and restorative space where the broken brother or sister finds shelter, table, name, and bond. It is not a hospital or a prison; it is a temporary home that seeks to repair what functional orphanhood damaged, offering the conditions of secure attachment that allow the gradual integration of a fractured personality.

The Isenheim Altarpiece that opens this manual reminds us that the Antonines were not only praying monks: they were caregivers who opened their monastery to receive the patients suffering from ergotism. That decision to transform a space of prayer into a space of welcome is the founding gesture of every therapeutically inspired Christian community. The therapeutic community is the Antonine monastery of our time: a place where wounded life is received as it comes, and where care of the body, restoration of the soul, and the awakening of the spirit occur in a single daily process.

For many years, addiction problems were addressed solely from moralistic or punitive perspectives, where use was interpreted exclusively as a lack of willpower or a behavioral problem. However, as the Judging section has extensively developed, addictions are complex and multifactorial phenomena involving biological, psychological, familial, social, and existential elements. For this reason, a therapeutic community must offer an integral approach that allows working on all the deteriorated areas of the person's life, avoiding any of the reductionisms that article 8.1.4 has identified as permanent temptations in the field.

11.6.1 The dimensions of the residential process

The residential approach unfolds the four dimensions that this manual has proposed as constitutive of the person. Not as watertight compartments but as facets of a single unity that are worked on simultaneously in daily communal

living:

The biological dimension

Prolonged substance use generates physical, neurological, and behavioral alterations that affect the overall functioning of the individual. Many persons enter residential processes with significant impairments in sleep, nutrition, physical health, impulse management, and emotional regulation. Therefore, the therapeutic community must promote healthy habits through structured routines, adequate nutrition, physical activity, personal hygiene, rest, and medical follow-up when necessary.

The goal is not solely to achieve abstinence, but to restore the physical well-being and functional capacity of the person. As chapter 9 has developed, the neuroplasticity that allowed the brain to learn addiction is the same that allows tracing new paths: healthy routines are not a disciplinary regulation but a biological pedagogy of relearning. Likewise, when dual pathology requires it, the community must guarantee access to psychiatric care and the medication necessary for stabilization of the nervous system, coordinating with the territory's health services.

Cf. art. 6 (Judging, Briefest Glossary)

Cf. art. 8.2 (Judging, The psyche, Trauma...)

The psychological dimension

Many persons present histories of trauma, abandonment, violence, rejection, low self-esteem, affective losses, identity problems, anxiety, depression, or severe difficulties managing emotions. Substance use frequently appears as a self-therapeutic attempt to anesthetize emotional suffering that has become intolerable. For this reason, the therapeutic process cannot be limited to observable behavior: it must focus on self-knowledge, emotional recognition, development of coping skills, personal responsibility, and the reconstruction of self-esteem.

Individual therapy, group work, psychoeducation, and continuous accompaniment become fundamental tools for promoting real and sustainable internal changes. In cases of dual pathology — which as chapter 8.2.2 notes are the norm and not the exception in the territories — the approach must heal the internal fracture that sustains the use, not just treat the visible symptom.

The social dimension

The person is part of an environment that can influence their recovery process positively or negatively. Many times there are dysfunctional family dynamics, violent bonds, social exclusion, unemployment, poverty, lack of opportunities, or circles of use that perpetuate addiction. Therefore, the therapeutic community must become a laboratory of communal living where the person can learn new forms of relationship based on respect, responsibility, healthy communication, and compliance with norms.

This dimension necessarily includes work with the family, understood from the systemic approach of article 8.4.5 as a system that frequently organizes around the symptom and whose transformation is a condition for recovery to be lasting. Family meetings, parent groups, and relational interventions are not a complement to the residential process: they are a constitutive part of it. Likewise, the model must include processes of social reintegration and employment that allow the person to rebuild their life project, recognizing — as chapter 6.3 has established — that work is a sacred dimension of human identity and not a prize awarded at the end of the journey.

The spiritual dimension

Many persons going through addiction processes experience a profound existential void, loss of purpose, hopelessness, and disconnection from themselves. Chapter 7 of this manual has analyzed this reality as a fracture of transcendence: the human being possesses a constitutive openness to the divine that, when blocked by trauma and use, leaves the subject in a state of spiritual orphanhood that no purely technical intervention can fill.

The Christian-inspired therapeutic community must be a space where spiritual awakening can occur in freedom. This does not mean imposing religious practices as a condition of staying — participation must always be promoted through invitation and human accompaniment, never through coercion or pointing fingers — but creating the conditions for the search for meaning to find a channel. *Lectio Divina*, Eucharistic adoration, confession, retreats, moments of communal prayer, service activities, and work on forgiveness are tools that chapter 7 has grounded as paths of reconnection with transcendence.

Spiritual accompaniment can help strengthen values such as honesty, forgiveness, gratitude, humility, empathy, and meaning of life. It can offer tools for re-signifying suffering, strengthening resilience, and fostering the construction of an identity based on values and goals that transcend the logic of use. The

purpose is not to generate religious dependence, but to contribute to the integral growth of the person. As article 7.1.4 teaches, universal spirituality is the door; community and sacramental life is the house to which that door can open. The brother or sister who does not profess a faith can find in the spiritual climate of the community — the silence, the care, the beauty, the rhythm of shared life — the soil where their own search begins to germinate.

11.6.2 Dignity and daily life as a therapeutic process

Many persons who enter a therapeutic community arrive having experienced a progressive deterioration of their dignity, self-esteem, bonds, and self-perception. Intense feelings of guilt, shame, rejection, personal failure, and hopelessness frequently appear. The person stops seeing themselves as someone valuable and begins to identify solely through their use or their life history. No person can sustain real changes if they continue to perceive themselves as someone without value or without hope.

For this reason, the therapeutic community does not function solely as a place of confinement, but as a space of learning and transformation where dignity is experienced in the concrete. Every daily activity becomes an opportunity to strengthen habits, values, and life skills: getting up at a set time, preparing breakfast, cleaning a shared space, learning a trade, resolving a conflict with a companion, apologizing, assuming a responsibility. The person needs to experience that they can once again be useful, capable, respected, and valued within a community. As article 6.1.2 has developed, the act of calling by name is the fundamental gesture of restoring ontological dignity. In the therapeutic community, that gesture is repeated hundreds of times a day.

Respectful treatment and the existence of clear but humanized norms are part of what the manual calls structured mercy: a framework of communal living that is neither the rigidity of the barracks nor the anomie of the street, but the loving firmness of a home that cares because it sets boundaries and sets boundaries because it cares.

11.6.3 Criteria of discernment for a therapeutic community faithful to the Gospel

Not every therapeutic community that declares itself Christian automatically responds to the spirit of this manual. The four-dimension framework that organizes the Judging section offers a practical criterion of discernment: when a residential proposal develops one dimension but denies another, what it is

denying is the correct understanding of the human person. Specifically:

- A community that works on the spiritual but rejects medical or psychiatric care incurs in the reductive spiritualism that article 8.1.4 criticizes.
- A community that works on the biological and behavioral but prohibits or ignores the spiritual dimension incurs in the biologicism that the same article identifies.
- A community that isolates the resident from all contact with their family and territory contradicts the relational understanding of the human being that chapter 6 establishes.
- A community that uses humiliation, physical punishment, or religious coercion as “therapeutic” tools denies the ontological dignity that article 7.1.3 declares inalienable.

These criteria are not an external judgment on existing communities, many of which carry out admirable work with scarce resources. They are a compass that the manual offers so that each community can evaluate itself honestly and grow toward greater integrality.

11.6.4 Sustainability and openness to the territory

Economic sustainability constitutes one of the fundamental pillars for the proper functioning and permanence of a therapeutic community. A center of these characteristics requires constant resources to cover basic needs such as food, infrastructure, maintenance, services, professional care, therapeutic activities, and social reintegration programs. For this reason, it is indispensable to develop responsible, transparent, and organized administration that ensures financial stability and continuity in care processes.

However, sustainability should not depend solely on economic fees or internal resources, but also on the ability to establish ties and alliances with different sectors of society. Coordination with state institutions, municipalities, non-governmental organizations, private companies, parish communities, community associations, and volunteer groups can become a key tool for strengthening the project’s functioning. These alliances allow for the generation of material, professional, and human support that directly benefits the people being accompanied.

Historically, many therapeutic communities have remained isolated or invisible, generating lack of awareness and stigmatization toward people in recovery. It

is necessary to promote greater openness and integration with the territory, allowing the surrounding community to know the work being done, participate actively, and understand that the rehabilitation of addictions also constitutes a collective social responsibility. The therapeutic community is not a world apart: it is a node within the care network that this manual proposes, and its effectiveness depends to a great extent on the quality of its connections with the territorial fabric.

11.6.5 The coordination with the outpatient model

As developed in the following section, the therapeutic community and outpatient treatment are not mutually exclusive alternatives but moments of a continuum of care. A person may begin their process in a parish outpatient accompaniment, require at a moment of crisis an admission to a therapeutic community, and return to the outpatient program to sustain their process in the territory. Another person may leave the community and find in the outpatient accompaniment the support network they need so as not to fall into the void that this manual has described as “the abyss of freedom.”

Admission to a therapeutic community should not be thought of as the only possible response or as a permanent destination. The challenge for pastoral ministry is to build the coordination between programs so that the person is neither trapped in a single one nor falls through the gaps between them. The ethics of care demands that the transition between modalities be accompanied and that no stretch of the journey be left without a safety net.

11.7 | The Outpatient Treatment Model: Flexibility and Centrality of the Bond

Within the institutional design of community responses, it is fundamental to diversify the modalities of care so as not to reduce intervention exclusively to residential or inpatient models. **Outpatient Treatment** constitutes a priority, viable, and high-impact institutional strategy that in many contexts of the region represents the only modality of accompaniment accessible to the majority of persons with problematic use.

11.7.1 Why the outpatient model is a priority

Outpatient treatment is not a reduced or lower-ranking version of residential treatment. It is a modality with its own identity whose relevance is grounded

in three realities:

- **Territorial accessibility:** Throughout much of Latin America, residential therapeutic communities are scarce, costly, or geographically inaccessible for the most vulnerable populations. The outpatient model allows deploying a response where the person lives, without requiring an uprooting that many subjects —especially women with dependent children, informal workers, or school-age adolescents— cannot sustain.
- **Preservation of bonds:** By allowing the person not to be disconnected from their everyday environment, outpatient treatment works with the real relational fabric of the subject. It is not about healing them in a protected environment only to then return them to a territory that remains unchanged; it is about accompanying the transformation of the subject and their environment simultaneously, which is consistent with the systemic approach developed in this manual.
- **Coherence with the ethics of care:** The outpatient model naturally embodies the principle of not conditioning access to accompaniment. The person does not need to be admitted to be accompanied; they need only show up. This flexibility is especially relevant for those in early stages of the change process (precontemplation and contemplation), where the requirement of admission can function as an access barrier that ends up driving the brother or sister away instead of receiving them.

11.7.2 Who it is directed to

A common but erroneous conception limits outpatient treatment to “less serious” or “less compulsive” cases. While it is true that some situations require the containment of a residential program —especially when there is vital risk, acute psychiatric decompensation, or total absence of a support network— the evidence and territorial experience show that the outpatient model can effectively accompany a broad spectrum of situations:

- Persons in early stages of problematic use where early intervention can prevent chronification of the disorder.
- Persons who leave a residential program and need transitional accompaniment that sustains the gains achieved and prevents relapse in the territory.
- Persons with stabilized dual pathology who require sustained follow-up over time without the need for admission.

Cf. art. 8.2 (Judging, The psyche, Trauma...)

- Women with dependent children who cannot access admission without losing the bond with their children or risking custody.
- School-age adolescents whose disconnection from the educational system aggravates the harm instead of repairing it.
- Persons experiencing homelessness or extreme vulnerability for whom the first task is relational approach and harm reduction, before any formal process is possible.

The referral criterion should not be based solely on the severity of use, but on an integral assessment that considers the subject's recovery capital, the presence or absence of a relational network, the existence of dual pathology, and the concrete conditions of life.

11.7.3 The components of the outpatient program

A comprehensive outpatient treatment is not an isolated clinical consultation. It must be structured as an accompaniment itinerary that integrates the following components:

- **Individual accompaniment:** Regular spaces for listening and follow-up where the person can process their history, identify their vulnerabilities, and build a life project. This accompaniment can be carried out by mental health professionals or by trained peer companions, according to the complexity of the case.
- **Group work:** Therapeutic groups, self-help groups, or peer encounter spaces that offer belonging, containment, and the possibility of learning from others' experience. The group functions as a laboratory of healthy bonds where the person can rehearse new ways of relating.
- **Work with the family:** The systemic approach developed in this manual demands that the outpatient program include an active family component. One does not accompany only the person who uses but the relational network that sustains or expels them. Family meetings, parent groups, and home-based interventions are a constitutive part of the process.
- **Psychiatric and medical care:** In cases of dual pathology or significant physical deterioration, the program must guarantee access to psychiatric evaluation and follow-up, as well as to the treatment of medical comorbidities. Coordination with the territory's health services is indispensable.

- **Promotional and community activities:** Trade workshops, sports, artistic and recreational activities that offer concrete alternatives to empty time and that strengthen social skills and self-efficacy. These spaces, which the manual has developed under the paradigm of “arriving before,” are not complements to treatment: they are part of the treatment.
- **Spiritual accompaniment:** For those who desire it, the offer of prayer spaces, prayerful reading, brief retreats, or pastoral accompaniment can strengthen the dimension of meaning and transcendence that chapter 7 has developed as constitutive of recovery.

11.7.4 The parish and the neighborhood center as a natural home base

One of the strengths of the outpatient model is that it can be deployed in the spaces the Church already possesses in the territory. The parish, the chapel, the neighborhood center, or the Hogar de Cristo can function as home bases for an outpatient program that does not require hospital infrastructure to operate. What it requires is a trained team, an organization of schedules, and the institutional decision to open its doors to this modality of accompaniment.

This does not mean that the parish becomes a mental health center. It means that it can offer the community components of accompaniment —groups, workshops, listening, activities, spirituality— coordinating with the territory’s professional health services for the components that exceed its competence. The parish outpatient model functions as a node in the network, not as a substitute for specialized services.

11.7.5 The relationship between the outpatient and residential models

Outpatient and residential are not mutually exclusive alternatives but moments of a continuum of care. A person may begin their process in a parish outpatient accompaniment, require at a moment of crisis a brief admission to a therapeutic community, and return to the outpatient program to sustain their process in the territory. Another person may leave a therapeutic community and find in the outpatient program the support network they need so as not to fall into the void that this manual has described as “the abyss of freedom.”

The challenge for pastoral ministry is to build this coordination so that the person is neither trapped in a single program nor falls through the gaps between

programs. The ethics of care demands that the transition between modalities be accompanied and that no stretch of the journey be left without a safety net.

11.7.6 The challenges of the outpatient model

Pastoral honesty requires acknowledging that the outpatient model faces its own difficulties:

- **Adherence:** Without the physical containment of a residential space, the risk of dropping out of the process is greater. The key to sustaining adherence is the quality of the bond: a person does not stop going to a place where they feel received by name.
- **Crisis management:** The outpatient program must have clear protocols for crisis situations —relapse, suicidal ideation, psychiatric decompensation— that include coordination with emergency services and the possibility of temporary referral to a residential program.
- **Team training:** Outpatient accompaniment demands a team that combines professional knowledge with territorial knowledge, as has been developed in the section on managing the tension between both forms of knowledge. Peer companions, community leaders, and health professionals must work with a horizontality that respects each one's competencies.
- **Network coordination:** The outpatient model cannot operate in isolation. It requires coordination with health services, social protection agencies, the educational system, and the judicial system. This coordination is often the weakest link and the one that demands the most institutional effort.

In summary, outpatient treatment is not a second-line resource for cases that do not reach the severity of an admission. It is the modality that best embodies the territorial vocation of this pastoral ministry: accompanying the brother or sister where they live, with whom they live, and in the reality they live, without tearing them from their history or waiting until the crisis is so severe that no option remains but admission. If the parish is the field hospital that Pope Francis proposes, the outpatient program is its permanent care unit.

11.8 | National Pastoral Ministry

11.8.1 The rationale for a National Pastoral Ministry

The creation of a National Pastoral Ministry responds to the urgency of bringing together the different responses that the Church already offers through projects, services, and communities, overcoming the dispersion of efforts to act as an organic and synodal body. It is imperative to find a common ground of agreement among the diverse local experiences, unifying criteria, guidelines, and languages that strengthen the ecclesial identity of the network.

This structure is the channel for transmitting the perspective of the universal and national Church, integrating the Pontifical Magisterium on addictions with the guidelines of the Episcopal Conference in the face of the specific challenges of each country. It is necessary to create a mystique of care for life that recognizes the sacredness of each person and promotes a “pedagogy of care” in the face of the throwaway culture.

Likewise, the National Pastoral Ministry acts as a motor for fostering the emergence of new pastoral responses, as well as the growth of existing ones, driving creativity and new projects in the territories where life is most threatened. Finally, it has the mission of developing a prophetic voice grounded in and founded on the Social Doctrine of the Church; a voice that denounces with courage the structures of sin and drug trafficking, offering clear criteria on sensitive topics such as public care policies and citizen security, always from the defense of human dignity.

11.8.2 The mystique that animates us

Our mystique is grounded in the centrality of Jesus Christ, who goes out to encounter the broken and suffering brothers and sisters. We are animated by the spirit of the Good Samaritan, who impels the Church to stop, draw near, and heal the wounds of those who have been left at the side of the road, offering a “therapy of love.” This work is lived from the pedagogy of care and mercy, recognizing in each discarded person the suffering face of Christ. It is not merely a technical service, but an act of worship and mystical communion that seeks to restore hope and the meaning of life through a spirituality incarnated in the everyday.

11.8.3 The cross-cutting nature of the National Pastoral Ministry's work

The National Pastoral Ministry of Addictions is not a watertight compartment, but a cross-cutting dimension of all evangelizing action. It provides essential inputs to diverse areas:

- **Youth Ministry:** Providing tools for prevention and accompaniment, in a particular way in the existential peripheries where young people are most vulnerable.
- **Family Ministry:** Strengthening the family as the first space of prevention and accompaniment.
- **Health Ministry:** Integrating the bio-psycho-social-spiritual approach in the integral care of the person.
- **Social Ministry and Caritas:** Coordinating the fight against exclusion and the promotion of integral human development.
- **Catechesis:** Including preventive content that heals and promotes values for life.
- **Others:**

11.8.4 The prophetic voice and influence on public policies

A team focused on the issue has the task of studying, reflecting, and offering inputs to the Episcopal Conference to denounce structures of sin. This prophetic voice must point out with courage and prudence the problems of drug trafficking, organized crime, and corruption that impose the law of the strongest in the territories. The Pastoral Ministry must influence the public sphere by demanding from authorities the enforcement of the Rule of Law, universal access to health care, and care policies that prioritize rehabilitation over criminalization. It is the voice of those whose voice is not heard in a system that privileges profit over human life.

Likewise, the national pastoral ministry can, when the situation warrants, be the body for filing complaints. Those who are in the territory cannot file complaints there, due to the risk to their own lives. The pastoral ministry can provide the means to channel those complaints to the appropriate bodies, if necessary.

11.8.5 Organization

The organizational structure brings together representatives from different dioceses under an integrated and synodal model of ecclesial management. In this sense, the development of diocesan pastoral ministries is necessary. The territorial representatives appointed in each diocese can work in coordination with thematic representatives, bringing together diverse perspectives in the pastoral ministry:

- **Schools and Universities:** As allies in preventive programs and early warning radar.
- **Parishes and Chapels:** Through local prevention teams that receive life as it comes.
- **Hospitals and Health Centers:** Integrating faith and science in interdisciplinary teams.
- **Treatment Programs:** Such as therapeutic communities, self-help groups, or Hogares de Cristo, which offer accompaniment and/or spaces of immediate welcome.

A mixed composition of bishops, clergy, religious, and expert laypersons is ensured to guarantee both ecclesial identity and technical competence.

11.8.6 Methodological Framework (Recognize, Interpret, Choose)

Following the paradigm of the Road to Emmaus, the methodology is processual and communitarian:

- **Recognize (Listening):** It means being present in the vital transitions of people, listening to their wounds without judgment in listening centers and low-threshold programs.
- **Interpret (Proclamation and Formation):** Offering a key for reading reality from the Gospel that gives meaning to existence, illuminating reality with the Word of God and the Magisterium.
- **Choose (Sending Forth and Mission):** Transforming the recovered person into a bold witness, recognizing especially the charism of peer companions who walk body to body with others.

11.8.7 Concrete actions the pastoral ministry can develop

For the National Pastoral Ministry to be not just a declaration of principles but an effective reality, the following priority lines of action are proposed:

- **Integral and Ongoing Formation:** Establish a national plan for technical and spiritual training for bishops, priests, and pastoral agents.
- **Network of Local Teams:** Encourage each diocese to have a diocesan pastoral ministry that functions as a local catalyst for the pastoral work.
- **Mapping of responses:** both ecclesial and those offered by States and civil society organizations.
- **Accompaniment Programs:** Prioritize the creation of **Listening Centers** and low-threshold programs where life is received as it comes, offering immediate and merciful welcome without prior requirements.
- **Peer Companions:** Formalize and recognize within the pastoral structure the charism of **peer companions**, integrating recovered persons so that they walk body to body with those who are beginning their liberation process.
- **Gatherings:** Organize and promote gatherings for reflection, sharing of experiences and perspectives. These strengthen the sense of belonging and of being one body in the face of the mission.
- **Production of Materials:** Develop prevention, formation, and information materials (print and audiovisual) adapted to the local culture, to be integrated in a cross-cutting manner in catechesis and ordinary pastoral work.
- **Communication and public presence:** Develop a communication strategy that allows the pastoral ministry to occupy space in mass media and social networks, offering a humanizing narrative about addictions that challenges the narrative of criminalization and stigma. This includes trained spokespersons, audiovisual materials, and ties with journalists committed to human rights.
- **Safe Environments:** Implement, as a non-negotiable requirement, **child protection protocols** and codes of conduct for all pastoral agents, ensuring that every ecclesial space is a healthy, transparent, and abuse-free environment.

- **Advocacy and Monitoring:** Organize a national database and a center for studies and documentation that allows tracking the evolution of the problem in the country, offering grounded inputs for the prophetic voice of the Episcopal Conference and dialogue with the State.
- **Institutional Alliances:** Establish permanent liaison protocols with the National Health System where possible, international organizations (such as CICAD/OAS), and other regional networks to ensure an integrated and professional response.

11.8.8 Operative synthesis

For its operability, the National Pastoral Ministry is defined as a service body of the Episcopal Conference with the following priorities:

1. **Identity:** Clear definition as a network of accompaniment and prevention under the umbrella of PLAPA/CELAM and national bodies.
2. **Formation Plan:** Creation of national schools of technical and spiritual formation for pastoral agents.
3. **Care Protocols:** Strict implementation of codes of conduct and child protection to guarantee safe environments.
4. **Institutional Relations:** Permanent liaison with the National Health System, international organizations (such as CICAD/OAS), and regional pastoral networks.

11.9 | The Latin American Pastoral Ministry for Accompaniment and Prevention of Addictions — PLAPA

We share below the unity document that gave rise to the Latin American Pastoral Ministry for Accompaniment and Prevention of Addictions (PLAPA). In it appear all the expressions of desire that fill our network, as well as the positions that gave birth to this manual.

Declaration in the framework of the Continental Gathering
Toward a Latin American Pastoral Ministry of Addictions

Unity Document

Convened by the Latin American Episcopal Council (CELAM), sharing in a synodal spirit, we have gathered virtually on February 15, 16, and 17, 2023, representatives of diverse pastoral projects, services, and ecclesial communities devoted to responding to the suffering of addictions, coming from 13 countries of our Americas, to reflect on and analyze the opportunity to give life to a Latin American Pastoral Ministry of Addictions.

We know that addictions are a multicausal and complex problem. And that in the struggle to accompany the suffering of our brothers and sisters we have walked common paths that unite us in embrace and in hope. At the same time, we learn from each other's good practices. For this reason...

We say YES to:

- The dignity of the person, the inalienable dignity of a child of God in whom no matter how we are or what we have done, there is always worth, there is always hope. The person who uses substances is always considered a subject of rights.
- That the subject of the pastoral ministry of addictions is that broken person discarded by society, who longs for liberation and needs to exchange dependence for autonomy, who has lost the meaning of life, whose self-esteem has been wounded, who is pierced by great pain.
- That our pastoral ministry understands the human being integrally, as a bio-psycho-social-spiritual subject.
- That the family and the community are also subjects of this Pastoral Ministry.
- The importance of peer companions: as the construction of brother/sisterhood for the person who uses. They are those who, having gone through a process of recovery from their own addictions, are in a position to walk body to body with those who are just beginning their process.
- New ways of bonding, emphasizing an integral life project.

We recognize that:

- It is necessary to highlight the harm that substance use causes to the person, the family, and society.

- We focus on the repair, reintegration, and reconstruction of the person.
- There is a normalization of some forms of use, such as alcohol, among others.
- We need to give greater importance to preventive work, placing emphasis on the values of life.
- We are concerned about the ease of access to substances, synthetic drugs, psychotropic medications, and the liberalization of their use in public spaces.

We share that:

- It is important to understand the sociocultural and economic context of our countries. We live in a consumer society marked by extreme violence, poverty that pushes people to homelessness, contract killing, human trafficking, prostitution, and so many other realities that violate the fullness of life.
- There is a high correlation between substance use, crime, and prison; small-scale drug dealing that superimposes the roles of user and seller, with the same victims who take it on as a means of livelihood.
- Addictions are not exclusive to one social class. All social classes are cross-cut by substance use in some form. Different social and age-related realities require diverse approaches.
- We often exclude the person when their addiction becomes conflictive and violent.
- Family and social bonds are important in the consolidation of interdisciplinary support networks.
- The family is key: it can be a provider or not of tools for processing emotions, which are fundamental for recovery processes, but it can also foster use, develop codependencies, and even become an obstacle in recovery processes.
- It is important to analyze the positive aspects, opportunities, and resources that reality offers us to face this challenge. In this sense we understand that it is necessary to read the signs of the times, and that if the problem of addictions is proper to this time, by responding with faith we are following in the footsteps of Jesus and building the Church as He shows us.

- The media are also important when planning preventive awareness-raising actions.
- The great contribution of the Church begins in care, accompaniment, and when it opens itself to the whole community.
- The systemic and integral approach involves the family, the neighborhood, the community, the Church, lived from the pedagogy of care and respect for human rights.
- In many of our countries a weak State presence regarding public policies and legal gaps is evident.

We see it as necessary that:

- The Church assume a greater commitment and presence; and that from the networks it possesses, greater advantage be taken of their potential.
- Our Bishops and Priests have a greater commitment and participation in this topic. To that end we see it as necessary to develop specific formation both for them and for our pastoral agents.
- The spaces for children and young people be utilized, such as catechesis, youth groups, and the richness of ecclesial movements, which are very suitable for prevention and raising awareness of the problem.
- Good practices be shared among different faiths, social movements, and NGOs.
- Schools and universities be considered as allies in preventive programs.
- Digital culture and social media be utilized.
- The permissive and romanticized culture of substance use, especially in the family environment, be confronted with courage.

We want:

- To see Christ in each one who is broken, to discover the suffering face of Christ in the Other.
- To offer hope, mercy, solidarity, love, and healing from Christian spirituality, following the witness of the Good Samaritan.

- To be a family that helps on the path of mutual healing.
- To overcome the challenge of the loneliness of teams that accompany with greater communion in diversity.
- To encourage each other in the hope of building a new world.
- To recognize the richness of charisms that allow us to expand opportunities.
- Interdisciplinary teams, where faith and science work together.
- Ongoing formation for better accompaniment.

That our words:

- Value, include tenderness, compassion, and love toward all people.
- Allow the person-subject to emerge and not the condition of dependence.
- Share in our environments a religious and theoretical-technical language that is dignifying, stimulating, proactive, inclusive, inspiring, coherent, and understandable to all.
- Know the language of people who use substances.
- Be stripped of all prejudice and receive life as it comes.
- Generate missionary disciples connected in ecclesial communities.

In Our Mother of Guadalupe, who receives Christ to give Him to the world which is its greatest hope, we place our shared dreams and, standing with Her at the foot of those crucified by this reality, we continue trusting in the transforming power of love that can do all things.

February 17, 2023

CHAPTER 12

Concrete Experiences

This second part presents institutional experiences with their own identity, verifiable track records, and the possibility of networking. Each experience includes a reference card to facilitate contact and collaboration.

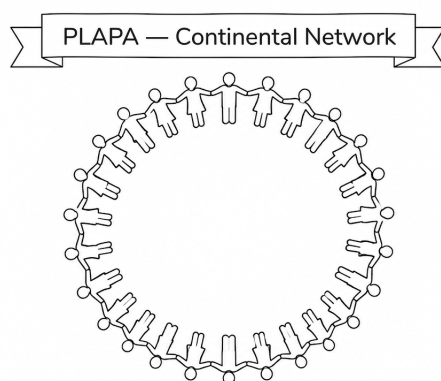


Figure 12.1: Network of concrete experiences of PLAPA

12.1 | Preventive Catechesis

Country: Uruguay

Description: Incorporation of preventive elements in catechesis programs

Contact: pastoraldeadicciones@caritasuruguay.org.uy

In the section on Pastoral Proposals by Area (11.1.12), within the Parish Area, we have developed the proposal for a preventive approach from catechesis.

Caritas Uruguay is implementing this proposal at the national level, and it can serve as inspiration for other countries. Here we provide their contact information.

12.2 | The Sobriety Ministry

Country: Brazil

Description: Pastoral network that brings together self-help, prayer, and support groups throughout the country

Contact: cnbb3@sobriedade.org.br

The Sobriety Ministry was born as a concrete response of the Church in Brazil (CNBB) to the challenge issued by Pope Saint John Paul II to combat the scourge of addictions. Its mission is to evangelize through the proclamation of Jesus Christ the Liberator, promoting the dignity of the person and the family through service, dialogue, and witness, making the excluded its preferred ones. In the face of a culture that commodifies disposability, this ministry responds to the biblical call of Deuteronomy 30:19, transforming the pursuit of sobriety into a radical choice for life.

Deut 30:19 — /
set before you
today life and
death, blessing and
curse. Choose life

12.2.1 Identity: The Self-Help Group (GAA)

The identity of this ministry resides in the experience of the 12 Steps of the New Life Program within the Self-Help Group, a space guided by the institutional motto: “Sobriety and peace, just for today thanks be to God.” The group’s work encompasses:

- **Dependencies on licit and illicit substances:** alcohol, tobacco, and other drugs.
- **Behaviors:** lying, stubbornness, rejection, obsessions, selfishness, lack of forgiveness, lack of acceptance, among others.
- **Mental health disorders:** anxiety, depression, phobias, panic attacks, among others.
- **Compulsions:** gambling, online betting, shopping, technology, emotional codependency, among others.

The strength of the group constitutes an effective resource for restoring emotional, spiritual, social, and community balance through mutual help and a systemic and behavioral model that involves the entire family.

12.2.2 The “New Life” Program: The 12 Steps

This methodology is based on the 12 steps: admit, trust, surrender, repent, confess, be reborn, make amends, profess the faith, pray and be vigilant, serve, celebrate, and rejoice.

The program does not limit itself solely to blocking substance use; rather, it proposes the rediscovery of dignity and the true meaning of life, fostering the therapy of unconditional love and mutual support. It is a gradual process that requires perseverance in the pursuit of sobriety and in the conversion of life in the light of the Gospel. Thus, it offers a path of hope and transformation for those who wish to free themselves from the bonds of suffering and live fully in all their dimensions.

12.2.3 Dynamics of the Pastoral Encounter

The Sobriety Ministry differs from other civic groups by its explicitly evangelizing character. Its weekly meetings follow a structure of welcome and prayer where it is proclaimed with faith: “Redeeming Mercy of Christ: grant us sobriety.” The core of the encounter is the Self-Help Group with the following characteristics:

- **Open and inclusive character:** Anyone can participate. It is not limited to drug dependencies but extends its scope to various types of addictions, compulsions, sins, and sufferings.
- **Separation by affective bonds:** Participants are not divided by their condition or substance, but members of the same family or persons with close affective ties are separated. The objective is to avoid confrontations, judgments, or reciprocal inhibitions during the encounter.
- **Respectful listening:** A safe space is guaranteed where one can speak without being judged. It is strictly prohibited to give advice, express opinions, or interrupt anyone sharing their testimony.
- **Confidentiality:** Absolute secrecy and discretion about what is shared in the meeting is the foundation of group trust.
- **Therapy of Love and Forgiveness:** By opening the heart and listening to the other, participants become sensitive to the pain of others, stimulating a change in personal conduct.

12.2.4 Action Fronts

The ministry articulates its service across five strategic fronts within society:

1. **Prevention:** Family and social education and awareness to prevent the onset of dependencies.
2. **Intervention:** Immediate welcome and guidance in moments of crisis.
3. **Recovery:** The path of the 12 steps and integration into community life.
4. **Reintegration:** Support for the return to family, work, and civic life.
5. **Political Action:** Participation and dialogue with drug policy and addiction prevention secretariats to demand and help propose public policies that respect human dignity.

12.2.5 The Sobriety Agent

This person is not a technician or clinical therapist, but a bearer of hope. Their mission is to express, with humility, the gratuitous love of the Father, serving freely following the example of Mary, our mother and mother of all, making the excluded the preferred ones through the Sobriety Ministry and, as Pope Francis affirms, seeks to combat that “invisible prison” of dependencies with the tools of faith, the shared word, and life in community.

12.3 | The Hogares de Cristo (Neighborhood Centers)

Country: Argentina

Description: Neighborhood Centers in parishes

Contact: maxfehrmann@hogardecristo.org.ar

A community and prophetic response from the popular neighborhoods

The Familia Grande Hogar de Cristo was not born from technical planning, but from a profoundly evangelical gesture: the washing of feet. On Holy Thursday of 2008, then-Cardinal Jorge Mario Bergoglio repeated the gesture of Jesus with young people who were struggling to overcome substance use. There he proposed the mystique that today guides hundreds of neighborhood centers: *Receive life as it comes and accompany it body to body.*

This foundational gesture, now projected globally by Pope Francis, is an ecclesial stance: faced with the temptation to wash one's hands before the pain of the excluded, the Church chooses the place of service. Where the world discards, the Hogares de Cristo reveal that love becomes presence and that the Church assumes the shared responsibility of not abandoning anyone along the way.

Pillars of Pastoral Identity

The response of the Hogares de Cristo is based on an incarnate spirituality sustained by three pillars:

- **Closeness:** It is the decision to let oneself be affected by the pain of one's brother or sister. It means placing at the center those whom society renders invisible, allowing their reality to penetrate one's own life.
- **Presence:** Closeness made into daily life. It is the being-there that gives certainty to those who have experienced orphanhood and abandonment: *I can count on you, you will not disappear.*
- **Bond:** From presence, the bond is born and the recognition of the name. For the Hogares de Cristo, the step from stigma to one's own name – from being an anonymous person on the street to being a child of the community – is the beginning of all healing.

The Community as Territory of Healing: Table, Home, and Family

Under the conviction that no one is saved alone, the Familia Grande Hogar de Cristo (FGHC) understands that substance use is often the symptom of prolonged loneliness. Therefore, the path is not only abstinence, but the reconstruction of belonging.

- **The Table:** It is not just about providing food, but about seating one's brother or sister at the table, integrating them as an equal.
- **The Home:** The neighborhood centers are homes. In shared life – eating, working, praying, and celebrating together – human dignity is rebuilt.
- **The Family:** The approach is comprehensive. Health, documentation, education, and faith form a single process that accompanies the person in their entirety.

An Epistemology of Learning

The FGHC proposes entering the territory as disciples. It is a ministry that learns to say “I don’t know” and allows itself to be challenged by the life of the other. In this horizon, relapse is not read as a moral failure, but as a part of the journey that demands more closeness. The door always remains open because the criterion is not efficacy, but the faithfulness of love.

Prophetic Dimension

Finally, the FGHC challenges structures. Where the drug market offers false belonging, the Church proposes a community that cares. It is a path that testifies that life can be reborn when it is welcomed and loved, celebrating each small sprout of life as a seed of resurrection.

12.3.1 The Cooperative: Our Daily Bread

Country: Argentina

Description: Food production cooperative of people in recovery

Contact: pannuestrolamatanza@gmail.com

El Pan Nuestro de Cada Día is a workers’ cooperative born along the pastoral path of the Hogar de Cristo of San José Parish, in La Matanza. It did not start as a business or as an enterprise designed from behind a desk. It was born from a concrete need that appeared every day in the accompaniment of the neighborhood centers: many young men and women managed to leave the streets, begin a recovery process, return to a home or a community, but continued without a real possibility of employment.

At first, the urgency had been different. The community went out to find people who were living on the streets. The first step was to bring hot food, open a place where they could rest, listen, accompany. Then came the more stable spaces of the Hogar de Cristo: the homes, the neighborhood centers, the accompaniment teams. But along that path, a question emerged that could not be avoided: how does the life of a person who begins to recover continue if they have no job, no routine, and no place where they feel needed? From that question, El Pan Nuestro de Cada Día was born.

The first form was simple: a food establishment in the San José Sports Complex, in La Matanza, where young people from the Hogar de Cristo who were in recovery began to work. By 2022, more than 50 people were working there, with

the ability to plan their lives, develop professionally, and reintegrate socially.

Over time, the experience grew. What had started as a food establishment gradually became a cooperative with different tasks and work spaces. Today, El Pan Nuestro de Cada Día combines production, cooking, customer service, baking, delivery, logistics, purchasing, cleaning, maintenance, and daily organization. In 2025, it is a Workers' Cooperative that provides employment to more than 250 people in La Matanza, strengthened in partnership with the Familia Grande Hogar de Cristo.

The cooperative does not operate in a single location nor perform a single task. In La Matanza, different spaces linked to the experience are recognized: the Virgen del Milagro de Caacupé Sanctuary, the Food Establishment – where the public is served daily – and the Colonia Mi Esperanza Bakery, where products are made. This diversity helps to better understand the dimension of the experience: it is not just about “making bread,” but about building a network of community work around the daily life of the neighborhood.

In the bakery, products are made for sale and distribution. In the food establishment, food is cooked and the public is served. Other companions handle purchasing, supply management, delivery, order reception, cleaning, space maintenance, and shift organization. Some have more experience and teach those who are just starting. Others are taking their first steps and need to learn from the most basic level: arriving on time, sustaining a task, taking care of a tool, working with others, notifying when they cannot come, receiving payment for their work, and managing some money.

That is one of the keys of the experience. El Pan Nuestro de Cada Día is not merely a productive enterprise. It is part of the community recovery process of the Hogar de Cristo. That is why it is not organized solely around efficiency or productivity. People who come from very difficult situations work there: problematic substance use, life on the streets, prison, violence, abandonment, years of exclusion. Some remain connected to residential homes, neighborhood centers, or accompaniment spaces. Others already have more experience and help sustain the newcomers.

The cooperative functions as a workplace, but also as a school for daily life. A trade is learned, but habits are also recovered. Food is produced, but bonds are also rebuilt. Work is done for selling, but also so that each companion can feel part of something again.

Many communities have workshops, clothing banks, fairs, courses, or small solidarity productions. All of that has great value. But in El Pan Nuestro de Cada Día, work does not appear as an activity parallel to the ministry or as a

way to sustain a project. Work is embedded within the recovery journey. It is a concrete tool so that a person can reorganize their day, regain confidence, take on responsibilities, and feel needed by others.

The experience also shows that labor inclusion is not achieved solely by obtaining machinery or supplies. A community that accompanies is needed. That is why, alongside equipment and training, the daily presence, listening, patience, organization, and the capacity to start over when something does not go well are fundamental.

As in every real experience, not everything is neat or easy. There are days when sales are low, a machine breaks down, someone does not show up, conflicts arise, or a companion relapses. But the logic is not to discard those who cannot keep up. The logic is communitarian: talk, sustain, organize, try again. That patience is part of the method.

For a parish that wants to start something similar, the main lesson is that one does not need to start big. El Pan Nuestro de Cada Día began from a concrete need and grew step by step. First, a community that goes out to seek, listens, and accompanies. Then a possible task: cooking, kneading, selling, delivering. Later, a more stable organization. Further on, training, equipment, partnerships, and new productive units.

The decisive thing is not to copy exactly a bakery or a food establishment. The decisive thing is to understand the method: that work be part of the accompaniment, that the protagonists be the companions themselves, that the community sustain the process, and that production be at the service of rebuilding lives.

In the Hogar de Cristo, it is often said that no one recovers alone. El Pan Nuestro de Cada Día shows a concrete way of making that phrase true: a table, a kitchen, a bakery, a delivery route, a work shift, a community that trusts, and many companions who, while producing the daily bread, find a place in life once again.

12.3.2 The AUPA Companions Cooperative

Country: Argentina

Description: Cooperative of companions in recovery and integration processes

Contact: cooperativaaupa@hogardecristo.org.ar

The Workers' Cooperative of Companions of Paco Users Limited (AUPA), born

in 2011 in Villa 21-24 and the NHT Zavaleta (CABA), constitutes a model of social inclusion through employment that challenges conventional assistance schemes. Registered with INAES (Registration 48,298) in September 2013, it operates under the umbrella of the Familia Grande Hogar de Cristo Federation and coordinates directly with the Nuestra Señora de Caacupé Parish. The proposal demonstrates that caring for the most vulnerable persons is inseparable from collective organization and from the dignification of those who provide care.

Target Population: Users of cocaine base paste in the City of Buenos Aires and the greater Buenos Aires metropolitan area, accompanied from their first request for help through their effective social inclusion.

Pillars of the Cooperative Proposal:

- *Work as bond:* The companions do not execute a cold protocol; they inhabit the territory and sustain a daily presence, transforming cooperative work into the therapeutic modality itself.
- *Reciprocal inclusion:* Many members are recovered persons from the Neighborhood Centers of the Hogar de Cristo; the cooperative dignifies their life trajectory by transforming them into care workers for others.
- *Self-managed formation:* Horizontal participation in assemblies and collective decision-making strengthen human capacities and community co-responsibility beyond the labor trade.

Model Summary

The AUPA experience offers a replicable response for Latin America in the face of the failure of traditional social services. It demonstrates that when formal institutions cannot reach the peripheries, the organized community can constitute itself as a collective subject of care. The cooperative form provides the legal and institutional framework necessary to guarantee labor rights, shared responsibilities, and sustainability over time, transforming pain into dignified work and community organization.

12.3.3 The 3 T Proposal: Land, Roof, and Work (Community Neighborhood)

Country: Argentina

Description: Community where people in recovery live and work

Contact: 3tmarcospaz@gmail.com

Inspired by the call of Pope Francis to organize around the Sacred Rights of every human being, the 3 T proposal (*Tierra, Techo y Trabajo* – Land, Roof, and Work) constitutes a structural and long-term response to poverty and social exclusion. Starting from the primary embrace in the territory (street, food, hygiene) developed in the Neighborhood Centers of the **Hogar de Cristo**, this model advances toward the consolidation of a **Community Neighborhood** in rural areas. This mechanism proposes a reverse migration process (from the city to the countryside) for families seeking a radical life change, away from the violence and substance use of the shantytowns.

The Three Sacred Axes of Human Development

The organization of the Community Neighborhood is structured directly around the three pillars of the 3 T:

- **Work (Dignity and Cooperativism):** It functions as a process of rebuilding the culture of work for those who are excluded from the formal labor system. Under a cooperative, assembly-based, and community discernment logic, efforts are primarily directed toward **agroecological food production** (meat, milk, eggs, vegetables, honey) to combat hunger and nutritional inequality. It also includes environmental care economies such as recycling, soap making, and preserve production.
- **Roof (Housing and Relational Stability):** Access to one's own roof is divided into two key stages during an estimated two-year process: a first phase of transitional housing in community spaces to internalize the neighborhood agreements, and a second phase of accompaniment in self-construction. The latter is financed through a **microcredit** system that activates local labor. Home ownership has a direct impact on reducing violence (domestic and gender-based) and in this way stabilizes educational, therapeutic, and life project trajectories.
- **Land (Laudato Si' and Care of the Common Home):** Facing the realities of exclusion in neighborhoods that border garbage dumps, life

in nature is embraced as a space for deep healing and spiritual connection. Continuous and practical environmental education is implemented: sustainable drainage systems, agroecological pest management, and comprehensive recycling. The most senior members assume the role of guiding newcomers in the practices of caring for the environment.

Organized Community and Addressing Complexity

The maintenance of autonomy in the neighborhood does not occur in isolation, but through a network of community and institutional bonds and supports prepared to absorb high complexity:

- **Integrated Therapeutic Teams:** Health professionals and neighborhood leaders coexist and work in a coordinated manner in the territory, ensuring spaces for daily individual listening, community assemblies, and pedagogical approaches.
- **Crisis and Mental Health Management:** The community has specific mechanisms to accompany relapses in substance use, severe mental health crises, and the management of persons with criminal cases or conflicts with the law, avoiding punitive exclusion.
- **Parenting and Community Environment:** Conflict resolution is managed through explicit collective agreements, promoting shared spaces for the development of children and adolescents in a violence-free environment.

Model Summary

The 3 T Community is consolidated as a beacon of hope and rootedness in social justice. By merging the mystique of the organized community with professional knowledge, it transforms stories of disposability and darkness into testimonies of healing, demonstrating that the restitution of the sacred rights to Land, Roof, and Work is the definitive path toward human dignity.

12.3.4 Casa Masantonio: Community Health in Extreme Vulnerability

Country: Argentina

Description: Hospital for cocaine base paste users, people living on the streets, and those with infectious diseases (HIV, TB, etc.)

Contact: casamasantonio@gmail.com

Casa Masantonio (with more than 10 years of experience) is a territorial accompaniment mechanism focused on public health and community-based care. It belongs to the Cooperative of Companions of Paco Users (AUPA) within the Familia Grande Hogar de Cristo Federation, and is closely linked to the pastoral work of the Virgen de Caacupé Parish (Villa 21-24 and Zabaleta, CABA, Argentina). It was born as an emancipatory and resistance mechanism against the dehumanization and organized cruelty that marginalizes the most discarded members of society.

Justification: The Gap in the Formal Health System

The greatest burden of disease among people in extreme social vulnerability and problematic cocaine base paste (“paco”) use corresponds to preventable and treatable pathologies (Tuberculosis, HIV in advanced stages, acute pneumonias, and respiratory infections). When a serious illness presents itself, the window of opportunity to save a life is biologically strict and does not respond to the subjective timelines of addiction treatment; it is a race against the clock.

The formal health system fragments the person and erroneously presupposes that the patient has resolved basic social determinants (food, shelter, economic capacity to acquire medications, transportation, and psychic stability to maintain a medical appointment). Lacking a **continuous care network**, traditional hospital approaches systematically fail, pushing users toward treatment interruption and extremely premature deaths.

“Body to Body” Accompaniment Methodology

In contrast to isolated, punctual clinical care, Casa Masantonio interposes a situated vulnerability clinic that operates under the following methodological axes:

- **Peer Companions:** The strategy is sustained by territorial leaders

and peers who have gone through similar realities. This eliminates the asymmetry of traditional medical power, building an indispensable bridge of trust for therapeutic adherence.

- **Comprehensive Care Network:** The administration of pharmacological treatment is embedded within the coverage of the most basic human needs. Curing the disease simultaneously requires guaranteeing a plate of food, warmth, a dignified shower, safe resting spaces, and affective accompaniment.
- **Management of Medical Complexity in the Territory:** Direct coordination with the State and hospital facilities for appointment facilitation, clinical follow-up, provision of complex medication regimens (such as Directly Observed Treatment, Short-course – DOTS for Tuberculosis), and accompaniment during hospitalizations.

Scientific Evidence of Effectiveness and Therapeutic Success

The Casa Masantonio model has moved beyond being merely a “novel pastoral experience” to consolidate itself as a social health technology validated internationally. A retrospective cohort study (period 2019–2023) published in the *Pan American Journal of Public Health* of the Pan American Health Organization (PAHO/WHO) produced compelling results on the effectiveness of the mechanism in a population of extremely high vulnerability (where 55% were effectively living on the streets and 77% were under problematic substance use):

- **Therapeutic Success in Tuberculosis:** Achieved a **93.8%** success rate in cure and treatment completion, compared to 70.2% recorded in the general population of the Buenos Aires Metropolitan Area (AMBA).
- **Reduction of Abandonment (Loss to follow-up):** Dropped drastically to only **2.1%**, compared to the alarming 19.9% in the conventional health system.
- **Decrease in Mortality:** Recorded a notably lower mortality rate compared to the usual average for this patient profile (4.1% at Casa Masantonio versus 9.7% in usual care strategies).

Model Summary

The Casa Masantonio proposal demonstrates that to achieve success in treating complex diseases in contexts of exclusion, it is biologically and socially indispensable to integrate professional knowledge with community and territorial accompaniment. Accompanying health “body to body” not only restores physical well-being and prevents epidemiological contagion in popular neighborhoods, but above all returns the human face and dignity to the most broken of the broken.

12.3.5 Espacio SumaySimi: Community-Based Approach to Severe Mental Illness

Country: Argentina

Description: Program for cocaine base paste users with severe mental illness and extreme social vulnerability

Contact: cooperativaaupa@hogardecristo.org.ar

The “SumaySimi” Space (from Quechua: *Sumay*, calm; *Simi*, speak; finding calm through meeting and being heard) was born in April 2019 under the umbrella of the AUPA Cooperative and the Familia Grande Hogar de Cristo in Villa 21-24 and the NHT Zavaleta. This mechanism arose to respond to a complex reality that overwhelms traditional protocols: people living on the streets with problematic cocaine base paste use who simultaneously present severe mental illness and/or physical and intellectual disabilities.

- **Justification (The Double Exclusion):** This population suffers absolute marginalization, as they cannot access psychiatric hospitals due to their street situation and substance use, are rejected by common addiction centers because of the severity of their psychiatric condition, and are expelled from shelters due to behavioral problems. The mechanism directly intervenes on this comorbidity to reduce chronicity and mortality.
- **Locations and Care Modalities:** The program distributes its accompaniment across two strategic locations in CABA:
 - *Outpatient Location (Casa GESA, Barracas):* Operates Monday through Friday during daytime shifts, providing support and follow-up to more than 100 people.
 - *Community Housing (Casa SumaySimi, Pompeya):* Permanent residence with 24/7 coverage and capacity for 20 people, providing the

housing stability indispensable for making any therapeutic process viable.

- **Operational Axes of the Proposal:**

- *Comprehensive clinical care:* Interdisciplinary team (psychiatrists, psychologists, social workers, and community workers) that conducts psychotherapies, physical health check-ups, and strictly supervised administration of psychiatric medications.
- *Work therapy and trades:* Carpentry, metalworking, and gardening workshops with a dual purpose: therapeutic (reorganization of routine and rehabilitation of cognitive-executive functions) and formative for labor inclusion.
- *Peer accompaniment:* Incorporation of persons recovered from substance use as protagonists of the team, whose testimonial and territorial experience improves adherence and reduces relapses.

- **Replicable Principles for the Community:** The model proposes four actions applicable to any parish territory or neighborhood center:

1. *Identify without discarding:* Detect dual psychiatric conditions in the neighborhood and not refer them blindly, maintaining the bond and walking alongside them.
2. *Structure the work:* Use trade workshops as tools for clinical rehabilitation of cognitive deterioration and not as a mere pastime.
3. *Professionals who go out:* Coordinate with psychologists and psychiatrists willing to break the office-based logic to intervene directly in the territory.
4. *Validate the peer:* Formalize and compensate the role of the peer companion for their unique legitimacy in building trust.

Model Summary

SumaySimi demonstrates that community lovingness and professional expertise need each other to humanize mental health. It is not a clinical center with added spirituality, but a true family that receives life as it comes, body to body and without preconditions, achieving that those who did not fit into any system finally find a space of belonging, healing, and dignity.

12.3.6 The Casas Libertad

Country: Argentina

Description: Program for incarcerated or released persons with severe social vulnerability

Contact: cooperativaaupa@hogardecristo.org.ar

The Casas Libertad emerged within the framework of the Hogares de Cristo network. From that pastoral spirit, the Casas Libertad accompany people affected by problematic substance use, social exclusion, and the penal system, placing at the center the bond, dignity, and hope.

The proposal is sustained by a simple yet profound conviction: freedom is not built solely with laws or individual decisions, but with community, time, and care. That is why the Casas Libertad do not work in isolation or “against” the State, but rather in coordination with penitentiary, judicial, and social agencies, contributing a human and territorial presence where fragmentation, bureaucracy, or abandonment often prevail.

The work is carried out across three major areas of accompaniment:

1. Accompaniment in contexts of confinement.

The Casas Libertad accompany incarcerated persons through visits, listening, concrete assistance, and relational support. The task is not limited to *going to prison*, but to sustaining life where confinement often deepens loneliness and hopelessness. The work is done from closeness, often with peer companions – people who also went through situations of substance use, prison, or exclusion – showing that change is possible. Spirituality is present as a horizon of meaning and hope, always from an open and non-imposed approach.

2. Post-penitentiary accompaniment

Release from prison is not understood as the end of the problem, but as the beginning of a fragile and decisive stage. The Casas Libertad maintain residential and community spaces where people can rebuild habits, bonds, and life projects. Through a *pedagogy of freedom*, one learns to live without substance use, without violence, and without crime, not through punishment but through mutual care, coexistence, and shared responsibility. Work, housing, and community are seen as fundamental rights for freedom to become real.

3. Legal-penal accompaniment

The Casas Libertad also accompany access to justice for people who often become lost within the judicial system. Many times, these are people with multiple cases, without understanding of their judicial processes or real possibilities of sustaining alternative measures. There, the accompaniment seeks to *humanize* justice: translate, guide, sustain, and build bridges between the person, their community, and the institutions. The law does not appear separated from concrete life, but linked to the territory, the bond, and the real possibilities of transformation.

In summary, the Casas Libertad seek to sustain real processes of transformation, understanding that no one changes alone and that even in the most damaged stories, a possibility of reconstruction still exists. More than a mechanism, it is an organized community that accompanies life before, during, and after confinement, betting on a society that does not discard people and that dares to care.

12.3.7 Community Enterprises

Unlike the corporate logic of the traditional market — characterized by individualistic competition, accumulation, and the discarding of the weakest links —, enterprise within the framework of the social and solidarity economy is born strictly from the *we*. It is defined as the pooling of wills, labor forces, knowledge, and skills of a group of people who are part of a community, with the explicit objective of improving the quality of life and socioeconomic development of all its participants.

The accompaniment method in our Neighborhood Centers contemplates a gradual and careful transition through three fundamental mechanisms:

- **Work therapy:** It is the work that allows one to connect with oneself
- **The Parish Workshop / Formative Space:** It is the initial instance where youth and adults recover or incorporate basic daily habits (time routine, care of tools, listening to instructions, teamwork, and tolerance for frustration). Here the primary objective is not profitability, but reconnection and the discovery of individual potential.
- **The Productive Unit (PU):** It constitutes the organizational evolution of the workshop toward a self-sustaining social project structured for the formal production and commercialization of goods or services. It requires a clear distribution of roles (who produces, who manages expenses, who

handles orders and logistics) and a strict economic record of income and expenditures.

In this structure, work is embedded within the recovery journey. Community patience becomes the method: when a companion goes through a crisis or a relapse, the organized community does not expel or discard them, but rather opens spaces for assembly, dialogue, and discernment to reorder the process and try again. The ultimate goal of these enterprises is to demonstrate that self-sufficiency of vulnerable sectors is possible when it is sustained by an affective and constant community network.

12.4 | Microcredits and Solidarity Finance

Country: Argentina

Description: Microcredit and financial education program for people in recovery

Contact: ecosol@caritas.org.ar

Solidarity Finance represents the operationalization of an economy that serves the life of people and says “*NO to an economy of exclusion and inequity where money reigns instead of serving*”. In territories of exclusion, access to the formal banking and credit system is completely barred due to bureaucratic and asset requirements. Facing this scenario, the **Revolving Funds** strategy promoted by Caritas and the Hogar de Cristo presents itself as an alternative based exclusively on neighborly proximity and reciprocal trust.

A Revolving Fund is a community lending instrument where money circulates in a transparent manner: when an entrepreneur or cooperative repays their credit, that same resource is immediately used to finance another companion’s project in the neighborhood. This dynamic ensures two fundamental guiding principles:

1. **Circularity:** There is no speculative accumulation or usurious interest; there is a constant flow of benefits that returns to the community base.
2. **Solidarity Guarantee:** The commitment and endorsement of the group or the Neighborhood Center sustain and support the compliance of each member, transforming the installment payment into an act of collective responsibility toward others.

12.4.1 Strategic Financing Lines

Microcredits are specifically directed toward four dimensions of productive strengthening:

- **Purchase of Supplies:** Acquisition of the raw materials indispensable for starting or ensuring the continuity of production without depending on abusive intermediaries.
- **Machinery and Tools:** Technical equipment that allows improving the scale, costs, and quality of work, accelerating the processes of self-sufficiency.
- **Space Improvement:** Infrastructure repairs, workshop adaptation, or preparation of commercialization and fair areas. In peri-urban or rural contexts, this item often directly impacts the improvement of the family home.
- **Technical Strengthening:** Financing for specific training in efficient administration, design, socio-community marketing, and use of social media for sales.

12.4.2 Methodological Guide for Comprehensive Accompaniment

For solidarity finance to fulfill its transformative role, the interdisciplinary team of the territorial mechanism must apply a three-step essential guide, under the premise that **money is not lent to an impersonal number, but rather a life project is supported:**

1. **Identification:** Listen attentively to the real need of the entrepreneur or cooperative in the territory. Jointly evaluate the viability and productive potential of the project, ensuring that the person has the necessary support in terms of health, civil documentation, and housing stability.
2. **Formulation:** Technically accompany the participant to translate their idea into a concrete and organized plan of income, expenses, and cost calculation, realistically determining the microcredit amount and a sustainable repayment installment schedule.
3. **Follow-up:** Conduct periodic and in-person visits to the workspace. This step is both technical and human; it involves celebrating the commercial

achievements of the enterprise, providing administrative tools in the field of action, and adjusting operational or personal difficulties before they put the process at risk.

12.5 | “Fortaleza” Social Reintegration Center

Country: Bolivia

Description: Juvenile detention facility with a restorative approach

Contact: centro.fortaleza@hotmail.com

The “Fortaleza – San Guillermo de Malavalle” Social Reintegration Center serves adolescents aged 14 to 18 (extendable to 20) under judicial measures in Bolivia. It implements a socio-educational and restorative model managed exclusively by civilian personnel, without police presence, placing the axis of the process on the dignity and transformation of the young person.

- **Context of Vulnerability:** The young people come from peripheral areas of high exclusion. Their trajectories are marked by school dropout, illiteracy, domestic violence, street situations, and problematic substance use (marijuana and “piedra”) closely linked to offending behaviors.
- **Intramural Multidisciplinary Approach:** An interdisciplinary team (educators, psychologists, social workers, pedagogues) coordinates key daily spaces:
 - Coexistence workshops, emotional strengthening, and gradual sexual education.
 - Relapse prevention and participatory design of an autonomous life plan.
 - Mandatory curricular education and technical/artistic training (electrical work, computing, music).
- **Challenges of the Intervention:** The mechanism works on the initial resistance and distrust of the adolescent, the fragility or absence of support from their families of origin, low self-esteem, and the need for more specialized human resources.
- **Post-Discharge Sustainability:** To mitigate the risk of returning to environments of exclusion, the center implements the “**Accompanying in the Return**” program, the only post-discharge mechanism in Bolivia that provides technical follow-up and support in the young person’s transition to the community.

- **Restorative Justice and Networks:** It promotes coordination with community, educational, and pastoral networks to dismantle social stigmatization, directing the horizon toward a justice that invites the young person to assume responsibility for the harm caused, repair their bonds, and reconcile with their community.

12.5.1 Model Summary

The Fortaleza Center proposal demonstrates that it is possible to replace traditional punitive control with a school of life and real opportunities. Through close civilian accompaniment and a pioneering post-discharge program, the model returns dignity, voice, and a future to historically excluded young people.

12.6 | The approach in the context of incarceration

Country: Argentina

Description:

Contact: pastoralcarcelariasinfronterap@gmail.com

In the section on Pastoral Proposals by Area (11.5), within the Area of incarceration, we have developed the proposal for an accompaniment approach in prisons. The Argentine Prison Ministry is implementing this proposal and can serve as inspiration for other countries. Here we provide their contact information.

12.7 | The Fazenda da Esperança

Country: Brazil (and other countries)

Description: Community of life for the recovery of people in situations of dependency

Contact: secretaria.presidencia@fazenda.org.br

The Fazenda da Esperança is a recovery proposal inspired by the daily living of the Gospel.

The methodology developed by the Fazenda is not oriented exclusively toward abstinence from psychoactive substances, but rather encompasses a comprehensive process of reconstructing the person. From this perspective, it is understood that addiction affects not only the physical dimension, but also

affective bonds, emotional stability, spiritual life, and the capacity for social and community integration. Consequently, recovery is carried out through a concrete experience of fraternal coexistence, work, and spirituality.

The daily dynamic within the community aims to foster the process of reconciliation of the person with themselves, with others, and with God. The therapeutic and formative itinerary develops gradually, respecting individual timelines and recognizing the particularities, wounds, and challenges present in each personal history.

The process begins with welcome. The person is received from the recognition of their human dignity, their history, and their potential for recovery, avoiding any form of stigmatization or reduction of their identity to the problem of addiction. From the beginning, a community experience oriented toward the rediscovery of fundamental values such as trust, mutual respect, and shared responsibility is promoted.

Daily coexistence constitutes one of the essential pillars of the proposal. Sharing life with other brothers and sisters in the recovery process makes possible personal confrontation, recognition of limits, and the construction of new forms of interpersonal relationship. In this way, the community is configured as a therapeutic, educational, and spiritual space that fosters overcoming isolation and the reconstruction of a sense of belonging.

Work equally occupies a central place within the recovery process, being understood as a pedagogical and therapeutic instrument. Through daily tasks – among them agriculture, cooking, cleaning, baking, animal care, maintenance, and other community services – the person rediscovers the value of effort, discipline, commitment, and social utility. Likewise, work contributes to the reorganization of interior life and the strengthening of self-esteem, frequently deteriorated by years of substance use, exclusion, and suffering.

Spirituality constitutes the fundamental core of the Fazenda experience. The community proposes the concrete living of the Word of God, especially through the practice of the so-called *Word of Life*, through which one seeks to live daily a verse of the Gospel in the ordinary situations of coexistence. In this sense, spirituality is not limited to a theoretical or doctrinal dimension, but is expressed in concrete attitudes of personal and community transformation.

Within this comprehensive process, fundamental aspects for the recovery and reintegration of the person are also addressed, such as:

- the recognition of one's own fragility and the need for help;

- the responsible acceptance of one's own personal history;
- the learning of forgiveness and reconciliation;
- the reconstruction of family and community bonds;
- the development of responsibility and autonomy;
- the daily living of sobriety;
- the rediscovery of the meaning of life and human dignity;
- the openness to hope and a renewed life project.

The Fazenda da Esperança understands that the recovery process does not occur immediately, but through a progressive path of interior transformation. For this reason, daily accompaniment, the testimony of those who have already walked this itinerary, and fraternal living constitute essential elements within the proposed methodology.

One of the most significant aspects of this experience is the protagonism assumed by the recovered persons themselves. Many of those who went through the process later discover a vocation of service and accompaniment toward those who arrive in situations of vulnerability. In this way, the person who previously needed help can also become an agent of hope and support for others.

Within this framework, the Fazenda da Esperança presents itself as a concrete pastoral response to the phenomenon of addictions, offering not only a treatment oriented toward overcoming substance use, but an experience of new life, grounded in love, community coexistence, and the living of the Gospel.

12.7.1 Living Hope Groups

The Living Hope Groups are community spaces where young people, families, and persons who completed their recovery process continue cultivating the new life discovered during their time in the community.

These groups arise from the understanding that recovery does not end with leaving the Fazenda, but needs to be sustained daily through healthy bonds, spiritual life, and fraternal accompaniment. Therefore, the weekly meetings become a place of perseverance, listening, and mutual strengthening, helping each person to remain firm on the path of sobriety and hope.

Meetings can be held in person or virtually, according to the possibilities of each region and community. In them, a climate of welcome and simplicity

is experienced, where each participant finds a space to share their life, their struggles, and their progress, without fear of judgment or exclusion. The center of each meeting is always the living of the Gospel, especially through reflection on the Word of God and the concrete experience of putting it into practice in daily life.

Prayer occupies a fundamental place within these meetings. Through moments of spirituality, testimonies, and interior silence, people learn to re-encounter God and to discover anew the profound meaning of their lives. The proposed spirituality does not seek solely to transmit religious content, but to awaken a living experience of love, belonging, and reconciliation.

12.7.2 Ambassadors of Hope

Within this mission arise the so-called Ambassadors of Hope, men and women who, after having walked a path of recovery and human and spiritual maturation, freely assume the commitment to accompany other brothers, sisters, and families. Their service is born from testimony and gratitude for the recovered life. They do not accompany from theory, but from the concrete experience of pain, of falling, and of the real possibility of starting over.

The Ambassadors of Hope thus become living signs that transformation is possible. Their presence helps especially those who are just beginning the journey, because they transmit closeness, understanding, and hope. They sustain community life, animate meetings, visit families, accompany moments of difficulty, and help build a true network of fraternal support.

12.8 | The Hogares Claret

Country: Colombia (and other countries)

Description: Model therapeutic community

Contact:

The Hogares Claret Foundation is a Colombian non-profit institution founded on May 12, 1980, driven by the Congregation of Claretian Missionaries. Its origin is directly linked to the crisis of substance use among young people that Colombia was experiencing at that time. Its founder, Father Gabriel Antonio Mejía, spent eight months in Italy learning about the therapeutic community model of Proyecto Hombre, an experience that became the seed of the first rehabilitation center for people with addictions in Medellín.

With more than 46 years of experience, its work addresses addiction, street situations, demobilization from the armed conflict, and conflicts with the criminal law, with special attention to childhood, adolescence, and youth.

Its mission is to accompany people affected by marginalization, addiction, and violence, helping them find the meaning of their lives. It is not a merely clinical treatment: the foundation is conceived as a project for life and hope, offering a loving and effective response to those who need support to build their own life project. Its institutional values are selfless service, love, self-improvement, responsibility, and respect for life.

The methodological heart is the **therapeutic community** model, based on self-help and mutual help, sustained by four pillars.

1. **Spirituality:** without it, the foundation affirms, there is no rehabilitation. It is not understood in a narrow devotional sense, but as a way of being and living in community, expressed through values.
2. **Consciousness-based education**, which promotes the creative potential and intrinsic well-being of residents, reduces stress, and develops cognitive and emotional capacities. It includes the use of transcendental meditation as a therapeutic tool, with scientifically measured results in young people with traumatic experiences.
3. **The Scout Movement**, which contributes character formation, manual skills, body care, and service to others, within a framework of community life and contact with nature.
4. **The Family Institute:** every eight days a formative activity is held with parents or guardians, recognizing that no recovery process is complete without involving the family.

To guarantee the quality of its processes, since 1994 the foundation has had the **Latin American Training Center**, which offers diplomas in drug dependency and addictions, certified by Claretian University. This commitment to the continuous training of agents is an element that every addiction ministry should seriously consider.

Hogares Claret maintains that happiness is not pleasure, but integrity: one is happy when one has a meaning that transcends the everyday and is at peace with one's own conscience. This conviction guides all its work and offers the ministry a fundamental lesson: accompanying a person with addiction is not simply helping them quit a substance, but helping them find a reason to live.

12.9 | Women's Homes

Country: Puerto Rico

Description: Residential and outpatient program for the accompaniment of women with substance use problems and life on the streets

Contact: madredominga@gmail.com

The Centro Madre Dominga, Casa Belén, Inc., located in the southern region of Ponce, Puerto Rico, has a track record of more than 26 years dedicated to the service, comprehensive accompaniment, and restoration of women in conditions of extreme social vulnerability. The proposal directly and specifically addresses women affected by Substance Use Disorder (SUD), alcoholism, complex mental health conditions, and situations of homelessness or life on the streets. Through a free operational design, the mechanism interrupts the dynamics of exclusion and disposability to transform them into processes of dignity, healing, and autonomy.

Under the institutional maxim *“For every woman rehabilitated, there is a family restored,”* the model assumes that the impact of accompanying women transcends their individuality, acting as a multiplying factor that repairs the surrounding family and community fabric.

12.9.1 Philosophical Identity and Intervention Approach

The proposal is grounded in a multidisciplinary model that merges the social and spiritual mission with contemporary clinical approaches of high effectiveness:

- **Trauma-Sensitive and Woman-Centered Approach:** Recognizes that trajectories of substance use and street life in the female population are traversed by prior histories of gender violence, abuse, and family disintegration. The intervention is designed respecting and protecting the singularity and rhythms of each woman.
- **Comprehensive Multidisciplinary Approach:** The technical team structure articulates psychological, social, medical, educational, and spiritual components, ensuring that no dimension of the person goes unattended.
- **Adaptive Outpatient Strategy:** Breaks with the bureaucratic and architectural barriers of traditional health systems through flexible therapeutic modalities that facilitate permanent and voluntary access to assistance services.

12.9.2 Community Outreach Strategies and Street Medicine

Facing the isolation suffered by women living on the streets, the Center deploys extramural intervention strategies to bring care directly to the daily settings of habitability and substance use of the participants:

- **Humanized and Judgment-Free Approach:** The first contact is defined by active and empathic listening, prioritizing the construction of a bond of mutual trust above any demand for immediate abstinence.
- **Mitigation of Primary Needs and Dignification:** Regular distribution of food, clothing, and personal hygiene kits. These actions address the immediate physical urgency while promoting essential practices of self-care and bodily dignity.
- **Primary Health and Wound Care:** Nursing and community health professionals perform street-level treatment of ulcers, lacerations, and complex wounds resulting from substance use and the inclemencies of the environment, reducing serious infections and serving as a bridge to the primary health system.

12.9.3 Harm Reduction and Response to the Opioid Crisis

The proposal transversally incorporates the **Risk and Harm Reduction** approach, assuming an active role in the region's public health in the face of the synthetic substance crisis:

- **Overdose Prevention in the Territory:** Practical training on the streets and socio-educational workshops on the risks associated with substance use. Includes the strategic distribution of **naloxone** for the reversal of opioid overdoses and the provision of fentanyl detection test strips.
- **Screening and Clinical Linkage:** Rapid HIV and other sexually transmitted infection detection tests, immediately coordinating the corresponding accompaniments, specialized medical treatments, and case management.
- **Transition Routes and Responsible Referral:** Activation of community and inter-institutional networks to channel effective referrals toward stable housing programs, voluntary detoxification, deep psychological support, and emotional stabilization.

12.9.4 Model Summary

The Centro Madre Dominga, Casa Belén, Inc., consolidates a clinic of proximity and tenderness in Puerto Rico, demonstrating that community outreach and harm reduction are the master keys for opening processes of change in the most excluded women. By interweaving the technical knowledge of case managers, psychologists, and nurses with a profound community mystique, the proposal restores women's sovereignty over their lives, sowing hope where disposability once prevailed.

12.10 | Hogares Crea

Country: El Salvador (and other countries)

Description: Therapeutic community

Contact: hogarcreass@yahoo.com

The Hogares CREA Association of El Salvador implements a comprehensive rehabilitation model for people with Substance Use Disorder (SUD) and alcoholism, grounded in the mystique of therapeutic communities and in the recognition of the intrinsic dignity of each individual. The proposal innovates by systematically adapting the celebrated socio-pastoral methodology of “**See, Judge, and Act**” to the clinical and pedagogical itineraries of recovery. This holistic approach transforms the residential space into a safe, structured, and welcoming environment, expressly designed to awaken critical reflection and the personal agency of the participant.

Unlike traditional clinical models of a purely directive nature, Hogares CREA positions the resident as the protagonist and expert of their own story, promoting mutual support and solidarity as the engines of personal and social transformation.

12.10.1 The Pedagogical-Therapeutic Method: See, Judge, and Act

The methodological proposal unfolds transversally in the daily life of the therapeutic community through three interconnected dimensions:

- **1. See (Critical Observation and Subjective Diagnosis):** Consists of generating safe spaces where residents develop the capacity to observe their own reality with honesty. Through circles of community reflection and

individualized listening sessions, facilitators guide the person to critically examine their consumption behaviors, dysfunctional patterns, problematic family dynamics, and the real impacts on their physical, mental, and social health. Shared observation allows the resident to see themselves reflected in the experiences of their peers, which drastically reduces defense mechanisms and breaks down the barrier of denial.

- **2. Judge (Collective Analysis and Root Cause Awareness):** It is structured as a pedagogical and participatory process of in-depth analysis. It is not approached from a moralistic or punitive perspective, but strictly from an educational and therapeutic one. The objective is for residents, accompanied by the facilitator team, to identify the personal, family, biographical, and sociocultural factors that shaped their trajectory of vulnerability. Understanding the weight of trauma, social pressures, lack of opportunities, and structural exclusions allows the development of critical awareness, dismantling paralyzing guilt and making way for subjective responsibility.
- **3. Act (Comprehensive Plan and Protagonism in Recovery):** It is concretized in the participatory design and execution of a realistic and meaningful action plan for life. Residents assume an active and co-responsible role through two levels of execution:
 - *Intramural Dimension:* Self-care management, fulfillment of responsibilities in community life, food preparation, socio-emotional skills workshops, and maintenance of common spaces.
 - *Extramural Dimension:* Active repair of family bonds, development of productive capacities, community volunteering, educational leveling, and guided processes of labor reintegration.

12.10.2 Monitoring, Support Networks, and Agency

To guarantee the long-term success of the proposal, the actions of the life plan are constantly monitored, evaluated, and adjusted according to the evolution of each person. The community is organized under a logic of **emotional support networks** based on mutual trust and horizontality. By validating residents as active agents of change — capable of making responsible decisions and of accompanying the recovery of their own companions — the mechanism fosters the development of autonomy, resilience, and a sense of solidarity-based belonging that endures beyond institutional discharge.

Model Summary

The Hogares CREA of El Salvador proposal demonstrates that the triad of See, Judge, and Act constitutes a powerful clinical and community tool for addressing problematic substance use. By merging the structure of the therapeutic community with a critical and non-punitive analysis of reality, the model returns to people in situations of exclusion their capacity for decision and their protagonism, transforming environments of disposability into schools of organized life, dignity, and solidarity.

12.11 | Munasim Kullakita

Country: Bolivia

Description: Comprehensive accompaniment program for children and adolescents with problematic substance use, life on the streets, and links to trafficking networks

Contact: fundacion@munasimkullakita.org

The situation of children and adolescents living on the streets and in contexts of high social vulnerability constitutes a structural problem that exposes them to serious risks such as violence, commercial sexual exploitation, human trafficking, problematic substance use, and absolute exclusion. Facing this scenario, the Munasim Kullakita Foundation — with a solid track record in the protection and restitution of rights — proposes a **Comprehensive Intervention Model** that synergistically articulates direct street contact, low-threshold community care mechanisms, and sustained processes of social inclusion.

12.11.1 Stages and Strategic Moments of the Intervention

The methodological process is not conceived in isolation, but as a progressive itinerary divided into three fundamental stages:

- **First Stage: Contact Work and Street Outreach**

- *First Moment (Initial approach):* Centered on establishing stable bonds of trust and affective communication through **Active Listening**. Simultaneously, situational community assessments are conducted to identify street dynamics, risk maps, and immediate needs of the population.
- *Second Moment (Work from the street):* Implementation of recreational, sports, playful, and socio-educational activities directly in the daily

living spaces of children and adolescents. The aim is to generate social support, promote their active participation, and activate the first engagement strategies for the restitution of their rights.

- **Second Stage: Care Mechanisms and Risk and Harm Reduction**

- *Open Space*: Functions as a permanent platform for community encounter, momentary shelter, and basic socio-educational support.
- *“Root of Hope” Community Kitchen*: A strategic mechanism that provides regular and dignified food support. It is consolidated as the operational axis of **Community Treatment**, acting as a point of inter-institutional encounter, social support, and coordination with allied networks in the territory.

- **Third Stage: Social Inclusion, Autonomy, and Follow-up**

- *Family Inclusion*: Processes of progressive reconnection and reintegration in family environments that certify conditions of safety and affection.
- *Personal Autonomy*: Development of soft skills and tools for daily life, oriented toward responsible decision-making and self-management.
- *Labor Inclusion*: Management of effective technical training, coordination with public employment programs, and design of sustainable long-term livelihoods.

12.11.2 Expected Results of the Model

Through the implementation of this proposal, the following quantitative and qualitative impacts are pursued:

- Direct mitigation and reduction of risks associated with human trafficking, sexual exploitation, and violence on public roads.
- Consolidation of adolescents’ trust in the protection system, ensuring their permanence and participation in the programs.
- Continuous access to dignified nutritional food plans and interdisciplinary professional accompaniment.
- Successful discharge of beneficiaries toward autonomous life through effective family or labor inclusion.

12.11.3 Institutional Coordination and Public Policies

The sustainability of the proposal rests on the basis of systemic co-responsibility. To this end, coordination, referral, and working groups with key actors of the Protection System in Bolivia are formalized: the **Ministry of Labor and Social Welfare** (for labor insertion and the private sector), the **Children and Adolescent Ombudsman Offices (DNA)**, the **Autonomous Departmental Governments**, and grassroots community networks.

Model Summary

The Munasim Kullakita Foundation proposal translates constitutional rights into a protection practice situated in the territory. Through a methodology that goes from the asphalt of the street to formal labor insertion, the model demonstrates that harm reduction and loving and technical accompaniment constitute the key for childhoods broken by exclusion to recover their voice, their dignity, and their autonomy.

12.12 | Samaritanos de la Calle

Country: Colombia

Description: Residential and outpatient comprehensive accompaniment program for people living on the streets

Contact: samaritanosdelacalle@gmail.com

The Street Dweller Care System of the Samaritanos de la Calle Foundation in Cali is composed of social dormitories, daytime shelters, transitional shelters, and specialized care centers organized into low, medium, and high threshold levels. These mechanisms transcend the notion of “a roof for the night”: articulated under the **Risk and Harm Reduction (RHR)** approach, they constitute the real gateway for people living on the streets to mitigate their daily survival mode, recover their fundamental rights, and build autonomy to reintegrate socially.

12.12.1 The Importance of the Risk and Harm Reduction (RHR) Approach

The theoretical-practical RHR model supports intramural and territorial actions through four key impacts:

- **Prevention of mortality:** Availability of naloxone for overdoses, early identification of seizures, and immediate coordination with the emergency health system.
- **Mitigation of diseases:** Supply of hygienic materials and treatment of complex wounds, preventing the transmission of HIV, hepatitis, and infections that overwhelm the health system.
- **Reduction of violence in public spaces:** Providing a safe environment for sleeping and resting directly reduces the rates of robberies, fights, and problematic substance use on public roads.
- **Building trust and dialogue:** By eliminating the threat of expulsion for active substance use, interdisciplinary teams achieve a comprehensive approach based on honesty, trauma processing, and voluntary evaluation of substance use.

12.12.2 Accompaniment and Resocialization Process (Non-Linear)

To prevent the process from breaking down early by demanding initial abstinence, the itinerary is flexibly organized into five stages:

1. **Bond:** Unrestricted access to food, shower, and bed, free of punitive conditions or prior requirements.
2. **Stabilization:** Coverage of basic needs and rest to reduce withdrawal syndrome and the stress of street life.
3. **Offer:** Activation of personalized institutional pathways (identification, comprehensive health, and education) according to the user's pace.
4. **Decision:** Self-determination of the person to begin detoxification processes, citizen regularization, or labor insertion.
5. **Project:** Progressive discharge toward transitional housing, autonomous housing solutions, or family reconnection processes with technical follow-up.

12.12.3 Mechanisms, Inclusion Strategies, and Projection

The institutional offering is diversified through strategies centered on the person and their real environment:

- **Institutional and Extramural Strategy:** Coordination of fixed care centers with street teams that conduct active searches and accompaniment in substance use territories.
- **Inter-Species Home:** A transversal low-threshold mechanism that allows users to enter with their companion animals, eliminating one of the main barriers to accessing the care system.
- **Sustainability Home:** A specific mechanism for graduates who have overcome street life and are consolidating their autonomy.
- **Active Labor Inclusion:** Formal insertion of approximately 80 recovered persons, employed by the Foundation or by public-private sector companies.
- **“CALIDOSOS” Strategy (City Brand – 2026):** A social insertion component that employs qualified persons who overcame street life for the care, maintenance, and beautification of Cali’s green areas and public spaces.
- **Cooperativism in Development:** A strategic line oriented toward the creation of an associated workers’ cooperative for graduates formally incorporated into the labor market.

Model Summary

The strategies of the Samaritanos de la Calle Foundation provide the minimum indispensable basis for making resocialization viable: a safe body, dignified treatment, and an open door. The RHR approach ensures that this door remains open precisely for the population that presents the greatest vulnerability and is excluded from traditional assistance models.

12.13 | Casa Comunitaria San José

Country: Argentina

Description: Outpatient accompaniment program for children and adolescents who are victims of abuse, violence, abandonment, and other serious problems

Contact: casacomunitariasanjose@gmail.com

The Casa Comunitaria *San José* (founded in 2020) arises from the intersection of pastoral and community accompaniment of families affected by violence,

substance use, exclusion, and poverty, together with territorial leaders and professionals embedded in the communities. It was born as an extension of the pastoral track record of the “Santa María Madre del Pueblo” Parish in Bajo Flores (neighborhoods P. Ricciardelli, Illia, Rivadavia 1 and 2, and Charrúa, in the Autonomous City of Buenos Aires), in response to the need to provide a specific response to children and adolescents damaged by traumatic experiences of serious gravity.

12.13.1 The Vision: Identity and Spirit of the Project

Its identity is defined by the following fundamental pillars:

- **Sense of “Familia Grande”:** The project is born, develops, and culminates in the community. It seeks to rebuild the “inner fabric” of children whose lives have been damaged by inequality and the absence of protective adults.
- **Mystique of Prevention in Popular Neighborhoods:** It is inscribed in the mystique of preventive work in popular neighborhood parishes. The goal is to *arrive before drugs and violence*, healing the roots of suffering to prevent exclusion from breaking life projects.
- **Rights and Tenderness Approach:** Under the inspiration of Pope Francis, it proposes to heal wounds with tenderness, recognizing children and adolescents as full subjects of rights.
- **Spiritual Compass:** The Gospel of Jesus and faith are the guide for looking from the heart and finding new forms of interior and community approach.

12.13.2 Accompaniment Methodology

The methodology of the Casa is **comprehensive, interdisciplinary, and artisanal**, adapting to the complexity of each particular situation to prevent the “shipwreck” of childhoods. Its main supports are the embrace from pastoral-community experience, a comprehensive clinical-social approach, and networking through intersectoral coordination. The work is carried out under the premise that only in Community can complexity be transformed.

12.13.3 Areas of Action, Mechanisms, and Lines of Work

The mechanism operates Monday through Friday during daytime shifts and structures its interventions in:

- **High-Complexity Outpatient Accompaniment:** Centered on children and adolescents who have suffered serious violations (abuse, violence, abandonment, sexual exploitation, etc.), comprehensively addressing the entire primary or extended family system through individual or relational evaluations and treatments.
- **Psycho-Social Therapeutic Approach and Workshops:** Frequent psychological care, Social Work accompaniment, and coordination with psychopedagogy, psychiatry, and therapeutic companions. Includes expressive workshops in play, art, and psychomotricity to recover speech and expression.
- **Initial Welcome:** A space for breakfast, lunch, or snack to receive those who arrive in a warm, hospitable, and safe environment.
- **Community Foster Family Program:** Prioritizes that families from the same neighborhood temporarily host minors, avoiding uprooting and traditional institutionalization. Facilitates careful transitions respecting the timelines of children and families.
- **Work with Bonds, Parenting, and Territory:** Groups for adults with parenting difficulties, home visits, advising on judicial cases, and coordination with health facilities, schools, and state agencies, accompanying community parenting in a preventive manner alongside the Neighborhood Centers.
- **Permanent Training and Coaching:** Training and supervision directed at territorial leaders, students, and professionals to transmit criteria for early detection, diagnosis, and specific tools for complex interventions in popular neighborhoods.

12.13.4 Networking and the Community

The proposal does not seek to replace the social network of the child or adolescent, but to strengthen it through:

- **Artisanal Networks:** Construction of support webs tailored to each need, directly coordinating with clubs, schools, and homes in the territory.

- **Co-responsibility with the State:** The State is recognized as the primary guarantor of rights, with the Casita assuming the community commitment to operationalize and make those rights effective in the territory.
- **Responsible Referral:** Access is through referrals from parishes or teams in popular neighborhoods, under the explicit commitment that the referring teams maintain active accompaniment of the family.

Model Summary

The Casa San José proposes a vulnerability clinic situated in the popular neighborhood, where the community and the professional are integrated in an artisanal manner to restore dignity and hope to wounded childhoods. It is consolidated as a high-complexity space focused on deep accompaniment, the protection of bonds, and the weaving of personalized support networks.

12.14 | Nobody Left Behind Because of Drugs

Country: Chile

Description: National awareness-raising space on problems related to narco-culture and substance use

Contact: fcarreno@caritaschile.org

Nadie Menos por la Droga (Nobody Left Behind Because of Drugs) is a movement that inherits the work carried out for more than 15 years by various communities of the Chilean Church.

Along the path traveled, together with people who work for the dignity of those who suffer because of drugs, we have learned that what primarily saves a person is not just a network of social services, but a sensitized and prepared community that opens its doors, mobilized by faith in God and the invincible dignity of every human being.

The Bishops of our country have stated: *it is indispensable to animate hope, strengthen the social fabric, attend to the quality of life and the repair of the damage that drug trafficking and poverty produce in so many children, young people, and families.* (CECh, Anunciar a Jesucristo caminando Juntos. Orientaciones Pastorales 2023 – 2026, n. 14).

We recognize that Jesus Christ is the one who inspires us, and today he asks us again: *Where is your brother?* (Gen 4:9). Where are the children expelled from

school or those young people kidnapped by drug traffickers to commit crimes? Where are the girls and boys who are victims of sexual exploitation as a means of payment to obtain drugs? Where are those who are alone, living in modern tombs that mutilate affections and leave in darkness the meaninglessness of their lives? And we will answer: *I do not know. Am I my brother's keeper?* (Gen 4:9).

The question led us to discover that we are radically social beings, that we exist from others and with others. Life passes through the encounter with the other in the hope of being brothers and sisters, of sharing the same blood and the same dreams. To renounce the question about one's brother or sister – as when Cain lowered his head and did not see his brother – leads to death, to meaninglessness. Each time I look at the other and let myself be challenged by them, we can intuit the presence of God who calls us to live with meaning. Currently, the *Nadie Menos por la Droga* movement is composed of various organizations that seek to respond to the call of Pope Francis when in 2018 he stated: *The Church, together with civil, national, and international institutions, and the various educational organizations, is actively committed in all parts of the world to counteract the spread of addictions by mobilizing its energies in prevention, cure, rehabilitation, and reintegration projects that restore dignity to those who have been deprived of it.*

In light of this navigation chart, with Caritas Chile we have initiated a process to *accompany the communities that accompany* people who suffer because of problematic drug use and the implications of this reality in their territories.

The above is rooted in the objective of contributing to the construction of comprehensive and community responses to the drama of drugs and violence, through the strengthening of local capacities in various dioceses throughout the country. We seek that those responses be Neighborhood Listening Centers where people (both those who suffer from drug use and their family members) are welcomed, accompanied, and recognized as legitimate others; while pastoral agents and volunteers receive training to be an effective and affective alternative.

To date, we have developed a way of working, whose core is the neighborhood listening centers and the substantive participation of people who have experienced situations of drug use, life on the streets, or other significant violations of rights. With all of them, we activate dimensions of welcome, formation, and celebration. Currently, the following organizations and communities are part of the movement:

- Caritas Chile

- PANAD (National Alcohol and Drug Ministry)
- Episcopal Delegation for Social Ministry Caritas
- Central Zone Vicariate
- Vicariate of Mercy
- Policlínico Enrique Alvear
- Fundación Hogar de Cristo
- Fundación EDUCERE
- Fundación DESPERTAR (Atacama)
- Fundación Mujer Levántate
- Hermanitas de Jesús
- Capilla Pablo VI (Pudahuel)
- Capilla André Jarlan (Lo Espejo)
- Santuario Inmaculada Concepción (San Ramón)
- Capilla de Las Ánimas (Santiago)
- Parroquia Jesús El Buen Pastor (Valparaíso)
- Capilla Espíritu Santo (Copiapó)
- Emerging communities: Temuco and Osorno.

PART V

Conclusion

Toward an Open Manual

CHAPTER 13

An Open Manual

13.1 | The network behind the manual

This manual does not constitute a point of arrival, but rather the reflection of a shared ecclesial journey that is born from the cry of our peoples and from the commitment of a Church going forth. The network that sustains these pages is much broader than the text itself: it is a fabric of knowledge and experiences that involves hundreds of pastoral agents, territorial teams, professionals, and communities throughout Latin America and the Caribbean.

It is essential to highlight that all the proposals developed in the *Act* section are not abstract theories, but proven lines of action and practical suggestions that are already transforming realities in various territories. Each criterion expressed here is the fruit of a critical reflection on action; each concept finds its correlate in the daily reality of our local Churches.

We recognize that these responses in general, by themselves, do not manage to bring into play all the dimensions of the human being. Each contribution is important. But at the same time, given the complexity of the addiction phenomenon, from the network and the manual we assume the challenge of sustaining a comprehensive perspective that avoids any reductionism, understanding that the person is an indivisible unity. Therefore, the manual offers criteria and orientations rather than closed answers, respecting the singularity of each life process and each community.

From the **PLAPA**, we offer ourselves as a nexus so that any community or pastoral agent can connect with the experiences described in this material. We

believe in the importance of bilateral meetings and the exchange of practices; therefore, we will facilitate the necessary connections so that no one feels alone in this mission. The manual is, ultimately, the visible face of a great pre-existing network that seeks to organize hope in our region.

13.2 | Methodology as a legacy: Synodality in practice

Beyond the technical and pastoral content, this manual leaves as its main legacy a working methodology that we have called *ascending epistemology*. This approach starts from the premise that knowledge is not imposed from pre-established theoretical frameworks, but is born from the attentive listening to territories and from the discernment of the questions that arise in the mud of daily practice. The knowledge captured here is, therefore, a situated knowledge that recognizes the authority of those who walk day by day alongside the most vulnerable.

The elaboration process has been a concrete exercise in *synodality*. The participation of nearly 300 agents was not merely consultative, but constitutive of the text. Through this ecclesial journey, we have sought for the manual to be a space where the diverse voices of Latin America and the Caribbean meet and recognize each other, overcoming the fragmentation of knowledge to build a comprehensive and shared perspective.

In this sense, technology has played a fundamental role as a tool at the service of communion. The use of artificial intelligence and the systematization of transcriptions from virtual meetings made it possible to process an immense volume of contributions without sacrificing the original richness of the testimonies or the particularity of local languages. This technical deployment did not seek to replace human thought, but to safeguard community participation, ensuring that no contribution was excluded due to logistical limitations. Thus, synodality in practice demonstrates that it is possible to weave networks of collective thought that sustain hope and action throughout the region.

13.3 | The proposal for a *Rolling Release* manual

This document is presented under the *rolling release* modality, which means that it is not considered a finished or static work, but a material in continuous updating. We understand that the phenomenon of addictions is extremely dynamic: every day new scientific advances, new territorial responses, and

deeper ways of understanding human complexity emerge. Therefore, this manual seeks to be a flexible tool that evolves at the pace of the challenges we face.

The proposal implies that, through the **PLAPA** network, permanent participation mechanisms are established for the incorporation of new elements. The digital version will be the central axis of this dynamism, allowing updates, corrections, and new contributions to be reflected in an agile manner, overcoming the fixity of the printed page. This manual is, in essence, a commitment to permanent learning and to the search for bridges between science and faith that provide effective responses to our brothers and sisters.

To guarantee the coherence and the technical and pastoral quality of this process, there is a curatorial team in charge of systematically evaluating and incorporating the contributions of the community. In this way, the manual not only grows in volume, but in depth, ensuring that the shared knowledge continues to be a faithful reflection of reality and a reliable guide for action.

13.4 | Application criteria and territorial inculturation

This manual does not intend to impose a single intervention model or offer infallible recipes applicable mechanically anywhere. On the contrary, its value lies in proposing criteria and pastoral orientations that must be discerned and inculturated in each territory. We recognize that addictions manifest in diverse forms depending on the geographic, social, and cultural context, which demands a flexibility that respects the singularity of each life process in diverse contexts.

The application of the tools described here requires a prior exercise of listening to one's own reality. It is not about transferring experiences from one country to another without mediation, but about extracting the underlying principles so that each local team can give its own creative response. The manual is presented as a frame of reference that comes to life when it is embodied in the language and practices of the neighborhoods, parishes, and accompaniment centers of our region.

In this sense, inculturation is not just a technical adaptation, but an act of respect for the history of each people and the dignity of each person. We invite pastoral agents to use this material as a guide for critical reflection, allowing the particularities of the context to illuminate and enrich the general proposals. Only through a situated perspective committed to the territory can

accompaniment be truly effective and transformative, avoiding disembodied responses that do not respond to the real cry of our brothers and sisters.

13.5 | Collaboration mechanisms

Active participation is the engine that allows this manual to remain a work in permanent construction. To this end, communication channels have been established through the official PLAPA website where territorial teams can submit their contributions. Contributions can be delivered directly through that digital channel, or through the National Addiction Ministry team, in those countries where the body has already been established.

These contributions can range from style and form corrections to conceptual and substantive observations that challenge or complement the current content. The collaboration process seeks to emulate the synodal dynamic of the first revision of the text, in which various agents made significant contributions that were integrated to enrich the comprehensive perspective of the manual.

We invite readers not to be passive recipients, but to share their experiences and critical reflections on praxis in the territory. Every suggestion received is an opportunity for the manual to be a more faithful reflection of what our brothers and sisters are seeing today in parishes and accompaniment centers.

13.6 | The curatorial team

To safeguard the technical coherence and pastoral spirit of this material, a team has been constituted to systematically evaluate and incorporate the community's corrections. This team is composed of a representative of the National Ministries, in those countries where the body has been established, and by representatives of the ecclesial institutions dedicated to the subject in more than one country. The designation of each curator must be supported by a letter of reference from their organization, addressed to the **PLAPA**, and has a duration of three years.

This curatorial team has the mission of discerning the contributions received, ensuring that the updates maintain harmony with the comprehensive and territorial perspective that defines the identity of our network. The role of curatorship does not seek to restrict participation, but to organize the shared knowledge so that the tool preserves its technical effectiveness and spiritual depth.

The curatorial team will meet every 4 months, in order to evaluate the correction or expansion proposals that have been received during that period. The meeting dates will be published on the official website, as well as the curatorial team's decisions.

Through this team, it is guaranteed that the manual grows in volume and quality, incorporating the scientific and pastoral advances that arise from the permanent dialogue between science and faith.

13.7 | The versions of the manual

To respond to the diverse formation and consultation needs in the territories, this material is presented in two complementary formats that allow maximizing its pedagogical and pastoral potential.

The physical version is designed to favor a linear and systematic reading, allowing the pastoral agent to follow the logical path of the proposal, from the analysis of reality to the theoretical foundation and the implementation of concrete responses. It is the ideal format for those who are beginning their journey in this ministry or wish to carry out a deep and thoughtful reflection on the content.

On the other hand, the virtual version constitutes the axis of the manual's dynamism. By incorporating a hyperlink system, it allows comprehensive navigation that relates topics to each other, overcoming fragmentation and favoring an overview indispensable for addressing addictions. In the digital environment, the content ceases to be isolated compartments and becomes a network of connected knowledge.

Given that this manual operates under the logic of *rolling release* or continuous updating, it is essential that users precisely identify which version of the material they are consulting. To this end, we have established a technical nomenclature that will accompany each edition:

- The identification is composed of the letter “v” followed by the last two digits of the year and the number of the corresponding revision.
- A cycle of three annual corrections has been planned to systematically incorporate contributions from the network and scientific advances.
- In this way, a version labeled as **v26.1** indicates that it is the first revision carried out during the year 2026.

This versioning system ensures that **PLAPA** teams and territorial agents always work with the most up-to-date material, guaranteeing that updates are first reflected in the digital version before proceeding to new physical printings.

13.8 | Prophetic dimension and political advocacy

The accompaniment of brothers and sisters in situations of substance use cannot be exhausted in the relief of individual wounds; it also demands a determined commitment to the transformation of the structures of exclusion that generate that suffering. Inspired by the notion of political charity, we understand that the mission of the Church and of the **PLAPA** network includes the task of denouncing the structures that suffocate life in our territories. This implies moving from immediate assistance to strategic advocacy, raising our voice against the realities that cause pain in our peoples.

The prophetic dimension of our work is manifested in the denunciation of the impact of drug trafficking and the globalization of organized crime, factors that compromise the integrity of the person and the lives of the youngest. At the same time, we feel called to challenge States to create and sustain public policies of care and comprehensive health that are truly humanizing and territorial. We recognize that our own salvation is at stake in our openness to the wounds of society, for in those wounds dwells Jesus Christ himself.

Our political advocacy does not seek power, but social justice and the protection of the absolute and inalienable dignity of every human being. Through networking with other social actors, we seek that the right to a life with meaning be a reality for all, especially for those who inhabit the peripheries of substance use.

13.9 | The delivery and certification of courses

This manual transcends its function as reference material to constitute itself as the foundation of a systematic formative itinerary destined for pastoral agents throughout the region. The delivery of courses based on this content will be carried out in a decentralized manner, actively involving the National Addiction Ministries and the various ecclesial institutions that make up our territorial network.

To guarantee that the training delivered is faithful to the spirit and content of this work, the **curatorial team** will be in charge of certifying the courses developed in the various territories. This certification mechanism aims to verify

the conformity of local formative proposals with the criteria and orientations expressed herein, ensuring that the comprehensive perspective and the Person First approach are respected.

In this way, the endorsement of the curatorial team ensures that the training received is not an isolated event, but part of a permanent learning process that evolves as the manual incorporates new revisions and contributions from the community. Certification represents, ultimately, a guarantee of technical coherence and spiritual depth for all agents who commit themselves to the service and accompaniment of our brothers and sisters.

13.10 | A horizon of hope: The light on the path

In concluding this manual, we must reaffirm that our hope is not placed in an idealized point of arrival, but in the very journey we walk alongside our brothers and sisters: Jesus Christ is the way, the truth, and the life. In the addiction ministry, we run the risk of measuring success solely by the eradication of the symptom or the fulfillment of therapeutic goals; however, the true light is not the end of the tunnel, but the spark of dignity that shines in each shared step. If we feed our hope only with the light of those who *arrived*, frustration will eventually overtake us in the face of slower or more painful processes. Christian hope is, fundamentally, a hope in the journey.

The fact that the Church decides to remain at the foot of the cross, walking alongside today's new crucified, constitutes in itself a success that transcends the logic of efficacy. Our mission is not that of the specialist who only seeks to cure, but that of the community that knows how to remain in the silence of the tomb, embracing broken life even when there are no immediate solutions. We discover that in the pain and death that addictions bring, there exists a privileged occasion to encounter the Crucified, and it is precisely in that embrace where the resurrection is foretasted.

That the most broken people find in the Church a family that embraces them and calls them by name is the most eloquent sign of the presence of Jesus among us. In this way, our parishes are not administrative institutions but a home and a shared table where orphanhood is healed with neighborly proximity and tenderness. Where the world discards, the Church chooses the place of service, assuming the shared responsibility of not leaving anyone alone on the journey.

We make ours the prayer of the Church so that this mission may be fruitful:

Grant us, Lord, hearts of mercy before all human misery. Inspire in us the timely gesture and word before the brother or sister who is alone and helpless. Help us to show ourselves available to those who feel exploited and depressed. May your Church, Lord, be a place of truth and love, of freedom, justice, and peace, so that all may find in it a reason to keep hoping.

Eucharistic Prayer Vb

We entrust all our work, our joys, and our frustrations to the maternal protection of the Virgin Mary, asking her to teach us to remain, as she did, at the foot of the crosses of our neighborhoods:

Blessed be your purity and eternally so,
for all of God finds delight in such gracious beauty.
To You, celestial princess, Holy Virgin Mary,
I offer you this day, soul, life, and heart.
Look upon us with compassion, do not leave us, Mother mine.

*Am I not here, I who am your mother?
Are you not under my shadow and my protection?
Am I not the source of your joy?
Are you not in the hollow of my mantle,
in the crossing of my arms?
Do you need anything else?*

Sources of the Magisterium and Cited Ecclesial Documents

Sacred Scripture

The biblical citations throughout the manual follow the text of the Jerusalem Bible.

Old Testament

Gen 1:26-27

Creation of the human being in the image and likeness of God. p. 174

Gen 2:7

The breath of life. p. 170

Gen 2:15

The mandate to cultivate and care for the garden. p. 115

Gen 4:9

“Where is your brother?” p. 434 and 519

Num 11:5

The temptation to return to the onions of Egypt. p. 39

Deut 30:19

I set before you today life and death. p. 484

Ps 63:7

The abyss that dwells within us. p. 74

Eccl 1:2, 14

Vanity of vanities. p. 193

Isa 53:4-5

He bore our sufferings, he was pierced for our rebellions. p. 32

Jer 2:13

Cracked cisterns that cannot hold water. p. 190

Mic 6:8

Act justly, love mercy, walk humbly with God. p. 160

New Testament**Matt 25:35**

I was a stranger and you welcomed me. p. 157

Matt 25:36

I was sick and you visited me. p. 24

Mark 3:33-35

Who is my mother and who are my brothers? p. 103

Mark 6:31

Come away to a deserted place and rest a while. p. 162

Mark 8:36

What does it profit a man to gain the whole world and lose his soul?
p. 292

Luke 4:18-19

The Spirit of the Lord is upon me. p. 117

Luke 5:31

It is not the healthy who need a physician. p. 215

Luke 10:33-34

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Luke 14:21-23

Bring here the poor, the crippled, the blind, and the lame. p. 164

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The father runs to meet him. p. 414

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I have prayed for you, that your faith may not fail. p. 281

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He calls his own sheep by name. p. 88

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By this they will recognize that you are my disciples. p. 240

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I will not leave you orphans. p. 182

Rom 7:19

I do not do the good I want, but the evil I do not want. p. 371

2 Cor 5:21

He who knew no sin, he made sin for us. p. 32

Gal 5:1

For freedom Christ set us free. p. 186

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