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National Recovery Month is Coming

The forthcoming month of September usually means that summer is coming to a close. Picnics are over, school begins, the weather changes, leaves begin to fall, and another season has passed. For many people however, September takes on a special meaning of change, reminders of journeys traveled to destinations of hope and better lives, families reuniting, and lost souls finding themselves. September is National Recovery Month. It is a time to remember that people can recover from addiction and behavioral health problems. It is a time to remember that treatment works. It is a time to remember all the professionals and loved ones who shared their lives to help others recover.

National Recovery Month reminds us as a nation that we have much to celebrate, but it also reminds us that there remains much to do. According to some of the statistics released at the beginning of January by the National Institute on Drug Abuse (NIDA), illicit drug use in America is increasing. Approximately twenty-four million Americans over the age of twelve used an illicit drug in the past month; this is an increase over the last ten years with marijuana use and painkillers leading the way. In some cases, other drug usage has remained the same or slightly declined.

However, new substances keep emerging, bringing along with them more challenges. Substances that can be abused always seem a step ahead of us. E-cigarettes and fake marijuana are two examples that have appeared in the last year. Additionally, we are reminded of the cyclical patterns of drug use and behavioral health problems that ebb and flow through the years. Heroin has made a big comeback again.

The articles in this edition of *Counselor* examine the ever-growing knowledge of continuing efforts at treatment and education, and at the same time, provide us with new insights, analysis, and techniques to better serve individuals, families, communities, and our nation. This issue features the third and final part of our "Cannabis Concerns" series. In addition, we are once again pleased to offer an article from the *Journal of Substance Abuse Treatment* on treating substance-abusing women in mixed gender groups versus women only groups. We haven't heard the term "codependency" much lately, but it is still with us and Jon Daily discusses that fact in his article.

I am pleased to announce that Gerald Shulman, MA, MAC, FACATA, will be joining *Counselor* as a regular columnist. He has over forty years of experience providing direct treatment services and clinical supervision. He is a licensed psychologist and was the author of all three editions of the ASAM *Patient Placement Criteria*. We welcome Gerald and look forward to his reading his column, "Counselor Concerns."

To close out the year, the next two editions of *Counselor* will be discussing process addictions with selected feature articles. The awareness of process addictions is growing and at the same time the need for understanding them and treating them will involve more and more clinical intervention. Keep an eye out for that special focus in our October and December issues.

On a personal note, as editor of *Counselor* I would enjoy hearing from you. Please take the time to comment on articles and send me your suggestions for future articles. I can be reached via e-mail at robert.ackerman@counselormagazine.com. To all of you who help those with substance abuse and behavioral health problems and their families, I wish you a happy National Recovery Month.

Robert J. Ackerman, PhD
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Changing the Environment of California Addiction Treatment, Programs, and Professionals

Pete Nielsen, CADC II, LAADC

Whether you call addiction treatment professionals "change agents" or "agents of change," one thing is for sure; the goal is to help people make changes in their lives that lead to improvements in quality of life. This year is a historic year for California as two of the largest, pioneering organizations in our history will transform their individual organizations into one consolidated entity: the California Consortium of Addiction Programs and Professionals (CCAPP). The consolidation has far-reaching implications for the environment substance use disorders treatment professionals provide services in, and brings with it yet to be discovered opportunities for treatment and recovery programs and education providers that operate in the state. CCAPP, representing more than 50 percent of AODA professionals in the state, will be the only organization to offer the updated IC&RC credentials to all counselors.

What Does the Change Look Like?

The California Association of Addiction Recovery Resources (CAARR) and the California Association of Alcoholism and Drug Abuse Counselors (CAADAC) are joining together to consolidate into one fully inclusive organization, the California Consortium of Addiction Programs and Professionals (CCAPP). Combined, CCAPP will serve approximately ten thousand addiction-focused treatment professionals and about five hundred recovery and treatment programs in California. All CAARR and CAADAC counselors and registrants will be conferred with new CCAPP credentials, without needing to apply, shortly after the consolidation is confirmed by the California Secretary of State—CAADAC and CAARR facilities will begin displaying their CCAPP membership certificates as well.

The consolidation goes beyond the coming together of two historically strong organizations; it represents a new future for the profession with some highly visible changes in the way the SUD business is conducted in California. Those whom CCAPP serves will be pleasantly surprised by the streamlined effect that the consolidation is making in certification functions, professional profiles, recovery home affiliations, sober living environments, educational programs, specialty credentialing, and access to member benefits.

The mission of CCAPP is to "promote excellence in the delivery of services focused on substance use and its associated problems by providing the highest level of advocacy, competency, and ethics among programs and professionals." The other two organizations under the auspice of CCAPP have their own individual missions as well. The CCAPP Education Institute mission is to provide education

and technical assistance regarding addiction, treatment, recovery, and associated problems. The CCAPP Credentialing's mission is to license and certify qualified addiction-focused professionals towards attaining the highest professional standards. The organizational structure demonstrates that CCAPP will be the foremost, single organization to serve addiction treatment professionals and programs in California.

How Does the CAADAC/CAARR Consolidation Impact Me?

Whether a counselor is CAADAC/CAARR certified or holds a registration or certificate from another organization, the news is good. CAADAC and CAARR counselors and registrants will be matriculated over to the new career ladder in a single, easy to understand process. Each will receive a notification about the new credential and a welcome package when the consolidation is complete. Those without a CAADAC or CAARR credential are also welcome to become members of the largest voice in California. Any currently or previously certified or registered professional interested in receiving information about the "transfer in" period just needs to e-mail CCAPP at transfer@CCAPP.us. Advisories on when to transfer, requirements for documentation for transfers, and important deadlines will be e-mailed as the dates approach.

CCAPP is also a membership organization with a strong record of representing programs. Any program members interested in receiving information about becoming a part of this historic change in California's treatment landscape can e-mail programs@CCAPP.us to receive important advisories about the transition and special events for facilities and programs.

The Inaugural CCAPP Conference!

CAARR and CAADAC traditionally hold separate conferences. To celebrate the consolidation and the historic unification of the profession in California, there will be one incredible conference in San Diego on October 30 through November 2, at the Mission Bay Hyatt. CCAPP invites all addiction professionals to come and share the excitement and be in the inaugural photo of CCAPP. It will truly be a celebration of the work that programs and professionals do in California, the contributions they have all made to this point, and a look into the bright future CCAPP has planned for all.

This conference will be a one stop shop for the addiction professional. With individual professional training and workshop tracks for executive directors/administrators, clinical supervisors, and a sober living manager track, there are options for anyone who works in the treatment profession. Counselors, interventionists, medication assisted treatment specialists, criminal justice professionals, prevention professionals, co-occurring disorder professionals, and women's treatment specialists will each find offerings to gain specialty education and network with others. There are also opportunities in education on cultural competency, ethics, motivational interviewing, neuroscience, the Affordable Care Act, and many more. To prepare for the implementation of an SUD license possibility in California, workshops to help individuals who inspire to have or currently have a full-time or part-time addiction counseling private practices will be provided.

The CCAPP Conference is located at one of the most popular destinations in California with many local attractions located right next to the hotel. Discover exciting things to do in San Diego. Whether it is relaxing on a deck chair and watching the boats in the marina, going sport fishing, taking a water taxi over to SeaWorld San Diego or hanging out in the Blue Marble spa, everyone can multitask on this trip and obtain some "burnout prevention" hours as well. The hotel has given our conference attendees affordable room rates starting at $119 per night, including complementary internet access. You can make room reservations by calling the Hyatt Regency Mission Bay Reservation Office at 1-619-224-1234. Please let them know you are attending the 2014 Annual CCAPP Conference.

There will be a Halloween costume dance on Halloween night. This is a chance to go out and get all dressed up as a superhero, horror movie character or your alter ego. There will be an ice cream social/networking event scheduled for one of the evenings. To encourage all to attend the inaugural conference, registration will be only $250 for CCAPP members for all four days. Smaller packages, including a one-day option, are also available.

With more than sixty different exhibitors from all over the country signed up for the CCAPP tradeshow, this is also a great opportunity to check out some of the latest and greatest items and tools to improve your program, services or individuals skills.

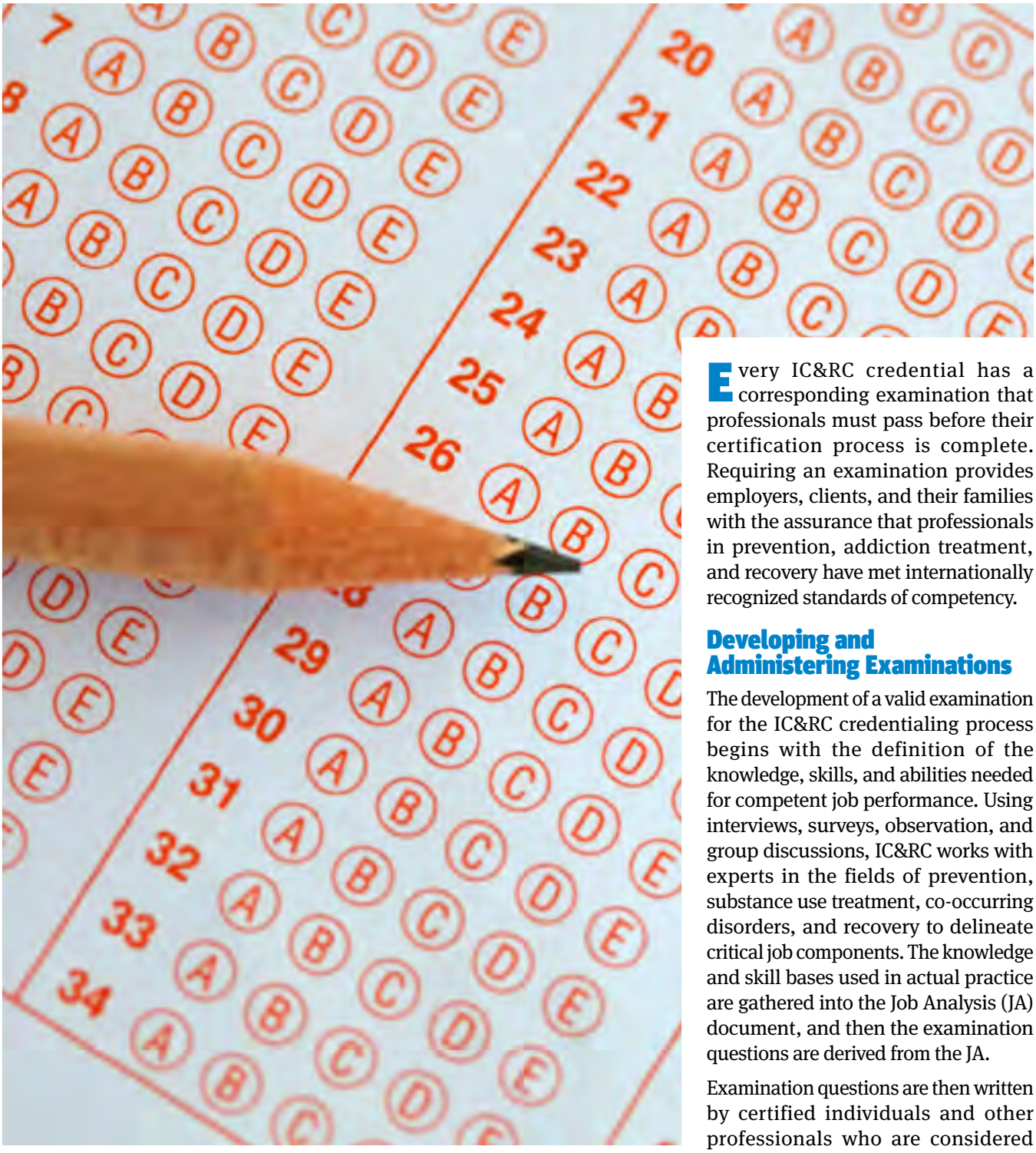
The conference is open to all addiction treatment counselors, social workers, therapists, physicians, nurses, and interventionists as well as addiction treatment providers, behavioral health organizations, and mental health providers. There will be continuing education units/hours approved by the BBS, BRN, CAADE, Breining, CADTP, and CCAPP.

The conference will be a momentous occasion; great things are on our horizon. Come join us this year, so you can say you were at the first-ever CCAPP conference. We look forward to seeing you all in San Diego! C

Pete Nielsen, CADC II, LAADC *is the interim executive director for the California Association of Alcoholism and Drug Abuse (CAADAC), the California Certification Board of Alcohol and Drug Abuse Counselors (CCBADC), and the California Foundation for the Advancement of Addiction Professionals (CFAAP).*

All about IC&RC Examinations

Mary Jo Mather



Every IC&RC credential has a corresponding examination that professionals must pass before their certification process is complete. Requiring an examination provides employers, clients, and their families with the assurance that professionals in prevention, addiction treatment, and recovery have met internationally recognized standards of competency.

Developing and Administering Examinations

The development of a valid examination for the IC&RC credentialing process begins with the definition of the knowledge, skills, and abilities needed for competent job performance. Using interviews, surveys, observation, and group discussions, IC&RC works with experts in the fields of prevention, substance use treatment, co-occurring disorders, and recovery to delineate critical job components. The knowledge and skill bases used in actual practice are gathered into the Job Analysis (JA) document, and then the examination questions are derived from the JA.

Examination questions are then written by certified individuals and other professionals who are considered

Subject Matter Experts (SMEs) in their field. SMEs come from around the world to be trained in item writing best practices. Every examination item then undergoes a three-tiered review process to ensure quality and accuracy prior to becoming a scored item on an IC&RC examination.

Since 2008, IC&RC has relied on Schroeder Measurement Technologies (SMT) to administer its credential examinations. SMT administers examinations each year in over forty professional categories and processes over 100,000 examinations per year.

In September 2009, IC&RC administered its first computer-based exams, and since then, more than 16,733 candidates have successfully used the system. On January 1, 2011, on-demand Computer-Based Testing (CBT) was instituted. The option to test nearly every day of the year, at sites around the world, offers tremendous benefits to candidates, moving them more quickly to certification and filling the growing need for professionals.

Preparing to Take an IC&RC Exam

To assist professionals in preparing for examination, IC&RC has developed Candidate Guides that provide detailed information about the IC&RC examination process. For each credential, the guide includes information on the following areas:

- Exam eligibility requirements and registration
- Exam administration and dates
- Rescheduling, cancelling, and missed exams
- Examination rules and security
- Special accommodations
- Scoring of exams
- Appeals, examination grievances, test disclosure, and retakes
- Examination content
- Sample questions
- The examination reference list

IC&RC has also developed practice exams for the Alcohol and Drug Counselor (ADC) and Clinical Supervisor (CS) examinations with IC&RC's testing company to mimic the exact look and feel of IC&RC's CBT platform. Each practice exam, which candidates have sixty minutes to complete, has fifty questions. After completing the practice exam, candidates will receive a score report identifying their areas of strength and weakness.

In addition to the IC&RC Candidate Guides, IC&RC has endorsed study guides for the Alcohol and Drug Counselor (ADC), Advanced Alcohol and Drug Counselor (AADC), and Co-Occurring Disorders Professional (CCDP/D) examinations.

For the ADC and AADC, IC&RC has endorsed *Getting Ready To Test: A Review and Preparation Manual for Drug and Alcohol Credentialing Exams*. This unique, self-guided, 734-page manual provides comprehensive materials to refresh and enhance candidates' knowledge on many of the major areas of information required for the examinations. The manual includes a 150-question, sample written exam and can be purchased at www.ReadyToTest.com.

For the CCDP/D exam, IC&RC has endorsed *THE BASICS, 2nd Edition: A Curriculum for Co-Occurring Psychiatric and Substance Disorders*. The two-volume set, by Rhonda McKillip, MEd, LMHC, MAC, CCDCIII, CDP, contains over 1,600 references, as well as detailed lesson content and handouts for group, topics and information for individual sessions, and a cross-training guide for mental health and chemical dependency professionals. Professionals may purchase *THE BASICS* at RhondaMckillipandTheBasics.com.

Taking the Next Step

IC&RC examinations are available exclusively through IC&RC Member Boards. Each Member Board determines the eligibility requirement, registration processes, and method of administration in its jurisdiction. Candidates interested in taking an IC&RC examination should contact the Member Board that has jurisdiction in the area where they live or work. Contact information for all IC&RC Member Boards—as well as Candidate Guides and links to practice exams—can be found at our website for professionals, Professionals.InternationalCredentialing.org.

Mary Jo Mather *is the executive director of IC&RC, the global leader in the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in twenty-four countries, forty-seven states and territories, five Native American regions, and all branches of the US military.*

The Final Act of Philip Seymour Hoffman

Maxim W. Furek, MA, CADC, ICADC

Philip Seymour Hoffman, aged forty-six, was found February 2, 2014, on the bathroom floor of his Greenwich Village apartment. A syringe protruded from his left arm. Police found nearly fifty envelopes filled with heroin, stamped in purple ink with the street name "Ace of Hearts," and others stamped with the Ace of Spades logo. Five empty bags had been discarded in the trash. Prescription drugs were also discovered.

He was called the "greatest actor of his generation" and the "gold standard." His performances in a huge body of work, including *Boogie Nights* (1997) and *Almost Famous* (2000), demonstrated a diverse range of tone, delivery, character, and an ability to understand and project subtle nuances. He won the Oscar for *Capote* in 2005 and his accomplishments were being noticed. A *Rolling Stone* article about Hoffman noted that "For the past few years, working with his friends in theater while acting in huge Hollywood roles, Hoffman seemed to reach new zeniths. He'd been nominated for Best Supporting Actor three times in five years, for *Charlie Wilson's War* (2007), *Doubt* (2008) and *The Master* (2012)" (2014).

After maintaining sobriety for twenty-three years, Hoffman unfortunately relapsed. In an interview with *60 Minutes* he discussed his past struggles with drug and alcohol addiction. "Anything I could get my hands on, I liked it all," he said (Prokupecz, Almasy, & Shoichet, 2014). Asked why he decided to sober up, he replied, "You get panicked . . . I was twenty-two and I got panicked for my life, it really was, it was just that. And I always think, 'God, I have so much empathy for these young actors that are nineteen and all of a sudden are beautiful and famous and rich.' I'm like, 'Oh my God. I'd be dead.'" According to

TMZ, Hoffman said last year that he'd fallen off the wagon, started taking prescription pills, and slipped into snorting heroin (Prokupecz et al., 2014).

His addiction revealed how difficult it is to navigate the road of recovery. In May 2013, Hoffman completed a ten-day detox for heroin dependence and, in January 2014, resumed a busy shooting schedule. He also attended the Sundance Festival to promote *A Most Wanted Man*, but wherever he went his addiction followed. In 2011, he told *The Guardian*, "I had no interest in drinking in moderation. And I still don't. Just because all that time's passed doesn't mean maybe it was just a phase. That's who I am" (Tauber, 2014).

Heroin Epidemic

Hoffman's death occurred in the midst of a nationwide heroin epidemic, a tsunami that exploded in concentric circles around Connecticut, New Jersey, New York, and Pennsylvania. In January 2014, a "public health crisis" was declared in the Pittsburgh area. Pennsylvania Attorney General Kathleen G. Kane warned, "There have been twenty-two deaths in Western Pennsylvania believed to be caused by a deadly mix of heroin and the narcotic fentanyl. Together, these drugs are creating an extremely dangerous and potentially lethal combination for users" (Pennsylvania Office of the Attorney General, 2014).

The heroin-fentanyl mix was nothing new. Seven years earlier, the same deadly mixture of heroin and fentanyl killed over one thousand users. In a national tally of the fentanyl deaths, the Centers for Disease Control (CDC) reported that the peak of the outburst was 150 deaths in June 2006 (2008). The profile of the characteristic victim: thirty-five to fifty-four years-old (58.6 percent), male (80.1 percent), and white (55.4 percent) (Furek, 2012).

The new batch appeared to be centered in Pittsburgh, and, as outlined in the Pennsylvania Office of the Attorney General press release,

> *The heroin is believed to be in bags stamped with the words "Theraflu," "Bud Ice," and "Income Tax." Heroin with these specific stamps has been identified by narcotics agents not only in Allegheny County, but also in Westmoreland, Armstrong, Butler, Lawrence, and Beaver counties. However, these stamped bags could already or eventually be available in other counties across Pennsylvania (*2014*).*

Some believed this batch would be deadlier then what was experienced in previous years. The Associated Press stated

> *With more and more addicts turning to heroin because crackdowns on powerful prescription opiate painkillers have made them more expensive and inaccessible, there is concern that more people may be exposed to fentanyl-laced heroin during this wave than in previous ones, including in 2006 when hundreds of people from Chicago to Philadelphia died after injecting the drugs (*Zezima, 2014*).*

The use of heroin has been growing steadily for at least the past five years. Unlike the heroin surge in the 1970s, the current use of opiates is far more concentrated among suburban and rural whites than among African-American and Latino communities. Additionally, it is far more potent. Although there have been changes, much of the illegal drug distribution has maintained a familiar continuity. As described by J. David Goodman,

> *Almost as long as there has been heroin in the United States, New York City has been its hub. Certainly much has changed since the 1970s, when addicts flooded shooting galleries and flashy drug traffickers like Nicky Barnes, known as Mr. Untouchable, became household names. The drug is still smuggled into the country from faraway poppy fields, still cut from kilo-sized quantities in hothouse operations secreted around the city, still diluted in coffee grinders, and still sold to needy consumers (*2014*).*

New England

The epidemic shifted to New England. In Massachusetts, authorities reported that almost two hundred people died of heroin overdoses in a four-month period. Governor Peter Shumlin of Vermont devoted his entire 2014 State of the Union message to the heroin crisis engulfing his state. Shumlin said

> *In every corner of our state, heroin and opiate drug addiction threatens us. It threatens the safety that has always blessed our state. It is a crisis bubbling just beneath the surface that may be invisible to many, but is already highly visible to law enforcement, medical personnel, social service, and addiction treatment providers, and too many Vermont families. It requires all of us to take action before the quality of life that we cherish so much is compromised.*
>
> *The facts speak for themselves: In Vermont, since 2000, we have seen a more than 770 percent increase in treatment for all opiates. What started as an Oxycontin and prescription drug addiction problem in Vermont has now grown into a full-blown heroin crisis. We have seen an over 250 percent increase in people receiving heroin treatment here in Vermont since 2000, with the greatest percentage increase, nearly 40 percent, in just the past year. In 2013, there were twice as many federal indictments against heroin dealers than in the prior two years, and over five times as many as had been obtained in 2010. Last year, we had nearly double the number of deaths in Vermont from heroin overdose as the prior year (*State of Vermont, 2014*).*

Vermont reflected a disturbing coast-to-coast trend. Nationwide, according to the Substance Abuse and Mental Health Services Administration, heroin use nearly doubled between 2007 and 2011. The number of Americans who reported being addicted to heroin increased from 2007 (179,000) to 2011 (369,000). Data from the Partnership at Drugfree.org indicated the number of Americans who reported past-year use climbed from 373,000 in 2007 to 620,000 in 2011 (2014).

"Urgent Public Health Crisis"

Calling the rise in overdose deaths from heroin and prescription painkillers an "urgent public health crisis," US Attorney General Eric Holder vowed that the Justice Department would

combat the epidemic through a mix of enforcement and treatment efforts. Holder noted that between 2006 and 2010, heroin overdose deaths increased by 45 percent. "When confronting the problem of substance abuse, it makes sense to focus attention on the most dangerous types of drugs. And right now, few substances are more lethal than prescription opiates and heroin," Holder said, adding that the Drug Enforcement Administration has opened more than 4,500 heroin-related investigations since 2011 (US Department of Justice, 2014). As a result of these aggressive enforcement efforts, the amount of heroin seized along America's southwest border increased by more than 320 percent between 2008 and 2013.

Moreover, Holder is encouraging law enforcement agencies to train and equip their personnel with the life-saving overdose-reversal drug, naloxone. When administered quickly and effectively, naloxone immediately restores breathing to a victim in the throes of a heroin or opioid overdose. According to a blog post by the Office of National Drug Control Policy (ONDCP), "Seventeen states and the District of Columbia have amended their laws to increase access to naloxone, resulting in over ten thousand overdose reversals since 2001" (Hardesty, 2014).

The cycle of heroin abuse commonly begins with prescription opiate misuse, as evinced by Philip Seymour Hoffman. Experts recognized that even before his death, things were amiss. Dr. Barbara Krantz wrote,

> *In the case of a relapse, as was the situation with Mr. Hoffman, we believe this process happens even before someone picks up a drink or a drug again. They begin to fall back into unhealthy behavior such as not reaching out for help when dealing with stress, isolating themselves, and not being accountable to friends and family. Addiction is a chronic disease and is therefore encoded on their brain. Therefore, once unhealthy behavior starts again there is a tendency to slip right back into old destructive familiar ways.*
>
> *It's important to understand that relapse isn't synonymous with failure. Just like any other chronic illness—people who relapse can recognize that they need help and get the support they need to get back on the path to sobriety. A person has to be actively involved in order to achieve a full recovery* (2014).

Corey Monteith

Even as we mourned Hoffman, many remembered a previous celebrity fatality. On July 13, 2013, Corey Monteith, aged thirty-one, the actor who played Finn Hudson in the Glee TV series, was found dead. The popular actor overdosed in a Vancouver hotel room after taking a lethal cocktail of heroin and alcohol.

Writing about Monteith's death, David Sheff observed

> *In America, we still view addicts as the Other: those on the streets huddled in alleyways or doorways, unkempt, uncouth, possibly dangerous. We walk around them, averting our eyes. Or we follow their antics on TMZ—Paris Hilton and Charlie Sheen, the brunt of jokes about their attempts at recovery followed by relapse. Monteith was a fresh faced, clean-cut heartthrob. When he died, a radio interviewer called and asked me to explain what happened. He said, 'But Cory seemed so normal.' He was so normal, even in his drug addiction, a condition he shared with twenty-three million Americans* (2013).

Monteith told *Parade* magazine in 2011 that he was "out of control" as a teen. He revealed that at age thirteen, he drank, smoked pot, and skipped school in Victoria, British Columbia, after his parents divorced. By sixteen, he said, his drug use had escalated. He was "doing anything and everything, as much as possible." At nineteen, he entered rehab for the first time (Mandell, 2013).

Ugly controversy surrounded events meant to celebrate the lives of Hoffman and Monteith. Cory Monteith's proposed tribute turned into an inquisition as his special prime time Emmy tribute was fiercely criticized. Writing for *Variety*, Andrew Wallenstein noted, "Monteith could have gone on to a tremendous career, but Larry Hagman, for instance, already had a tremendous career, and putting Monteith on a pedestal casts a shadow over the memory of this iconic Dallas star" (Wallenstein, 2013). The writer also noted that "the Emmy recognition will put deserved focus on the perils of drug addiction."

Another feud ensued when rapper Drake criticized *Rolling Stone* for replacing his cover photo with that of Hoffman's. Drake had been selected to appear on his first *Rolling Stone* cover. After being replaced, Drake tweeted in frustration, "I'm disgusted with this . . . RIP to Philip Seymour Hoffman. All respect due. But the press is evil." Drake stated that he felt "violated." He later offered, "I once again apologize to everybody who took my cover comments the wrong way" (*Huffington Post*, 2014).

Generation X

Heroin was introduced to members of Generation X (1965–1978) in slow, deliberate measures. In the early 1990s, heroin (diacetylmorphine), in the form of the cheaper, higher potency Mexican black tar heroin, emerged as an accepted mainstream drug. Grunge bands Nirvana and Alice and Chains and motion pictures *Pulp Fiction*, *The Basketball Diaries*, and *Trainspotting* acknowledged America's fascination for the culture of the heroin user. As Generation X recklessly embraced heroin, a number of grunge musicians succumbed to the drug, people like Kurt Cobain, Shannon Hoon, Kristen Pfaff, Layne Staley, and Mike Starr. In 1994, the US State Department warned of a possible heroin epidemic: "While at US street prices, cocaine and heroin are competitive, at the wholesale level heroin has a strong advantage," the report said. "With the likelihood that heroin will be to the 1990s what cocaine was to the 1980s, Latin American trafficking organizations are poised to cash in on a heroin epidemic," the report predicted (Gedda, 1994).

Alfred W. McCoy documented the cultish appeal of heroin in the *Historical Review of Opium/Heroin Production*. McCoy observed:

> *Stigmatized during the 1960s as a ghetto drug, the mark of the social*

marginal, heroin has been reborn in the 1990s as the badge of the hip American nihilist. For those at the cutting edge of a young, creative crowd known as "Generation X," heroin is the drug of choice, the symbol of authentic alienation. On the East Coast heroin is back as an old friend, a simple respite from the roller-coaster rip of crack-cocaine and all its craziness. It is on the West Coast that heroin's rebirth as a style statement has been most complete. In Los Angeles, films such as Drug Store Cowboy *and* My (Own) Private Idaho *have mythologized the drug, adding an allure to addiction for the city's edge actors. In San Francisco, bands like Pale Horse and Morphine celebrate the drug, making its trademark dragon iconography a fashionable logo for club-cruising gear, stylish caps, and t-shirts. Seattle's "grunge movement" is wrapping the drug in an ambiguous embrace, and the heroin-related deaths of local rock icons Andrew Love and Kurt Cobain give it a cultish degeneracy (*n.d.*).*

Hoffman portrayed an addict who frequented upscale Manhattan heroin dens in *Before the Devil Knows You're Dead* (2007). An article published in *Entertainment Weekly* divulged,

*Once again, he brings a dimension to this sort of action that you rarely see: He shows you, vividly, the despair of the addict—the despair that gets bathed, thanks to the drug, in temporary ecstasy. And it's hard to watch those scenes now without trying to imagine the demons that may have been driving Hoffman himself (*Gleiberman, 2014*).*

There was something unique about him, his openness, perhaps his ordinary, unassuming persona. He easily made us take notice. After his death we wondered what demons drove him to self-destruction. There were others—ordinary, unfortunate individuals, young and old—who died in a similar manner. Hoffman wasn't the only one. But in his final act, Philip Seymour Hoffman, the "greatest actor of his generation," gave the heroin epidemic a name, a face, and a further reason for concern. C

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Secular Alcoholics Anonymous: Nonreligious Treatment for Nonreligious People

Dorothy H.

I got sober on Sunday, March 27, 2011. I woke up with a hangover and no excuses for my behavior. I saw my alcoholism for the first time and it was selfish, abusive, and ugly. It had busted out my front teeth when I was nineteen years old while on a binge. It had made my life so unmanageable that I couldn't figure out how to replace my shoes when they fell apart, so I duct taped them together. I had only two pairs of underwear, my clothes had countless holes, I couldn't keep a full-time job longer than one and a half years, and I couldn't take responsibility for myself. I was tired of creating excuses for this behavior and tired of defending it.

I was tired of hiding.

I called my friend Eric, who was in Alcoholics Anonymous (AA). Eric found someone to give me a ride to a women's meeting. Within a few weeks of attending mostly women's meetings I became frustrated and exhausted with all the God language and the repetitious statements within AA. I began to practice "double think," internally editing out the God word to be able to hear the positive message of recovery in these traditional meetings. I kept feeling that I was still hiding, like I did as a child. I came to my turning point when I was three weeks sober and was wearing a medical walking boot following foot surgery. One night I listened to a woman give her personal share in the style of a southern preacher.

I instantly felt trapped. I scanned the room and saw the other women praising and encouraging her. I literally couldn't get up and walk out. I felt like the walls were closing in on me. For the first time, I actually looked at the Twelve Steps, which were on the wall behind the podium, and saw all the times God was mentioned. The thought came to me that if I didn't "come to believe," then I was doomed to die a loveless, alcoholic death.

I was done! I decided all AA had to offer me were religious testimonials about people turning to their gods. I called Eric and told him that all AA had for me was religion and that I could go to church for that, which I wasn't going to do. So I might as well drink!

Eric, who is a believer, begged me not to give up on sobriety or on AA. He told me about the We Agnostics meeting in Hollywood and asked me not to drink until I went to that meeting. That Friday night I took a two-hour bus ride and walked two miles in my walking boot to get to the meeting.

I instantly felt at home when I heard these words read from the meeting format: "to assure suffering alcoholics that they can find sobriety in AA without having to accept anyone else's beliefs or deny their own." Jerry B., who was thirty years sober, led the meeting. Jerry stated in the beginning that he was an atheist. I was stunned! My first thought was, *Is that allowed*? Are people allowed to be atheists within AA? His atheism and other members' philosophical views showed me that intellectual diversity in AA was actually possible!

From that meeting on I felt I was home. I could be open and honest; I did not have to follow the practice that many people who believe in God say in AA, "Fake it 'till you make it," which more accurately meant for me, "Hide it until you believe in God."

Over the years I watched people from other parts of the country come to our meeting to tell us that they started a We Agnostics meeting in their hometowns after visiting us or that they also attend We Agnostic style meetings in their cities because of the intolerance they felt in AA. I have also seen a deep relief from people when they entered their first We

Agnostic meeting. I have witnessed believers act fearful when they hear there are meetings where there are nonbelievers. I never understood their fears because I have only experienced love and acceptance from these groups.

I realized that all the We Agnostics and other secular meetings needed to work together to carry the "message to the alcoholic who is still suffering." We needed to raise our voice within AA to make room for people like us who used religion and faith as an excuse to relapse, or those who just wanted a safe place where they could talk about falling to their knees asking their ancestors for help. To make room for those who couldn't relate to the God-centric language and dogma that exists within AA. To provide a place where what mattered first and foremost was not drinking and everything else was truly just a "suggestion."

The answer was a convention.

I brought it up to another We Agnostics member, Pam W., and she loved the idea. We spent three weeks sharing our ideas with each other, clarifying what the overall goals of the convention would be, and most importantly, how to make it clear that we wanted to remain in AA! That AA works and has worked for nearly eighty years we had no doubt; we just wanted to keep the doors of AA open for everyone. Out of these initial conversations, the We Agnostics and Freethinkers International AA Convention (WAFT IAAC) was born.

We instinctively knew WAFT IAAC had to be about the international We Agnostics and Freethinkers fellowship as a whole—not about individual groups, nor the individual steering committee members—and that we needed to see ourselves as servants to the fellowship. Knowing we could not do it alone, Pam W. and I, and later Jonathon G., turned to the fellowship for help. We learned there are over 150 meetings worldwide located in five different countries. I began to contact the other groups and got an overwhelming response of excitement, joy, and relief at the idea of the convention.

During my outreach work I began to see the historical picture form around what I was doing. The first agnostic groups were formed in Chicago, Illinois, in 1975, followed by my home group in Hollywood, California, which was founded in 1978. I see the convention as a new phase of secularism in AA where the fellowship can convene to address itself for the first time.

It has saddened me to learn how deep the rift is among WAFT and traditional AA. The majority of our active supporters are people with ten to forty-five years of sobriety who are terrified to make announcements in traditional AA meetings that a convention for WAFTs even exists. Yet there have been people like Jane J. of New York City who hand-addressed nine hundred envelopes to send to AA meetings across the USA, and others who clock multiple hours of online research to spread the word that AA is available to nonbelievers. WAFT meetings were formed so people could stop hiding; the convention will accomplish the same thing on an international scale.

Agnostics and freethinkers have always been a part of AA's international fellowship, yet only since 1975 have there been WAFT meetings. The long-term sobriety of many members of these meetings shows that you do not need to believe in God to stop drinking. We want to make sure that all suffering alcoholics know that AA is available to them.

Since announcing the convention, our support has grown far and wide. We have gotten reports from England, France, Japan, Canada, and nearly every state in the USA that AAs and their groups are organizing to come to the convention. WAFT IAAC's appeal is simply part of AA's promise: the ability to live a completely honest life in action and belief.

Our support has given us two distinguished keynote speakers, Marya H., a professor and author with Hazelden publishing, and the Reverend Ward Ewing, who has been an ally of AA for over thirty-three years and was one of AA's nonalcoholics trustees for eleven years. The convention is an open event; everyone is welcome to attend on November 6, 7, and 8 in Santa Monica, California. For more information and to purchase tickets, please visit our website at www.waftiaac.org.

Dorothy H. *is the cofounder of the We Agnostics and Freethinkers International AA Convention (WAFT IAAC) and the chairwoman of the steering committee of WAFT IAAC and president of the WAFT IAAC, LLC. Dorothy H. is originally from the San Fernando Valley of Los Angeles, California. She received her BA in english from San Francisco State University, her MA in history, and a graduate certificate in archival administration from Wayne State University in Detroit, Michigan.*

Truth and Language

Rev. Leo Booth

"And what is the truth?" asked Pontius Pilate (John's Gospel, 18:38, Good News Bible).

This question is asked in an exchange between Jesus and Pilate before Jesus was sentenced to death. It concerns the nature of language and how we seek to express and describe beliefs we believe or think are true.

The background to this question comes after Pilate asks Jesus if he is a king. This has a vague reference to the Jewish authorities who had suggested that Jesus was pretending to be "the Messiah" or "King of the Jews." Jesus' reply is interesting: "You say that I am a king. I was born and came into the world for this one purpose, to speak the truth. Whoever belongs to the truth listens to me" (John's Gospel, 18:37)

The language is both philosophical and colorful; obviously Jesus is not an earthly king according to what any person at that time would understand a king to be. Jesus suggests that his kingdom is not of this world. He is philosophically playing with language—suggesting, in a challenging manner, that truth is the foundation stone for his kingdom.

The point I wish to make throughout this article is that the language we use is not always intended to be taken literally. Metaphor and poetry are often used, especially in seeking to describe or explain the actions of the Creator, or God or Higher Power. It is as if the mysterious activities of God, as we experience them, necessarily call forth poetry. We are metaphorically grasping in language for an understanding of God and how this mysterious entity, which is beyond everyday comprehension, relates to us.

As I write this article, the movie *Noah* has just been released and not surprisingly it has created controversy. Why? Because the artistic telling of this story, understanding why God sent the flood and how this catastrophe specifically affects Noah's relationship with his son Ham, clashes with those who understand and read the biblical account literally. Those who believe that what is written is what happened, end of discussion.

But was the story of Noah intended to be taken literally?

In the same week that this movie was released I watched the PBS documentary of the *History of the Jews* by Simon Schama. It is fascinating. He suggests that according to Judaism, the Divine can never be named and any reference to the Divine should use that encompassing term "God," the Otherness beyond creation. The history of the Jews is seen and understood in the telling of their story, both tragic and wonderful; how they struggled to deliver the message that the Lord, our God, is one God—monotheism. With this awareness, metaphor and poetry are necessarily at the heart of their story. Vivid language and artistic drawings are used to depict and reveal God's interaction with the Jews and their understanding of their chosen-ness. Respectful discussion, commentary, and argument become the foundation of the Jewish story. This is important background information in understanding and interpreting the sacred Torah.

Truth, according to Simon Schama, is not always found in the literal translation of the words being used. Indeed, Truth is beyond any literal fundamentalism and can only be understood in symbolism, ritual, and metaphor.

Is this information germane to recovery? Does it have any relevance to understanding the message of Alcoholics Anonymous (AA)?

Most definitely! Instead of the Bible, we have a book, euphemistically referred to as the *Big Book*. Additionally, the discussion among members of AA is not dissimilar to those who discuss the scriptures and the language used to describe God's involvement in the story of redemption.

I am personally of the opinion that the *Big Book* gives a simple and insightful understanding of alcoholism. It contains, for me, spiritual

truths. It has suggestions for alcoholics and those living with alcoholics that have undeniably helped thousands into recovery. Also, this book has been used as the foundation stone for most self-help healing. When we consider the background of those who wrote it and the year it was published, it is deserving of the term "miraculous."

But is it divine? I think not. Should it be open to discussion and interpretation? Most definitely. Would you get drunk if you have a different insight or choice of words? No. People have gotten drunk after years of reading and studying this book. Furthermore, some people have stayed sober who never read the *Big Book* or heard about Bill W. or Dr. Bob.

Indeed, Bill W. and Dr. Bob never intended their words to be taken literally. I received a copy of a letter in which Bill W. wrote to Ed Webster in 1946:

"Personally I'm very glad to see many people writing about AA and circulating the material about, even though some folk seem to think I should do all the writing. To me this idea is nonsense. AA is not one point of view, it's many."

Again he wrote to Ed in 1949:

"God forbid that Alcoholics Anonymous ever becomes frozen or rigid in its ways of doing or thinking. Within the framework of our principles the ways are apparently legion."

In *As Bill Sees It* (Bill W., 1967, p. 191):

"There are few absolutes inherent in the Twelve Steps. Most steps are open to interpretation, based on the experience and outlook of the individual."

In the pamphlet "A Member's Eye View of Alcoholics Anonymous" (1970) we read:

"There is no 'party line,' no official dogma or doctrine to which the members subscribe, no creed that we recite."

The house that AA helps a man to build for himself is different for each occupant, because each occupant is his own architect.

History teaches us that it is wiser to leave the Divine in the heavens and not claim it is here on earth. Many wars have been fought and millions killed at the hands of those who claimed to speak or know the truth.

I thank God every day that I am able to think, discuss, and change my mind on a regular basis.

What is truth? Maybe a really good idea . . . until we discover a better one! C

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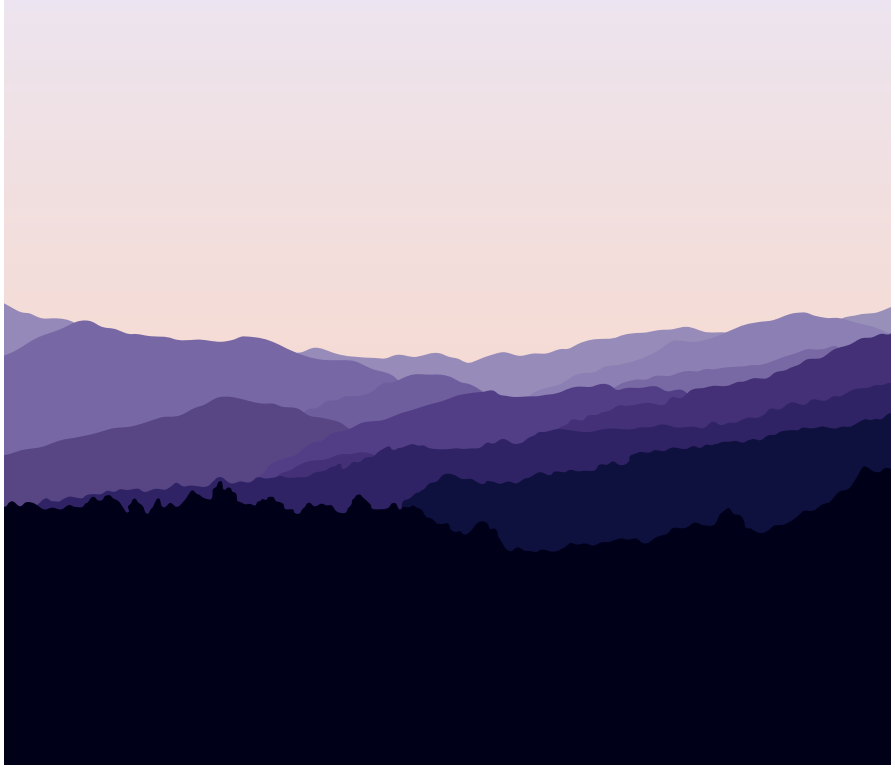
The Virtue of Patience, Part II

John Newport, PhD



This is the final installment in a two-part series that focuses on applying the virtue of patience in recovery from addiction. The first column focused on patience as a vital ingredient in the overall recovery process. This column deals with the value of patience in our ongoing quest to integrate a wellness lifestyle in our recovery.

The toxic lifestyle patterns adopted in the course of addiction to alcohol and other drugs are fully ingrained and consequently quite difficult to change. Examples that immediately come to mind include the abysmal diets of most alcoholics and addicts, together with their nicotine addiction.

Conquering Nicotine Addiction

Between 70 and 85 percent of practicing alcoholics and addicts are also addicted to nicotine. Many are heavy smokers and the majority carry their nicotine addiction over to their recovery. Nicotine dependence is an insidious addiction and is the leading cause of death among people in recovery. Indeed, both founders of AA died as a consequence of their nicotine addiction.

I know from personal experience that heavy doses of determination and patience, together with unflagging persistence, are essential in successfully quitting smoking. Indeed, the average smoker quits five to eight times before kicking the habit for good.

Many former addicts swear that nicotine is a harder drug to kick than heroin. Unfortunately, after several failed attempts at quitting, many smokers convince themselves that they are unable to quit and stop trying. Again, mega doses of both patience and perseverance are required to successfully quit for good. Fortunately, state health departments throughout the country have now made available stop smoking quit lines staffed by trained counselors; these programs often provide free-of-charge nicotine replacement therapy as well. Nicotine Anonymous and stop smoking classes and support groups, sponsored by both the American Cancer Society and American Lung Association, provide valuable support to persons struggling with quitting.

Other Examples

Other examples of disruptions in our lives that require persistent application of patience to overcome include overly sedentary lifestyles, food addictions, eating disorders, lack of harmony in our relationships, and lack of a grounded spiritual focus in our lives.

While many younger alcoholics/addicts manage to remain physically active while in the throes of their addiction, this is often not the case with older chemically dependent persons. Indeed, when one's lifestyle revolves around sheer survival and feeding his or her addiction, concern with taking care of oneself falls by the wayside. Sound nutrition takes a back seat, as does caring for our bodies. Adding a healthy dose of regular exercise to our lives once we have initiated sobriety requires a strong desire to take care of ourselves, together with consistent application of patience and persistence.

Likewise, tackling food addictions that often emerge in early recovery—including addiction to sugar and overeating—or dealing with serious eating disorders such as anorexia and bulimia requires courage and persistence, combined with an abundance of patience.

Problems involving lack of harmony in our relations with others are a hallmark of the addictive lifestyle, and these problems frequently carry over into the early and middle stages of recovery. Many if not most newly recovering alcoholic/addicts experience considerable difficulty in detaching from former peers whose presence threatens to pull them back into their addiction.

Consequently they experience considerable anxiety in attempting to form meaningful relationships with people who are clean and sober. In particular, women in recovery often remain addicted to forming relationships with abusive men. Extricating ourselves from alliances with others who pose a threat to our sobriety, while attempting to reach out to wholesome potential friends and acquaintances, most definitely requires continued determination and persistence. While we are undergoing this major transition in our social supports, we must be patient with ourselves concerning our sometimes faltering attempts to connect with others who will not pull us down.

As the absence of a grounded spiritual focus draws us into addictive use of alcohol and drugs and other destructive behaviors, forming a relationship with a higher power is a basic cornerstone of all Twelve Step programs. We need to learn to turn to a beneficent higher power for continual guidance in walking the path of recovery. This is particularly true as most of us are overly hard on both ourselves and others, and need to accept the consolation and guidance freely offered by a beneficent power greater than ourselves. In addition, deepening our connection to our higher power is extremely important in cultivating the patience and serenity needed to confront life's problems head on without falling back on alcohol and drugs.

Coping with Illness

We are all confronted with illness at many points in our lives. Many of these episodes are relatively mild, such as a routine cold or minor athletic injury. Other manifestations of illness, including chronic illnesses such as arthritis, diabetes, and hypertension—together with more serious debilitating illnesses, such as heart disease, HIV, and the many forms of cancer—tend to pose a heavy toll on both our bodies and our psyches.

An unrelenting flare-up of arthritis or a serious physical injury can throw our lives completely out of balance, triggering uncomfortable feelings of loss of control, helplessness, and despair. In addition to these feelings, a truly threatening illness, such as a major heart attack or latter stage cancer, provides a very frightening confrontation with our own mortality.

Strong qualities of faith and patience are essential in learning to live with any form of chronic illness without letting it take control of our lives. When forced to face the consequences of a truly devastating illness, I believe that we are best served by the qualities of patience and perseverance that enable us to maintain and practice a strong sense of faith in a beneficent higher power, while embracing the admonitions set forth in the Serenity Prayer "to accept the things we cannot change" while manifesting "the courage to change the things we can" and "the wisdom to know the difference." It is extremely important during these times to consciously savor the many wonderful things we have already experienced in our lives, while focusing on our hopes for the future, particularly our hopes concerning those whom we hold near and dear to our hearts. As we tend to attract what our minds choose to focus on, when faced with a devastating illness we are challenged to become "incurable optimists" concerning our body's God-given healing potential, while at the same time placing the ultimate outcome squarely in the hands of our higher power.

For anyone seeking a fuller treatment concerning the application of faith, patience, and perseverance in dealing with devastating illness I would highly recommend *Love, Medicine, and Miracles* by Bernie Siegel, MD, published in 1998.

Please feel free to share these reflections with your clients or anyone else who might benefit from the message. I would be happy to hear from you concerning your own experiences in applying the virtue of patience in integrating a wellness lifestyle in your recovery. I can be reached at drjohnwellness@hotmail.com. C

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Happiness and Empowering Mental Attributes

Sheri Laine, LAc, Dipl. Ac

Pharrell Williams is a funky, soulful singer who has written a contagious, foot-tapping song named "Happy" that has become number one in twenty-five countries including America.

When I see my patient Analise, I am reminded of the happy positive feelings this song portrays.

It is always a special pleasure to see patients like Analise. She is a "glass half full" type of person. As single mother in her thirties who is studying medicine, she has been coming to my clinic for the past eighteen years for tune-ups that keep her equilibrium strong.

In talking with her I notice that she relates to most situations objectively. Her perception of circumstances is centered and even. She does not react emotionally or project negative, anxious thinking onto situations that she can or can't control.

Some might call her a critical thinker, as she allows for other possibilities to be discovered in situations, staying fluid in her thinking to other options and ideas. Because she is flexible in her thinking and choices, she finds creative ways to move forward if her first plan of action fails.

Analise is resourceful, which gives her and her daughter permission to look forward to change, and go with the flow of life rather than fight against it. I see real determination in the way that Analise lives her life. It has been a very long haul as a single mother for her to complete medical school, yet she has shown strength of spirit in her calling, and continues to always move forward with the ever-changing tides of life. She is not uncomfortable in asking for outside help and support when she needs assistance, and has a wonderful support team around her and her daughter.

As an emergency room doctor she will need the mental strength and emotional stability that she possesses, which will keep her even and balanced when situations can and will be harried, unfortunate, and stressful. She remains calm and open to life and its stirring moments, knowing not to expect that there will not always be a positive, uplifting ending.

For the most part her life remains steady and balanced as Analise incorporates regular meditation, acupuncture, exercise, and healthy eating into her busy lifestyle. She makes time to rest even with her busy schedule and hospital rotations.

Another wonderful attribute Analise processes is the ability to laugh, while not taking herself or her lot in life too seriously; she can let go and have fun. Her mental strength has allowed her to move forward in life when her marriage failed, and to see the new path before her as an opening to yet another new opportunity in her spiritual and emotional growth. Her perception of life is one of innovation and optimism.

She is "Happy," and as the song goes, her happiness is her truth.

Sheri Laine, LAc, Dipl. Ac., *author of* The EnerQi Connection, *is a California-state and national certified acupuncturist/herbologist licensed in Oriental Medicine. She has been in private clinical practice in Southern California for twenty-five years. In addition to teaching, Sheri speaks throughout the country about the benefits of integrative living and how to achieve a balanced lifestyle. Please visit her at www.BalancedEnerQI.com.*

Motivation from the Inside Out: The Client's Perspective, Part II

Dennis C. Daley, PhD

This is the second column in a three-part series on client motivation to change. The first part discussed motivation as a state, examined levels of motivation to change, and provided examples of clients with different degrees of motivation. This column reviews common motivational struggles and factors affecting clients' motivation to change such as severity of symptoms, moods and emotions, beliefs and thoughts, coping strategies, impulsive decisions, support from others, and past experiences in treatment and/or recovery. I end with a few observations and questions for therapists or counselors to consider.

Common Motivational Struggles

Clients reported struggles with accepting and managing their substance use disorders (e.g., "my strong desire for drugs interfered with my desire to stay sober and attend my therapy sessions or NA"), psychiatric illness (e.g., feeling increasingly depressed or anxious, which as one woman stated, "pulls me down, and puts me in a rut I cannot get out of,") or other areas of life (e.g., not working out or exercising regularly, not going to church or practicing spiritual principles in daily life, not going to work or school regularly or not managing money wisely). This is not surprising and shows that clinicians often work with clients who struggle with developing or sustaining their motivation to change, and remain engaged in a recovery program over the long-term. Some embrace recovery and work hard while others struggle and are not sure it they are capable or even want recovery. However, even the ones who work hard in recovery may lose focus, make impulsive decisions based on perceived immediate rewards, experience ambivalence about change or a significant decrease in their motivation to continue recovery or change their lives. Ambivalence about change and impulsive decisions can lead to early treatment drop out, which is associated with poor outcome, such as increased risk of relapse to substance use or a recurrence of psychiatric illness.

Factors Affecting Motivation to Change

For many clients, interpersonal and environmental factors can impact on motivation (Corrigan, Mueser, Bond, Drake, & Solomon, 2009; Madden & Bickel, 2009; Marlatt & Donovan, 2007; Ralph & Corrigan, 2005). Recently, I asked several groups of clients what affected their motivation to change or interfered with taking action when their motivation was low. They identified many internal and external positive and negative factors.

Severity/Symptoms and Reactions

Some clients are more adversely affected by their disorder or disorders and are more likely than others to feel a decrease in motivation to change. Others are more resilient and able to sustain the desire to change over the long-term, often working through periods of low motivation. The following are a few comments from clients showing different ways they reacted to their disorders:

"When I got real depressed, I quit caring about sobriety and was more likely to drink or use drugs."

"When my voices—hallucinations—got too loud and strong, I isolated myself, and missed my doctor and counselor appointments, sometimes stopping my meds."

"When I stuck with treatment, no matter how anxious or depressed I felt at times, I got better."

"My cravings for drugs or alcohol always decreased if I rode them out, didn't act on them, and used coping skills I learned in treatment."

Moods and Emotions

Managing emotions or moods is a major issue in the recovery from many psychiatric or substance use disorders. Any emotional state or mood—positive as well as negative—can affect motivation to recover, depending on whether the client

has and uses skills to manage these. Lowered motivation can lead to failure to cope with a negative emotion or mood, contributing to a relapse (Daley & Thase, 2004; Marlatt & Donovan, 2007). Here are examples from several clients:

"I felt hopeless, so why should I bother doing anything about my mental condition?"

"I got bored with sobriety and needed some fun, so I cut down, then stopped my recovery activities."

"When I reminded myself of the blessings in my life and felt grateful, I got more motivated to fight through my struggles and stick with my recovery."

Beliefs and Thoughts

Many of the slogans or self-talk strategies used in Twelve Step programs and cognitive behavioral therapies aim to help clients identify and change cognitive distortions or faulty thinking, which impact motivation to change. Examples from clients include:

"I worried that I was a burden to others if I shared my mental health problem."

"I believed I should have been able to get myself out of a funk on my own when I didn't care about my recovery or my life."

"I resisted my doctor's suggestion to take an antidepressant to help improve my depression because I thought I should be drug-free."

"When I told myself I deserved recovery and would get well, I committed to it."

"Just because I obsessed about getting high didn't mean I would get high, so I talked myself out of making a bad decision."

Coping Strategies

Using active coping strategies may reduce relapse risk as the client copes positively with a high-risk situation or change in motivation. Clients may face any number of high-risk factors related to their illness, support network, living environment, and their internal thoughts and feelings. Using active coping strategies increases the client's ability to deal with high-risk factors and maintain motivation to change. Examples shared by clients include:

"I let criticism from my family drag me down."

"Praying didn't work, so I said 'the hell with it' and quit trying, which only made things worse."

"When I felt stressed out and thought about dropping out of school, I talked with my counselor and decided not to."

"I repeated the NA slogan—'this too shall pass'—to remind myself that low motivation does change, and it did as being patient paid off for me."

Impulsive Decisions

The desire for immediate pleasure or relief can win out over the desire for delayed or long-term benefits of controlling impulses and the desires to use substances or engage in unhealthy behavior (Madden & Bickel, 2009). Some addicted clients report doing well until feeling overwhelmed with an impulse to drink or use drugs. Scientists suggest that there may be competing brain regions responsible for choosing immediate pleasure (limbic system) or choosing to work for long-term improvement based on delaying the decision to use substances at the present time (frontal regions). Clients sometimes verbalize two sides that create conflicts in their recovery: the healthy, recovering side, and the sick, addicted side. Several clients have expressed variations of this by saying they felt, "the devil on one shoulder and an angel on the other." They also reported giving in to the unhealthy side, which led to relapse.

Impulsive decisions are common with some psychiatric disorders, such as bipolar illness, or antisocial and borderline disorders. With the latter personality disorders, impulsive decisions can be made to hurt oneself (e.g., cut or burn oneself, threaten or attempt suicide, or threaten others) or engage in high-risk behaviors (e.g., sex with strangers, gambling, violence towards others, other addictive behaviors). With antisocial disorder, it is common for clients to live in the moment without thinking about the consequences of their behaviors on self or others, such as breaking the law, quitting a job without another to go to, ending a relationship due to boredom, or acting on desires to do something harmful to others or society.

Support from Others

Social support is important for everyone, and positive, supportive social networks are helpful for recovery from a medical, psychiatric or substance use disorder. This is one of the reasons that the founders of AA started the First Step with the word "we" rather than "I." They knew recovery requires connection with and support from others. The models of recovery from psychiatric or mental illness also promote the importance of social support, belonging, and connection with others (Corrigan, Mueser, Bond, Drake, & Solomon, 2009; Ralph & Corrigan, 2005). Negative social networks can interfere with recovery while positive ones can aid recovery, especially during times when motivation wavers:

"When others criticized me, I took it to heart and let it get me down, losing some of my desire to change my life."

"When I hung out with others getting high, it was only a matter of time before I joined them."

"It was hard to trust and let others into my life, but when I did, life was much better."

"I learned the hard way, but I learned that I just can't be around old friends and even family members getting high because I let them mess with my motivation."

Past Experiences

Clients with histories of multiple relapses or recurrences often need help overcoming feelings of guilt, shame or demoralization. They need to know recovery is possible and that there is hope for them regardless of their past history. The best they can do about past relapses is learn from them and

figure out ways to sustain their motivation to change during periods in which they struggle with recovery. Examples from clients include:

"I been in the psych hospital so many times I wonder if I'll ever get better."

"This is my sixth time in rehab—Will I stay sober this time?"

"I had two years of sobriety before, so I know I can stay off alcohol."

"I had many years between episodes of depression, so I know recovery is possible because there are lots of people who care about and support me."

"When I stay on meds and keep my sessions, even when I don't feel like it, good things happen to me."

Observations

- Changes in motivation are common, especially in the early phases of recovery. However, even clients with stable recovery can experience dips in motivation related to their recovery or other areas of life.
- Poor or low motivation is best seen as a clinical issue to address rather than a reason to not work with a client or discharge a client from treatment.
- Many factors impact on motivation, both in positive or negative ways. It is our role as counselors to help clients understand what affects their motivation and learn strategies to manage periods of low motivation.

Questions to Consider

- What factors do you see most often with clients that impact on lowering their motivation to change?
- What factors do you see most often with clients that impact on increasing their motivation to change? C

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A Tour of Helping Others Live Sober

Michael J. Taleff, PhD, CSAC, MAC

Starting this column, and from time to time, I would like to introduce you to some research centers around the country and world. Many of these places are doing really interesting addiction research. The findings coming out of these centers are on the cusp of solid and innovative ideas for our field. Some even supply concrete counseling ideas for those who work in the trenches. I would venture to say that knowing about such centers and the work they do puts you right up there with a truly informed addiction professional.

We start with a research center housed at Case Western Reserve University's Department of Psychiatry, School of Medicine, in Cleveland, Ohio. They have a website called Helping Others Live Sober, which you can find at www.helpingotherslivesober.org. The director is Maria Pagano, PhD, an associate professor who heads up the addiction research team at this center. For the past ten years, she has studied factors influencing the course of addiction recovery, including the influence of comorbid psychiatric disorders, stress, and medication-assisted treatment. Her primary research interest is on understanding the role of service in keeping addiction in remission.

To introduce you to this program, we first take a tour of this program's website, highlight some of the features offered at this site, and then review some relevant research generated by this program.

Inside the Helping Others Website

Once you get to this site, you'll find five items in the main menu bar. I am just going to highlight a few of these items, but please peruse around. The five major menus include "Home," "About," "Research," "Sharing," and "Contact." In the "About" selection, you'll find a sub-menu entitled "FAQ" (Frequently Asked Questions). Pan down to the question: "For the first time visitor to the Helping Others Live Sober website, what are some of the features that must be seen?" In this section, you will find an audio link. Here you can listen to audio clips of "Shared Experiences" where others have shared their perspectives on recovery. It even includes a way for someone to contribute their own recovery story to the website, anonymously if so desired. This link is going to give you any number of clinical ideas to use right away.

The next suggested menu item is under "Research." Scan down to the section called "Study Measures." Here you're going to find an impressive list of addiction-oriented test instruments. Some of the tests can be printed right away and used directly in an appropriate clinical case. Others are copyrighted, but there are directions on how to obtain those tests. Looking over these tests, it seems there is no end to the clinical conditions where these tests might prove useful.

Lastly, look under the main menu item called "Sharing." Here you will find a set of subitems that can easily be adapted to your everyday counseling work. For example, there is subsection called "Art" that displays a number of addiction-oriented drawings and paintings with attached explanation captions. From just a brief scan of the artwork presented here, I could think of a variety of clinical applications where a practitioner could utilize this material straightaway. Take a look and see what ideas you can come up with.

Now, addiction research programs usually specialize in certain areas of research. The mission of the Helping Others Project aims to "improve the quality of life for youth, families, and communities by providing a continuum of scientific information, education, and personal experiences on the role of service in addiction recovery" (Helping Other Live Sober, n.d.). Let's take a look at what they have produced.

Some Helping Others Research

There are a number of good research findings coming out of this center. We only have room to briefly describe a few of them. One noteworthy investigation was just published early last year (Pagano, White, Kelly, Stout, & Tonigan, 2013b). It used data from the old Project Match study, which followed a sample of outpatient clients for ten years. The aim of the Pagano study was to measure the impact of Alcoholics-Anonymous-related helping (AAH) factors on long-term participant outcomes. AAH factors are considered active ingredients of AA such as Step-work and meeting attendance. Controlling for variables that could have skewed the outcomes, the results indicated that there were significant direct effects of AAH linked to meeting attendance and greater abstinence across time. This study also found that those engaged in AAH were more likely to have an increased interest in others. What does that mean? Basically, by helping others addicts get out of their

self-absorbed thinking that AA posits as a root cause of addiction. Other ways that helping others may benefit the alcoholic is by delaying or postponing one's own urges to drink, giving rise to a fresh recall of the consequences of using alcohol or drugs, and prompting a sense of sober recreation fostered by the increased interest in others.

Not long ago, Pagano and some of her colleagues saw the need to create a valid assessment for measuring client engagement in service activities within AA (2010). It is called the Service to Others in Sobriety (SOS) questionnaire. The SOS is a short, twelve-item tool that has good psychometrics, meaning it shows itself to be valid, consistent, and reliable. This is the first valid instrument to measure a client's participation level in formal and informal service activities within AA. Formal service generally consists of public outreach like visiting prisons, while informal service includes saying hello to a newcomer in the program. There isn't space to detail the SOS, so I encourage you to take a few minutes and go to the Helping Others website under the "Research" tag. Scroll down to "Study Measures" and the SOS is listed alphabetically. The instrument is interesting and easy to use. So, after you examine it, the question is this: How might you be able to use it? Suggestions from the study included informing your treatment planning, assisting with your clinical decisions, and perhaps reframing the way we all think about helping. Should you elect to use the SOS, I am sure the folks at Helping Others would be interested in your treatment applications, or possibly your idea for a research project.

Related to the SOS was a study by a Helping Others team that applied the test to adolescents (Pagano et al., 2013a). A main focus of this study was to assess if the SOS could be used with adolescents. They found that indeed it could. Yet a more interesting discovery was of the significant correlational findings between the adolescent's SOS scores and treatment outcome. After assessing 195 adolescents, this research team found that elevated scores on the SOS were significantly associated with less alcohol and other drug cravings, higher meeting attendance, and doing more Step-work. Such factors improve the likelihood of long-term abstinence. The idea is that encouraging items found on the SOS, while in treatment, may help more youths to identify with service opportunities relevant to their sobriety.

Lastly, from a number of other studies that came out of Helping Others, some wide-ranging findings were determined. For instance, by helping others, the helper appeared to get some kickback benefits. Some of those benefits included the reduction of one's own depression levels, reductions in their own cravings, and some helpers even found that they could quit smoking. A general finding from this assemblage of research was that one's own health benefits are magnified when helping others with the same condition. Additional studies showed benefits from volunteering over five hours per week were collated with less stress, greater self-esteem, and reduction of developing addiction problems. This ream of data indicates that helping others puts things into perspective and reminds one to live a day at a time. Should you wish to read the details of these studies, you can find at least nine of them in the "Research" menu bar of Helping Others.

There you go—a brief summary of a wonderful addiction research program. It contains list of solid research results and an array of practical clinical tools, which you can use as soon as you log on to the site. Do give it a visit. C

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The Use and Misuse of Language by Addiction Counselors, Part I

Gerald D. Shulman, MA, MAC, FACATA

The language we use has the potential to have a significant effect, either positive or damaging, which is especially important in relationship to a disease marked by stigma and misunderstanding. Many people—including people with substance use disorders themselves, clinicians, payers, and policy makers—view substance use disorders as conditions that are self-inflicted, matters of criminal behavior, indications of immorality, and generally unworthy of our time and resources. We have the opportunity to effect attitudes and beliefs by the language we use. This column is the first in a three-part series that will address specific terms and their correct or incorrect use.

"Abstinence" vs. "Sobriety"

Abstinence connotes the state in which the individual with a substance use disorder no longer uses psychoactive substances excepting prescribed drugs taken as prescribed. In contrast, sobriety, which includes abstinence, is much more than mere abstinence, as it contains the concept of mental, emotional, and spiritual growth in a recovery process and stability in terms of the substance use disorder.

"Abstinence" as the Measure of Recovery

Abstinence is sometimes used as a representation for recovery. However, depending on the treatment outcomes desired, abstinence may not be a reliable indicator of recovery. For example, the patient referred to addiction treatment by child welfare because of child maltreatment, who no longer uses substances after treatment, but continues to neglect or abuse his or

her children is not "in recovery" from a child welfare perspective. Similarly, a patient referred to addiction treatment from the criminal justice system because of having committed a crime while under the influence of alcohol or other drugs, who no longer uses substances but continues to engage in criminal behavior, is not "in recovery" from a criminal justice perspective. In fact, cessation of drinking and drug use may permit the criminal justice referral to more efficiently apply his or her criminal skills now that he or she is no longer impaired by the substances. This belief that "abstinence is everything" is what has caused the field to be historically so resistant to the appropriate use of psychiatric medication, and what currently causes much of the reluctance to use antiaddiction medications—both agonists like methadone and buprenorphine and antagonists such as oral and long-acting injectable naltrexone (Vivitrol).

"Abstinence-Based Treatment"

This term reflects addiction treatment where the goal is total abstinence, in contrast to various harm-reduction strategies or moderation management. It becomes problematic because the approach may make no distinction between the phase or severity of substance use, such as someone who abused alcohol but never suffered from loss of control and returns to nonproblem drinking versus the individual who is addicted and has lost the ability to control use. It also tends to argue against the appropriate use of prescribed substances, particularly psychiatric or antiaddiction medications.

"Abuse"

This term was a substance use disorder in the DSM-IV when one of four criteria for the diagnosis was met, but is not a diagnosis in the DSM-5 where it is most comparable to mild substance use disorder. The term "abuse" is often and incorrectly used to describe the entire range of substance use disorders (e.g., The National Institute for Drug Abuse). Since "abuse" connotes a willful or voluntary component, when it is used in this fashion, it demeans the disease model.

"Addicted" vs. "Physiologically Dependent"

"Addiction" is defined as a primary, chronic, relapsing neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. It is characterized by impaired or loss of control over substance use, compulsive use, continued use in spite of adverse consequences, and craving. In contrast, "physiological dependence" is a state of cellular adaptation that is manifested by a drug-class-specific withdrawal syndrome that is produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist (ASAM, 2001). The misuse of these terms is common when describing patients on an agonist drug for maintenance such as methadone or buprenorphine. Some clinicians use the two terms interchangeably as if they are the same or equivalent, which creates or justifies opposition to certain treatment modalities such as opioid maintenance treatment. The belief is that methadone maintenance is unacceptable as a treatment modality because patients are "still addicted," as evidenced by their continuing use of an opioid (methadone), rather than the individual who remains physiologically dependent.

"Addiction"

When first used, the term was usually restricted to physical dependence on a psychoactive substance, generally an opiate. Over time, the application broadened to include alcohol and other psychoactive substances, but then was again broadened to include a variety of compulsive and impulse control behaviors engaged in to the point of self-harm including gambling, shopping, running, exercising, Internet use, sexual behavior, eating, working, and relating to others, and has been extended to ingestion of certain foods such as sugar and chocolate. The only one of these addictive behaviors that became an addiction diagnosis in the DSM-5 was gambling disorder, which had previously been listed as an impulse control disorder in the DSM-IV. The reason that these others weren't listed—although some were identified "for further study" in the DSM-5—is because the workgroup determined that there was insufficient credible research to justify addictive labels for them.

While any behavior can become compulsive and harmful, describing these behaviors as "addictive" diminishes the significance of the term when applied to dependence on psychoactive substances. I believe that we should use the appropriate diagnostic terminology instead of "such-and-such addiction" whenever possible. For example, using "compulsive sexual behavior" instead of "sexual addiction," "compulsive internet use" instead of "internet addiction," and "compulsive overeating" or "binge eating disorder" instead of "food addiction."

The American Society of Addiction Medicine (ASAM) defines addiction as

> *a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.*
>
> *Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission* (ASAM, 2011).

"Administrative Discharge"

"Administrative discharge" usually refers to a staff-initiated discharge for treatment noncompliance, rule infraction, patient lack of cooperation with treatment protocols or sometimes "just being difficult." The specific reasons for the discharge are often the same reasons for the admission—drinking or illicit drug

use during treatment. Since in this case, the drinking is symptomatic of the alcohol use disorder and the illicit drug use is symptomatic of the drug use disorder, the corollary in mental health treatment would be administratively discharging the patient with schizophrenia because of hallucinations or in medicine discharging the patients with tuberculosis for coughing. While drinking or drug use during treatment for substance use disorders is not acceptable, it is not uncommon and we should avoid the knee-jerk reaction of automatic discharge. Instead, we need to revisit and modify the treatment plan.

"Aftercare"

This usually applies to professionally or peer-directed treatment and support after primary treatment to solidify the gains made in treatment and reduce relapse potential. The problem with the term is that it begs the question of why a patient should continue in treatment after he or she has already been treated. Furthermore, in some cases aftercare is an afterthought on the part of addiction professionals during primary treatment. A more appropriate term is "continuing care." Since length of time in a treatment system might be the best predictor of positive treatment outcome, continuing care may be as important as or even more important than the primary treatment.

"Alcohol Misuse"

"Alcohol misuse" refers to risky or harmful drinking behavior by individuals who are experiencing physical, social or psychological harm from alcohol, but who do not meet the criteria for an alcohol use disorder as outlined in the DSM-5. It often implies the lack of intention on the part of the misuser; for example, the older adult who doubles up on the dose of medication after missing a dose. There is little agreement on how this term should be operationalized. For example, the federal government warns against women having more than one drink a day because of the risk of breast cancer (American Cancer Society, 2013). At the same time, the Agency for Healthcare Research and Quality (AHRQ) describes risky or hazardous drinking for women as "more than seven drinks per week or more than three drinks per occasion" (2012). The term is also sometimes not clearly distinguished from diagnosable alcohol use disorders.

"Alcoholism"

The importance of this term cannot be overstated when considering the value to an individual who stands up at an Alcoholics Anonymous (AA) meeting and says, "My name is Bob and I am an alcoholic." The problem with the term stems from the fact that it is neither diagnostic nor precise. The term is used to describe an entire range of drinking behaviors, including the physician who thinks that an alcoholic is anyone who drinks more that he or she does. It may be applied to someone who is an alcohol abuser (DSM-IV) or has a mild alcohol use disorder (DSM-5). These are individuals who most of us would not consider "addicted" in the true sense of the term, meaning they exhibit loss of control, compulsion, continued use in spite of adverse consequences, and cravings. A good example of this kind of drinking would be college students who set out to get drunk. Its use in clinical or research applications is problematic because it does not discriminate between mild and severe forms of an alcohol use disorder. This muddling of the two diagnoses creates obstacles to applying the research findings to the real world of treatment. Some people who are labeled "alcoholics" are able to return to nonproblem drinking because the term "alcoholism" in some cases is used to describe an alcohol abuser or someone with an alcohol use disorder. At the same time, the term may be used to describe those who are alcohol

dependent (DSM-IV) or have a severe alcohol use disorder, thus leading some to believe that any alcoholic can return to social drinking. The recommendation is not that we stop using the term, but rather that we be precise and mindful of the context in which we are using it.

"Amotivational Syndrome"

This is a psychological condition associated with diminished inspiration to participate in social situations and activities, with episodes of apathy caused by an external event, situation, substance (or lack of), relationship (or lack of), or other cause. It is very frequently associated with cannabis use, but interestingly it was not included as a diagnostic criterion for cannabis use disorder in the DSM-5.

The second part of this series will discuss the correct usage of terms such as "binge drinking," "discharge vs. transfer," and "graduation." C

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Adolescent Substance Abuse and Suicide

Fred J. Dyer, MA, CADC

More and more therapists, substance abuse counselors, mental health workers, and probation officers are observing adolescents who present with a history of suicidal ideation and attempts. The question at hand is determining the interrelatedness between adolescent suicide and substance use.

In 2000, the National Center for Injury Prevention and Control reported that there were 3,994 suicides in the United States by people under the age of twenty-five; 1,621 of those suicides (41 percent) were nineteen years old and younger, and three hundred were between the ages of ten and fourteen (2005). Bell and Clark, in their research, report that suicide is the third leading cause of death among fifteen to twenty-four-year-olds in the United States (1998).

Overview

The significant increase in suicide among American teenagers in the last five decades coincides with enormous changes in drug use among youth in the United States. However, the relationship between suicide and drug use in adolescents is not a simple, linear one. Rates of adolescent substance abuse have fluctuated in recent decades (Johnston, O'Malley, & Bachman, 1999). Similarly, drugs of abuse have varied over the years. Research on adolescent suicide and substance abuse has been confounded by changes in diagnosed adolescent substance abuse disorders, lack of prospective studies, changes and advances in the treatment of adolescent substance abuse, including dual-diagnoses, and failure to investigate the presence of substance use in earlier studies of adolescent suicidal behavior.

In a detailed review of the literature, Crumley (1990) concluded that substance abuse in adolescents appears to be associated with a greater frequency and repetitiveness of suicide attempts, more medically lethal attempts, an increased seriousness of intention, and greater suicidal ideation. Yet the presence of substance use or a substance use disorder in an adolescent with suicidal behavior is not a complete explanation for the behavior. As Crumley points out, the frequent presence of substance use in studies of adolescents with suicidal behavior may point toward an association between adolescent suicide and substance abuse, but does not prove that substance abuse is a cause for the suicide. In the research studies and review papers discussed in this article, the rates of substance abuse in adolescents with suicidal behavior vary widely. Multiple factors may interact with the presence of substance use in youth, which may increase the risk for suicide in a teenager. Some of these factors were examined in a comprehensive review by Brent, Kolko, Allan, and Brown (1990), which examined psychopathological risk factors for adolescent suicide and suicidal behavior.

Research and clinical practice consistently demonstrate that an estimated fifty to one hundred times as many adolescents attempt suicide—one adolescent attempts suicide approximately every sixty seconds in North America—with estimates of at-risk adolescents as high as one million (Straus, 1994). Adolescent girls attempt suicide three or four times more frequently than boys do. However, they generally use less lethal means (e.g., substance overdose vs. firearm) and consequently have a significantly higher rate of survival (Bagley et al., 1990). A comprehensive search of PsyInfo databases (1990–1995) was conducted to identify these factors reported in the literature as being associated with adolescent suicides and suicide attempts. Eighteen major risk factors are identified in the literature (Pagliaro, 1995):

- Absence of maternal figure
- Access to firearms
- Alcoholic family
- Conduct disorder
- Depression
- Dissatisfaction with family relationships

- External locus of control
- Gender identity crisis: gay, lesbian or bisexual sexual orientation
- Hopelessness
- Lack of reasons for living
- Lack of social support
- Loneliness
- Low self-esteem
- Physical or sexual abuse
- Previous psychiatric inpatient treatment
- Previous suicide attempt
- Serious early childhood losses
- Substance use

Depression was found to be the most frequently reported factor associated with adolescent suicide or suicide attempts. An examination of this factor and its relationship to the other identified risk factors revealed that it was significantly correlated with suicide ideation and attempts and most of the other identified risk factors.

Assessment and Treatment

Rowan (2001) suggests the following regarding assessment and treatment for adolescents with substance abuse and suicidal ideation:

- The frequency and consequences of drug use are important information to consider.
- The adolescent may have legal, educational, interpersonal, family, work-related or medical consequences.
- Stressors such as an arrest for driving while intoxicated, school failure, loss of friends or family discord can significantly impact an adolescent's emotional well-being.
- Comorbid psychopathology, such as depression or ADHD, is often the presenting problem, but one should assess for the presence of multiple coexisting disorders such as social phobia, other anxiety disorders bipolar disorder or a psychotic disorder.
- Inquiry into the presence of a firearm in the home or access to a weapon is necessary.
- In treatment, the most severe and life-threatening issues should be addressed first. Initially, the clinician must determine whether the adolescent is an acute risk to him- or herself. The adolescent may initially require an inpatient hospitalization or day treatment program.
- Treatment must be individualized to address the myriad of potential diagnoses and problems facing the adolescent. Residential drug treatment, dual-diagnosis day hospitals, and after-school drug treatment programs combined with individual therapy by a child psychiatrist or psychologist are potential treatment venues.
- There is frequently a need for multimodal treatment including group, family, individual, and milieu therapy, as well as crisis-oriented interventions. Remedial education is frequently required. Treatment of adolescents with suicidal behavior, substance abuse, and comorbid psychopathology can be challenging and often requires extensive resources.

Bell and Clark (1998) suggest the following suicide prevention and intervention strategies:

- Crisis centers and hotlines
- General suicide education
- School and community gatekeeper training programs and peer support programs
- Hospital personnel and police as community gatekeepers
- Intervention after suicide
- Screening programs
- Early detection
- Primary prevention of suicide

Conclusion

A major consequence of suicide consists of years of potential life lost to an adolescent as the result of premature death. Because most suicides occur at home, the psychological problem facing the first family members who accidentally discover the body of the suicide victim must be emphasized. It is no longer simply a question as to whether substance abuse is a precipitant to suicide—whether directly or indirectly. The remaining question for adolescent substance abuse treatment programs and mental health facilities is whether we assess only for suicide and not look for substance abuse as a factor in the adolescent's attempt and completion. C

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Ask the LifeQuake Doctor

Dr. Toni Galardi

Dear Dr. Toni:

I have been following your column for about a year now. My closest girlfriend is a therapist and she keeps *Counselor* magazine in her office and I read it when I come to visit her. I am writing you now because although my husband is very wealthy, he is also extremely paranoid about anyone knowing our business so he has forbidden me to seek therapy. I hope you can offer some light in my dark tunnel.

Here is the situation. We have been married for fifteen years. I have known him for twenty-five years. I was his mistress, so to speak, when he was married before. What pushed him to finally end his last marriage was being diagnosed with brain cancer. He has spent a lot of money on the latest treatments and they have kept him alive in spite of a stage four diagnosis. He has become a very angry person. In order to cope with his mood swings, I have been drinking more wine. Although I know this is not a good thing for me to be doing, my bigger concern is that I think my husband's cancer is getting worse. He tried to strangle me last night and after I managed to get away he had a grand mal seizure, hit his head on the safe in our closet, suffered a concussion, and had to be stitched up.

When the paramedics came out, I told them that he had tried to strangle me but that he has brain cancer—it was not a typical domestic violence situation. I managed to talk them into not including the strangling in their report.

He became incensed with my having let the paramedics come to our home. He is incredibly afraid of hospitals. I am

afraid the violence could happen again given the frequency of seizures he is having now. However, I cannot leave him when he is this sick. He also told me that if I ever did leave him, I would not end up with one red cent. I have put too much into this marriage to walk away now. I know that sounds greedy, but I am not leaving him and ending up penniless.

Should I take his gun he keeps for protection and learn how to use it at some firing range so that I can protect myself from him killing me?

–Baffled and Terrified

Dear Reader:

There are a couple of things to address here. First of all, go to an AA meeting and stop drinking. The worst thing you could do is use a loaded gun while drunk, not to mention the fact that you need to sober up, period.

Secondly, speak to an attorney and find out if you live in a community property state. What your husband is telling you may not be accurate. If you are only staying for the money, you need more information. If you genuinely love him and just want him to get treated, tell his doctors that he is progressing into violent behavior. They need to know this so they can adjust his medications.

Thirdly, do not pick up the gun he has. Police officers are continually upgrading their skill set so they can respond in any emergency with accuracy. You will not. What you can do is buy pepper spray over the internet and stun him if and when he lunges at you again.

You are in danger as long as you keep this a secret. The right authorities need to be advised so they can advise you properly. I am sure he gives you a lot of cash. If he does, instead of buying Jimmy Choos with the money, ask your friend for the name of a good therapist who treats addiction and chronic illness. It will help to have more information to move forward in the right direction. C

***Dr. Toni Galardi** is an author, licensed psychotherapist, professional speaker, astrologer, and life transitions strategist and is available for consult by phone or Skype. Have a question for The LifeQuake Doctor? You can reach her through her website, www.lifequake.net or at DrToni@drtonigalardi.com, or at 310-890-6832.*

CODEPENDENCY REVISITED:

Examining the Neurobiology that Can Lead to Addiction

Jon Daily, LCSW, CADC II

The term "codependency" has always been tethered to addiction. It is used to describe a person in a relationship with someone who is active in an addiction. In the 1940s, the term given for the addict was "alcoholic." As a result, the label given for the person in a relationship with the alcoholic was the "coalcoholic." Years later, society and the clinical community at large realized that chemical addiction was not limited to alcohol. While the sixties era was in full swing, many people were using a variety of drugs ranging from marijuana to LSD. During this time, the people using were viewed as "addicts" and the people who were in relationships with them were called the "coaddicts." Eventually, the clinical community moved away from referring to someone as "addicted," instead referring to them as "chemically dependent." It was then that the term "codependent" emerged.

Codependency is defined as a psychological condition or a relationship in which a person is controlled or manipulated by another who is affected with a pathological condition, typically narcissism or drug addiction. In broader terms, it refers to the dependence on the needs of, or control of, another (Merriam-Webster, n.d.). It also often involves placing a lower priority on one's own needs, while being excessively preoccupied with the needs of others (Codependents Anonymous, 2010). Codependency can occur in any type of relationship, including family, work, friendship, romantic, peer or community relationships. According to Codependents Anonymous, codependency may also be characterized by denial, low self-esteem, excessive compliance, or control patterns (2010). Narcissists are often considered to be natural magnets for the codependent.

When we are born, we are inherently vulnerable and totally dependent on our caregivers for food, safety, and regulation, thus making an infant's attachment, or bonding, to one or more caregivers critical for physical and emotional survival (Wallin, 2007). Because the infant must attach, the infant adapts—for better or for worse—to the needs and vulnerabilities of the caregiver. Infants integrate behaviors, feelings, and desires that can be contained within the caregiving relationship, but they defensively exclude, dissociate, and disown behaviors that threaten the attachment bond (Wallin, 2007). When caregivers lack the capacity to help children feel safe, loved, lovable, and validated for their uniqueness, the development of codependency may then serve the defenses these children adopt.

During early years of life, the personality and uniqueness of a child blossoms within the space created by the relationship between the child and the caregivers. When infants experience the stomach pains of hunger, they cry out to be fed. If their caregivers respond promptly with food, then the infants learn that they can trust their biological experiences and emotions. They also learn that along with their power to cry out for help, they can trust that help will be provided. Over time, when

attuned caregivers respond predictably, consistently, and warmly in response to an infant's needs, a sense of trust within the self and others builds.

For example, a child might want to be physically close, held, and touched in play or in comforting. If caregivers have the capacity to meet these needs, this reinforces the child's sense of self-trust. From infancy, children begin to integrate the notion that it's okay to approach others to have their needs met. In addition, children learn to recognize both their own needs as well as what others offer to meet those needs. This ongoing stream of information and feedback are therefore integrated into the attachment relationship, which in turn underpins the development of the self.

When validated, children recognize and honor their own needs, experiences, and interests. In addition, they build an ability to recognize others who are affirming, soothing, stimulating, and regulating. This in turn, allows children to feel safe approaching others and forming relationships that will regulate both their needs and emotional states.

It is essential that children are able to integrate a consistent sense that their needs and traits will be warmly acknowledged and met by their caregivers. When this integration does not occur, it is then that children are more likely to split off from the parts of themselves they perceive are unacceptable to caregivers and others. A lack of integration may manifest in a mistrust of others as well as a lack of trust of their own thoughts, feelings, desires, and traits.

It is clear that the development of the bond, along with the process of integration, is important for general well-being (Kreppner & Ullrich, 1998). It is important to note that this bond also builds the template and expectation for all relationships throughout one's life (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Beginning in infancy, children mentally represent their attachment figures and construct ideas and expectations for relationships with both these original figures and others. Bowlby called this the internal working model (IWM) of attachment (1988). While still in infancy, a child internalizes patterns of relating to people, most generally the parents, and therefore forms ideas about ways to relate to others based on these representations (Bowlby, 1988). These representations are also thought of as the underlying structure that shapes the nature of sensation, perception, memory, feeling, thought, and behavior, and are likely to become consolidated as personality and/or personality disorders. In other words, children understand their range of relationships based on early interactions with caregivers, which they have internalized and organized (Laursen & Collins, 2004). Each attachment relationship shapes the child's mental schema, which then shapes expectations for future relationships and interactions.

In the first eighteen months of life, the brain is blooming and pruning billions of neurons. It is during this stage of neurological development that the brain is right-hemisphere dominant (Cozolino, 2006). In addition, we have twice as many neurons in the brain during the first year of life than we do as adults. In this early stage of development, the brain builds neural networks that serve as memory, representations, and routes to process the flow of information received both from the body and the external environment. To some degree, genetic inheritance is a predetermined blueprint of neurobiology; however, the environment is responsible for contributing or inhibiting neurons in forming neural networks. Moreover, during the period of right-hemisphere dominance, which is an experience-dependent stage of brain development, these neural networks shape what we now know to be our unconscious. The right hemisphere of the brain involves creativity and the development of language, visual perception, patterns, and impressions. In these early years, impressions and perceptions are not guided by capacities for reason and logic, which later attempt to explain behavior and allow us to understand and interpret the nuances and complexity of relationships. During our first eighteen months, within the regions of the right brain, we build a significant piece of the way we see ourselves, feel about ourselves, approach or avoid others, and regulate our affective states, which we then play out unconsciously in our daily lives (Schore, 2003; Siegel, 1999; Cozolino, 2006).

Unfortunately, not all caregivers have a broad capacity to nurture a child's blossoming self and encourage the development of a favorable IWM. We know for certain that when caregivers do not respond to a child's needs

appropriately or the response is inconsistent, this lack of an appropriate response impedes the development of a positive sense of self and a healthy internal regulatory system within the child. As a result, a child may learn to both mistrust internal experiences and mistrust others as a resource for coregulation. Sadly, children in negative or inconsistent circumstances often split off from aspects of themselves and mistrust others. Further, they may overly rely on themselves and experience avoidance for regulation which sadly, inhibits their psychological and neurobiological regulatory systems to be properly built.

A Case Study

In the following case study, the present but passive and distant father says little and doesn't shoulder responsibility for being uninvolved and incapable of attunement. We cannot know for sure how the child discussed below would have fared in infancy and early childhood if a father or grandparent had been either a primary or secondary caregiver.

However, with more and more fathers becoming actively involved with their children during infancy and early childhood, new research may reflect the more equal roles of parents in society.

Jason (Insecure Attachment: Dismissive-Avoidant)

Parents Who Avoid the Developing Self in their Child Leads to a Child Who Avoids his own Internal Self and Avoids Others.

Fifteen-year-old Jason was a quiet, shy, and passive adolescent, but was also an original thinker and a mechanically gifted young man. Always ready to take on the challenge of fixing things others couldn't, Jason preferred being by himself while he worked on motorcycles, go-carts, and other creative mechanical projects in his garage. Introverted, strong-willed, and stubborn, Jason's behavior left his parents confused about how to direct him after he started sneaking out, skipping school, using drugs, and ultimately becoming expelled from school for selling drugs on campus. Jason violated every limit his parents set, and continued doing as he pleased despite his parents' attempts to implement boundaries. As an introverted, quiet person, and socially inept in many ways, using drugs served as his social lubricant and selling drugs reinforced his sense of belonging to an accepting group.

When I evaluated Jason, I was struck by his preoccupation with trying to figure out the therapeutic process in order to avoid engaging. Instead of cooperating, he searched for the path of least resistance out the door. With each question I asked, he became quiet as he looked away and stared at his lap, the couch, the walls, and back to his lap. He looked anywhere but at me. After these long silences, he would glance up at me as if he forgot what I just asked him. When I reiterated the question, he came up with one or two word answers and started looking around the room again. During early treatment, I thought Jason was simply expressing his resistance to and frustration about being forced into counseling—hence the passive-aggressive silence and slow, minimal responses. I believed that as counseling progressed Jason would soften up, as others do, and see our sessions as a safe place to explore his life, thus being able to grow and find relief. However, because Jason wasn't verbally skilled and insightful, I moved away from the typical talk therapy. Instead, we went for walks along the river or played ping-pong or checkers. However, it soon became clear that he wasn't actually walking or playing checkers with me, but rather, was absorbed within himself and just happened to be next to me, much as toddlers might "parallel play." In contrast with early treatment, where he resisted and showed frustration through nonengagement, I now saw his lack of capacity to engage in and negotiate relationships as the result of his early childhood experiences. It accounted for what could be called "odd" social relationships.

Left-brain dominant, Jason might have been viewed as anxious or depressed, or as suffering from schizoid personality disorder or having Asperger's. Perhaps he was simply a very resistant teenage boy. Although I could have easily put him into any of those categories, those labels would have limited my understanding of Jason and wouldn't effectively inform the direction of his treatment. To discover what he needed, I had to understand what it felt like to be Jason, including what it felt like to be Jason as a child growing up in his family. What was it like to be nurtured and guided by his father? How had he experienced his mother's affection, caregiving, love, and nurturance? Why was Jason avoidant of others and his internal experiences? What purpose had his substance abuse served?

I asked Jason's parents, Patty and Rick, to meet with me so that I could gather Jason's developmental history. Patty was an educated, professional woman, who was dressed to fit her role as a university professor. She appeared assertive, but at the same time I sensed weariness in her. Rick, a blue-collar, hardworking contractor, came to the appointment in his work jeans and a t-shirt. Like Jason, he presented as quiet, shy, and passive. Rick wore his sunglasses during the first half of the session, as if hiding behind them for safety. I asked Patty and Rick about what their life was like when Jason was born: stresses, supports, and unexpected events, such as the deaths of friends or family or job losses. With each question, Patty first glanced at Rick to see if he wanted to answer, but he passively shrugged as if he didn't care who responded or as if he didn't have a ready answer. Patty then turned to me and answered the questions.

Perhaps she was tired, I speculated, because she was doing all of the interpersonal and emotional work in their family. When Patty answered questions about Jason's first year, she immediately looked even more tired. Then she mentioned that Jason and his older brother were only seventeen months apart, so she had been exhausted by caring for an infant and a toddler.

Patty had spent much of her life climbing the academic ladder as a university professor and researcher,

ultimately having her children in her mid-thirties, a situation that proved more difficult than she'd anticipated. Already worn out from parenting her first child, she became depressed when Jason was born. I asked about family and community support and learned that Patty's family lived about 1,500 miles away. As a private person, and admittedly socially anxious, she didn't like to share her personal life with professional friends. In the early years of her children's lives, Patty received only minimal emotional support from Rick, who also did not share in the care of the two young boys. She was forced to become overly reliant on her own exhausted internal resources to cope with life's ongoing and new demands. Viewing her job as a source of emotional respite from the family demands, Patty longed to go back to work when Jason was three months old.

When I asked how she responded to Jason when he was upset or hungry, she was candid in her answer: "I know there were times when he needed soothing and I just let him cry, and there were times he was hungry and I just didn't care to respond right away."

Jason's developmental history provides a plethora of information about the course of his development. Jason certainly carries the genes of his father's shy, quiet, and avoidant personality; Jason's receptive mirror neurons might have picked up his father's affective state and avoidant behavior and integrated it into his own neural networks. I also believe more telling variables exist. In actuality, Jason grew up with tired and avoidant parents. As a result, he did not experience others as a source of consistent, warm, and predictable soothing or attunement. Rather, he experienced inconsistency at best, and more commonly, his life was a place in which he received no response, leaving him to go inward and to overly rely on himself to get his needs met. When turning to others, Jason found that they didn't acknowledge and nurture his developing self and meet his dependency needs. This meant that Jason's affect regulation system never fully developed. His internal working model of himself and others left him feeling unworthy of nurturance and support from others. This then becomes a pattern of mistrusting others to be sources of help to stimulate and soothe affective states.

Jason grew up believing that he needed to stay out of his mother's hair. In addition, his father only engaged with him when a mechanical issue was involved. No room existed for Jason to connect to his own internal emotions; when he expressed them in his early years, he was left alone with the unregulated emotional state. With no one attuned to him, shame was created and therefore a strong need to be "unseen."

Over time, the negative experience repeated, leaving Jason's opiate and dopaminergic systems contracted and unable to thrive (Siegel, 1999; Schore, 2003). However, when Jason used street drugs, these deficient systems are activated to fire. Moreover, because others did not attune to his emotional states, Jason was left believing, "Others don't feel what I feel, and because they don't feel it and only I do, something must be wrong with me." This belief system is core to codependency.

Jason's expression of affective states did not promote attachment. Instead, he seemed to be a source of his mother's stress, which led him to think he had to disown his internal experiences and distrust them when he felt these experiences physically and mentally. It became clear that his father Rick lacked the capacity to attune, and his passivity indicated a missing component in his own development that left him unable to connect with his own internal processes and emotions.

Consequently, Jason had learned not to trust others as a source of support, soothing, and safety.

Because his affect regulation system was not fully built, he had a limited range of affect and limited capacity to cope emotionally (Schore, 2003). His personality was narrow, turned inward, and brittle because of his parents' lack of capacity to nurture and develop their son's full range of self in his early years. Finally, Jason learned that relief came from avoidance and over-reliance on himself to get his needs met. As a teen he found that street drugs and alcohol reliably and consistently served to medicate his emotional states. Furthermore, his drug dealer and drug culture responded to him every time he called out to them. As stated earlier, caregivers with a limited capacity to nurture their children's developing self can lead children to split off from parts of the self. They suffer from insecure attachment and avoidance, but they may also take on characteristics of another insecure attachment type, such as anxious preoccupied children. These children effectively become the caregiver and must attune to their parents' emotional state and needs, making this situation a setup for codependency.

Looking at this case, it also appears that codependency/insecure attachment can be a transgenerational issue. In other words, children might adopt the attachment inadequacies of the parents. In Jason's case, he used drugs to sooth his insecurity, but his drug use was a consequence of and a solution for failed relationships. If it wasn't drugs, it may have been enmeshed relationships, workaholic tendencies, eating disorders, gambling or other behaviors used to sooth and avoid.

The Neurobiology of Codependency

I remember years ago telling a group of addictions counselors, "codependency is a brain disease." They looked at me as if I was trying to be tricky, but I wasn't at all. I meant it. Simply put, everything mentioned about early childhood experiences hitherto is not only about the development of the self, relationships and the mind, it is also about neurobiology. Schema, beliefs, learned behaviors; adaptive defenses are neurobiologically networked for better or for worse. When relationships shape our minds, they are also shaping the neural networks in our brain.

Siegel states that when we are "feeling felt" in early childhood, our dopamine system expands, and the psychological correlate tethered to this relationship experience is the allowing or wanting

to "be seen" (1999). Conversely, he defines shame as simply the absence of attunement. Sadly, most clinicians understand that shame can be an even more explicit weapon in families. Siegel goes on to purport that shame contracts the dopamine system and the tethered psychological experience is a person who wants to be "unseen."

In addition, Schore's research has shown that in the attuned moment between child and caregiver, both have the biological experience of the opiate system firing (2003). These systems serve to reinforce the attachment and bond within the relationship. When people have healthy relationships, both the dopamine and opiate regulatory systems are built and sustained.

This leads me to some final points. In 2007, William Harbaugh set out to pinpoint what exactly would happen within the brains of people who are given money and a choice to keep it or donate it to charity. With his psychologist colleague Ulrich Mayr, he placed subjects in an fMRI scanner, while a computer monitor in front of them presented them with opportunities to donate to a food bank from a fund of $100 in real cash they'd received at the beginning of the experiment. The suggested donations could be as low as $15 or as high as $45. The subjects' donation decisions had meaning, since they would be allowed to keep whatever money was left over. What he found was that when people donated to charity the part of the brain that was firing was the nucleus accumbens (NAC).

The NAC is the epicenter of dopamine in our brain. Evolution may have hardwired us this way in order to keep our DNA passed on, and certainly we are biologically hardwired to attach to others. Connecting the dots, if lack of attunement and growing up having to take care of your caregivers so that they can take care of you or experiencing toxic shame contracts dopamine, it makes sense then that codependents are driven to give of themselves as it helps put their dopamine back in balance. In essence, it helps them, for a moment, feel they are loveable.

Finally, the hole in the self for the codependent is not a food hole, not a drug hole or a gambling hole. It is a deep, relational hole in relationship to self and others. Unlike other addictions, codependent behaviors actually come the closest to filling the relational hole. It is a complex issue with many layers, and is a subject in which it is essential that the dialogue continues. C

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CANNABIS CONCERNS, PART III

MEDICAL MARIJUANA AND HOSPICE

WHERE IS THE EVIDENCE?

BRIAN W. JONES, DHSC, CHPCA, &
KASINDRA M. JONES, MSW, CSW

Hospice has never been averse to utilizing alternative methods to treat pain and ease symptoms at the end of life (Kozak et al., 2009). Music, massage, pets, and other holistic pain interventions are hallmarks of palliative care. Treatment modalities for hospice should be based upon evidence-based practices, as indicated in the last few years with a definite push in the hospice industry to move towards an evidence-based model (Jones, 2013). However, quality of life contains an element of subjectivity and may not always be supported from an evidence-based model. While evidence may not support a certain intervention, if no harm is being done, should that be a treatment used for hospice patients who request it?

If there were little to no evidence to support a given holistic pain intervention, but a patient requested that therapy because it provided a higher quality of life to them, a prudent and resourceful hospice clinician would seek to provide such services. To go further, cigarette smoking has no positive medical effects, yet patients in hospice are not routinely encouraged to quit smoking unless a safety issue is present. It is not uncommon for a hospice inpatient unit to allow patients to smoke in designated areas. So while no medical benefit occurs, if a patient defines better quality of life as continuing to smoke, then hospice generally tries to accommodate the patient. Such is in keeping with the hospice philosophy of care. While smoking may provide the patient a sense of calmness, everyone recognizes that smoking is not

allowed in hospice because it somehow alleviates physical pain. That is not the intention of allowing a patient to smoke.

Added to this quality of life discussion is the use of medical marijuana by hospice patients. A relevant question is, "If there is no evidence-based practice, should hospice clinicians advocate its use to alleviate pain?" Already a number of hospice clinicians seem to support the use of medical marijuana to treat pain and symptoms in their patients (Uritsky, McPherson, & Pradel, 2011). A greater question is whether the notion of quality of life trumps evidence-based practice when there is no strong research available in support of medical marijuana. What about an industry moving away from experiential treatment to evidence-based practice? The issue is complex and seems to go beyond the simplicity of a patient's desire to alleviate pain.

In 1996, California became the first state in the nation to pass legislation to legalize medical marijuana (Furlow, 2012). Since that time nearly twenty states and the District of Columbia have legalized medical marijuana in varying degrees (Wall et al., 2011). This cumulative legalization has legitimized marijuana to the point that recently Gallup indicated, that for the first time, a clear majority of Americans have advocated for its legalization for both recreational and medicinal purposes (Swift, 2013).

It was the Controlled Substance Act of 1970 that initially banned marijuana and classified it as a Schedule I drug, indicating that it had no medical value (Mu-Chen et al., 2012). The drive to legalize medical marijuana has been fueled by various reports and studies which seem to show effectiveness in treating certain debilitating illnesses. Some research has shown evidence of efficacy with cluster headaches and neuropathic pain (Napchan, Buse, & Loder, 2011; McQuay, 2010), while others have indicated that medical marijuana has a positive effect on those suffering from posttraumatic stress disorder (PTSD) (Trossman, 2010). In chemotherapy patients, medical marijuana has been shown to help with severe nausea and in patients with acquired immunodeficiency syndrome (AIDS) it has shown promise with cachexia (Bostwick, 2012).

However, much of the research has been anecdotal in nature and not backed by solid scientific methods (Dresser, 2009). The random controlled trials (RCT) in existence are scarce, although the ones in existence appear to be well designed (Kollas & Boyer-Kollas, 2011). Even so, little is known about the long-term affects of marijuana use, although it could be argued that such is irrelevant with hospice patients. Additional research on medical marijuana has shown impaired respiratory status, stroke, increased risk of motor vehicle fatalities, addiction, psychotic disorders, suicide, testicular cancer, and increased anxiety (Harvard, 2010; Hall & Degenhardt, 2010; Bramness, 2012; Singh, Pan, Muengtaweeponsa, Geller, & Cruz-Flores, 2012; Lacson et al., 2012). In addition, most of the research available centers around tetrahydrocannabinol (THC), just one of the estimated four hundred components in marijuana, some of which may be therapeutic while others may be toxic in nature (Joyner, 2010). In spite of this, even researchers who point out concerns about medical marijuana negate some of the side effects indicating that they are fairly modest especially in comparison to the side effects of other medicines (Van Ours, 2012). One positive aspect of marijuana, compared to some other prescription pain medications, is that there is no lethal dose of marijuana (Joyner, 2010). Yet, all of this raises

concerns as to why a substance with so much controversy related to efficacy has managed to be a legalized medicine without rigorous scientific data to support it (Bostwick, 2012).

In states where marijuana has been either decriminalized or made medical, confusion has existed among the medical establishment on what their role should be. Recent research in Colorado among family physicians shows a hesitancy to prescribe medical marijuana. These physicians are not convinced of its medical merit and are concerned about potential side effects with its usage (Kondrad & Reid, 2013). One real issue for physicians relates to the potency of the marijuana that they are asked to prescribe. The potency of marijuana varies by state and is not generally regulated (Hoffman & Weber, 2010); its overall potency has more than doubled since the 1990s (Price, 2011). High-potency marijuana carries the potential for seizures and other undefined risks (Mehmedic et al., 2010). In fact, increased potency has even led to acute psychotic episodes in Canadian emergency departments. All of this suggests that medical marijuana is hardly a "carefully calibrated medication" (Pagán, 2013). The California Medical Association, in a state where medical marijuana has been legal since 1996, does not want their doctors being gatekeepers for a medicine that really is not medicinal (Knopf, 2011).

Jaime Montolavo, a Kentucky resident, indicated that he turned to illegal marijuana when prescription medications were unable to alleviate his pain (Musgrave, 2013). Individuals like Jaime make a compelling case for a substance that provided relief when conventional medications failed to. Other patients have touted that the therapeutic potential of marijuana does seem to exist (Knopf, 2011). These patients undoubtedly have a difficult time understanding why a substance that has brought symptom relief continues to be halted from legalization in some states, while other states move forward with marijuana as a legal form of medication.

Legalizing a substance that can be inhaled, ingested, or applied topically, with such little medical and scientific data related to its efficacy and side effects, seems to be a public health step backward instead of forward. There are still so many questions that need answering. For example, since there is virtually no regulation on potency, depending on who is dispensing, does this mean traffic fatalities will increase due to mental impairments? Does this mean that more people will be addicted? States that have passed laws to legalize medical marijuana have been shown to have increased usage among adolescents (Cerdá, Wall, Keyes, Galea, & Hasin, 2012). How will all of this affect future generations?

Since the ban on marijuana in the 1970s, there has been little actual research on the marijuana plant itself. The ban has prevented randomized quality and extensive controlled trials on marijuana. This leaves some believing that medical marijuana is not yet ready for prime time (Pagán, 2013). Reclassifying marijuana as a schedule II narcotic like morphine would open the doors for more research on marijuana and how best to use it and bottle it (Bostwick,

2012). A scientific evaluation would allow marijuana to go through a rigorous process and potentially be approved in some form by the Food and Drug Administration (FDA) as a therapeutic medication (Dresser, 2009). Classifying marijuana as a schedule II medication is the most viable option, as this is the same process other potential medications have to go through for the safety of the public.

While it may be popular with the masses to legalize marijuana as a medicine or to totally decriminalize all marijuana usage, it is questionable whether this is based on scientific fact and research. The research suggests that the efficacy of medical marijuana has not been established. If that potential exists, let that be found out scientifically.

While the legal utilization of medical marijuana is still prohibited in many states, in the states where it is legal there

are many ethical quandaries for hospice employees. The federal law still considers marijuana an illegal substance, although the federal government has been lax in enforcement (Dennis, 2013). It is not something that can be placed on a patients medication administration record (MAR). It typically cannot be dispensed by a pharmacy. The recommended dose for a patient is unknown, although the risk for a hospice patient is low and an overdose unlikely (Joyner, 2010). The current evidence for its use seems weak at best. At the same time, advocates for medical marijuana often cite the need to legalize it for all based on the supposed needs of a few terminally ill patients.

From a quality of life perspective it would seem that terminally ill patients using marijuana, whether the rationale is medicinal or recreational, would be ethically justifiable. There are many ethical theories that would support its use for those with a limited life expectancy. Societal problems with increased usage among adolescents, driving while impaired, and potential addiction are really nonissues for terminally ill patients. However, to justify its use among hospice patients and then jump to a conclusion that it should be legalized for all based on evidence-based practices lacks credibility. This is an issue where politics, popular vote, research, and medicine are in conflict. Hospice clinicians need to understand that the support of medical marijuana for their patients is not based on evidence, but upon quality of life. An emotional argument can be made for its usage among the general population, yet a scientific argument is more difficult to arrive at. However, as further research is conducted that may change over time. Anecdotal, experiential, and popular vote should not be the primary drivers of care for the terminally ill.

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LISTENING FOR PSYCHIC RETREATS IN EARLY RECOVERY TREATMENT FOR SUDs

MARGARET ANN FETTING, PHD, LCSW

Many of us like the experience of being intoxicated, and that desire creates trouble for some of us. This article explores what drives this desire and proposes an analytically-minded treatment path for these troubles.

An Integrative Treatment Model (ITM) comprised of four stages is briefly introduced and this article focuses on the work of the third stage: early recovery (Fetting, 2012). Additionally, the psychoanalytic concept of psychic retreats is introduced. Awareness of this aspect of the mind deepens the treatment provider's understanding of what's behind the well-known and difficult to reach isolative mind and behavior of a person with a substance use disorder (P/SUD). A psychic retreat often becomes the "drug of choice" during the early recovery stage; this theory is further explored through a brief case study.

Building on Brown—An Integrative Treatment Model (ITM)

The ITM presented builds on Stephanie Brown's (1995) well-regarded cognitive, behavioral, and developmental model of recovery. The four stages begin while one is actively drinking or using and move through transition, early recovery, and ongoing recovery.

The model is diagrammed in figure 1. It identifies the P/SUD's journey of identity reconstruction, the essential ingredient in recovery. The recovery identity is always in a state of movement—forward, resting or languishing, or backward, and a therapist's recognition of and contact with this moving sense of self is essential. Growth is not linear; thus the arrows move back and forth between stages. Relapse often occurs along the way, as integration of these selves takes time, but eventually relapse occurs much less or stops altogether.

Brown's work reflects her allegiance to abstinence and the disease theory of addiction, though her model seems to easily incorporate other treatment goals, theories, and strategies. The ITM assimilates the work of psychoanalysts, social workers, psychologists, SUD specialists, and educators to enliven Brown's very substantial work. The primary tasks of each stage are infused with a psychoanalytic sensibility; these clinical compass points and interventions invite a deeper connection between therapist and patient. These also encourage more patient self-reflection, which promotes thinking before activity, contemplating in place of compulsivity, and tolerance of frustration rather than discharge. Slowly, the P/SUD begins to let go of a life dominated by impulse and defense.

The therapeutic relationship feels less turbulent when a nondirective, reflective, analytic perspective and attitude are coupled with the more traditional and sometimes confrontational contemporary SUD treatment approaches. This article suggests that the combination of these clinical styles promotes more engaging treatment, and thus prevents relapse.

The Work of the Early Recovery Stage

We now move to the early recovery phase. The lives of recovering P/SUDs are no longer organized around not using. Life is more than behavioral sobriety. Gone is the chaos of the using stage, the turbulence of the transition stage. Gone are constant cravings and pervasive temptations. Rituals of

sobriety and moderation are supported by a new lifestyle.

There are many satisfying developments. There is life without daily drinking episodes; dinners, weekends, parties, and holidays without drunken destruction. There is increased household stability, more consistency in work performance, and the development of new intimacies in relationships.

These satisfying developments also bring challenges. A welcoming of a new life includes a departure from the old. The recovering P/SUD puts his world under scrutiny—how he parents, what he does, how he enjoys activities, and who he spends time with are all up for grabs. There is a reorganization of so many aspects of his life. His relationships with his partner, family, friends, and work are examined. Some existing bonds are intensified and deepened; others are weakened and disrupted. There is so much going on within and between everyone in the P/SUD's world. He struggles to make sense of his longing for the familiar, excitement for new possibilities, and apprehension about the future. It is important to make room for all this psychic digestion (Eigen, 2002, p. 184).

The P/SUD's sober emotional reactions to these new realities and experiences feel unbearably painful. He struggles through the reorganization of his internal world and the reconstruction of his external life. Supporting this struggling mind is an important therapeutic task of early recovery.

Landscape of the Mind of the Person with a SUD

The mind of the P/SUD is saturated with alcohol and other drugs during using. It is preoccupied with their perpetuation. The mind of the P/SUD is busy crafting constant adjustments during the transition stage; it is occupied with staying afloat and is neither preoccupied nor occupied. It is free to feel and then learn to think.

A primary therapeutic task of the early recovery period is to listen for this mind and, on hearing it, begin to explore and investigate its operations. What does this mind do with itself without alcohol and other drugs (AOD)? How does this mind process everyday thoughts and feelings? More specifically, how does the newly "natural" mind experience and work with pain? It is a mind overprimed to escape suffering and underprimed to live with discomfort and uncertainty. The ways it has responded to pain are visible for the first time in years.

Psychic Retreats

John Steiner (1993) is a member of the British Psychoanalytical Society and a former consultant psychotherapist at the Tavistock Clinic in London. He was theoretically and clinically challenged by patients who appeared stuck in their psychotherapeutic or analytic treatment, and with whom meaningful contact was difficult. Steiner needed to understand why, so he developed the concept and theory of psychic retreats.

Each reader is now asked to consider a complex aspect of the mind that is camouflaged while under the influence, and that makes itself known during early recovery. It is proposed that a clear understanding of the functions and facets of a psychic retreat is needed to truly grasp the struggles of this stage.

New conflicts live within the P/SUD's mind and between her relations with others. There is so much suffering. Years of using hark back to instinctive avoidance. Psychic retreats become the drug of choice for many, as the P/SUD's "use" of her retreat occupies her mind and prevents clear thinking about her conflicts. It also stalls therapeutic work, disturbs relations between the sponsor and the sponsee, and disrupts communications among family members.

Understanding a retreated mind and grasping its function become very useful clinical tools when working with a psyche prone to escaping human pain and then compounding this escape with drugs and alcohol. An evasive and confusing early recovery treatment relationship is then comprehended. A connection, which might otherwise remain elusive, is allowed to deepen.

Furthermore, introducing this concept into the world of recovery treatment is extremely useful in understanding the retreated mind behind isolative behaviors—both antecedents of relapse. Grasping a retreat's complexity and befriending its operations requires clinical effort, practice, and skill. Patients are then more likely to respond with curiosity and appreciation. Most grasp the idea, relish its precision, and are soon able to engage in ongoing conversation about their mind's retreated operations.

Functions of Psychic Retreats

Psychic retreats are well-worn internal structures of the mind that are organized and deployed during a P/SUD's infancy and childhood (Steiner, 1993, p. 105). According to Steiner, they are the mind's way of offering shelter during early overwhelming trauma and neglect (1993, p. 8). Retreats camouflage early suffering and later cause suffering during adolescence and early adulthood. Alcohol and other drugs provide ongoing relief; many retreat-prone individuals develop substance use disorders.

P/SUDs in early recovery go through periods of evading real connection. Changes feel overwhelming, growth pain feels unbearable, and moving through it all seems impossible. The initial excitement about recovery has diminished. Protection is more important than contact and many P/SUDs in treatment decide to stop the work.

Structure

All people psychically retreat at times, but not everyone repeatedly relies on a psychic retreat as a pathological form of survival. Not all psychic retreaters become P/SUDs, just as not all P/SUDs are psychic retreaters. Steiner states that psychic retreats, as states of mind, are highly structured systems of primitive defenses, including projective identification and splitting (1993, p. 2). The former gets rid of unwanted emotions; the latter keeps difficult ones apart. In either case, emotions remain inaccessible.

Retreats are also tightly organized networks of object relations that seduce parts of the personality (Steiner, 1993, p. 13). Dependent and destructive parts of the self, unsuccessfully projected onto external objects in times of need, are instead projected onto a group of internal objects with a distinct character or "feel" (Steiner, 1993, p. 47, 53). Retreaters have described this "safe haven" as a mafia gang, a choir of young boys, a table of statisticians, a group of leprechauns, military commanders, an island, a glass room, a force that powers through, a light bulb, *Charlie and the Chocolate Factory*'s great glass elevator, a dome, a warm humming sound or a fortress. Steiner notes that the individual mind determines if these internal objects protect these projections with vengeance, arrogance or hostility, or shelter them within a warm withdrawal (1993, p. 8).

A Faustian deal is entertained. This organization of the mind despises human weakness, vulnerability, truth, and growth. The individual or recovering P/SUD is afraid of these characters. The organization offers a perverse promise, "We will take away your fears, if you honor our hatred of truth and don't listen to yours." The individual signs on, "I will give you omnipotent power over me, if you protect me from my fear of vulnerability and provide a shelter

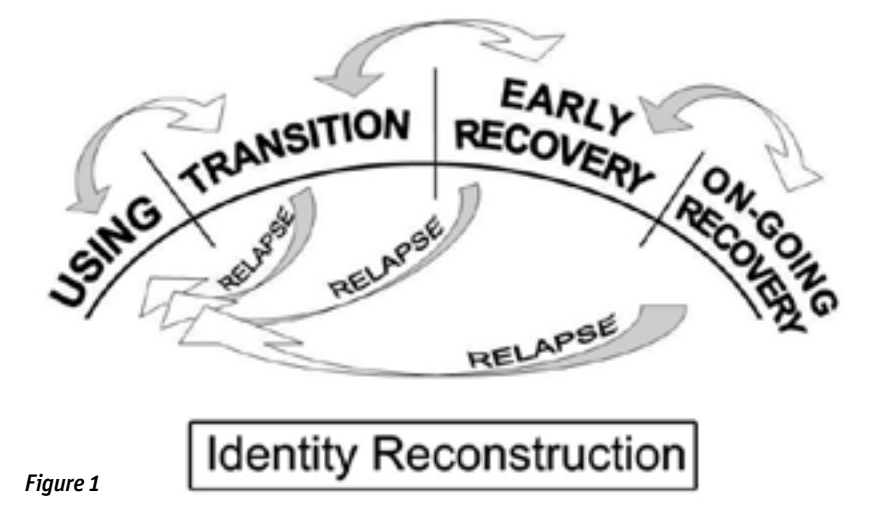

Figure 1

that prevents exposure of this." Thus, a family business is born.

Retreats provide an area of the mind where reality does not have to be faced, where fantasy and omnipotence can exist unchecked, and where growth and development are sacrificed (Steiner, 1993, p. 5). They are alternately felt as a refuge of relief and resignation, or a site of defiance and triumph. They are unconsciously recalled during overwhelmingly painful moments.

Treatment

Clinicians are at a real loss without the watchful sense that retreats may become the pathological organization of choice during early recovery. Reality avoided for years, and sometimes decades, presents unbearable challenges to the P/SUD's newly sober psyche. The P/SUD lacks experience with conflict and its resolution with the help of real people. Reliance on others feels untenable; reliance on his own mind brings a sense of company and comfort.

Clinicians are stymied without understanding the omnipotence and perversion these seductive structures provide retreat-prone P/SUDs. The immediate safety and security they furnish obstruct contact with reality, connection with others, and ongoingness in the therapeutic dyad (Steiner, 1993, p. 5). Patients visit and depart these "sites" or dwell and become entrapped by them.

Clinical Case

Below is a journal entry, written by James, a fifty-two-year-old patient in my private practice. He was committed to abstinence and dedicated to his therapy. James was able to gain tremendous insight into his lifelong use of psychic retreats during his early recovery work. This poignant entry provides an example of a psychic retreat's powerful place in a child's, and later an alcoholic's mind. It also demonstrates the tremendous loss involved in courageously letting go, and moving away from the domination of these lifelong pathological protectors.

> *Yesterday, I was all alone. I wanted someone, anyone. I could not tolerate my aloneness. I wondered about others' lives, what goes on in homes, how people move around each other, and how people experience the struggle of being with each other. Since I was a little boy, I have always felt this struggle cannot be seen or shared. It shows weakness and weakness is shameful. What if you are doing it wrong and what if you are feeling the wrong thing? You could be making someone mad about who you are, the way you are being in your life. Better to dodge contact altogether. It may be treacherous; it may bring big trouble for you.*
>
> *I can see how my leprechaun gang came into being. I was always alone in my mind. They reached out and told me that I'm the smartest, that I have the most sensitivity and talent, the most bounce and chutzpah. I'm the one it comes easiest to; people take to me, and to my enthusiasm. I always get what I want. I can see how the leprechaun gang provided me company and comfort when no one was there.*
>
> *I always found them anytime I felt scared, mad, embarrassed, sad or confused. They were just waiting for me. I talked about what was going on, and they listened. They understood when I felt unsure and frightened. They had answers. They told me not to worry about these feelings. They told me I didn't need to talk about them to anyone. They assured me that I was just fine. They told me to keep up my enthusiasm and act like nothing was wrong. They reminded me that I get a lot of good attention from my optimistic nature. I felt I could go back into the world after our discussions. I felt like I knew what I was doing; that things would be okay. I felt their support behind me.*
>
> *They were my friends, and they are such good, good friends. They make me cry. They have been there for me my entire life. It is only with sobriety that I understand them, and how they have worked.*
>
> *I am crying now because if I leave them, I will hurt them so much. They will not understand why I have to go. They will be lonely and won't know what to do. They are very sad now, sitting outside in a circle around the fire; they don't want me to leave. They are so sad, and I am so sad to leave them. They are nice leprechauns, and they have only meant well. Now they feel they are wrong and are being punished. They are despondent and confused. I love them so much, but it's time for me to try something and someone else. You will be okay. Maybe you will find a nicer way. You have each other, you sweet leprechauns. Thanks.*

The work of early recovery continued. A language of leprechauns brought closeness between us. The leprechauns lost their exclusive control over James, yet they continued to fight for his allegiance. He fought their pleas. Sometimes their seductions appealed to him and he was lured into hostile hiding. Other times, he was able to resist their perverse temptations. Eventually he preferred our conversations over their protections. For the first time in his life, he was able to choose dependency with another human being, over the historically trusted protectors of his mind. He struggled to be continually truthful with me about his experiences of vulnerability and pain. He continued to choose talking over pathological protection. James began the courageous journey of emerging from his lifelong retreat. The work of "seeing and being seen" had started (Steiner, 2011).

Margaret Fetting *is a licensed clinical social worker with more than thirty years of experience, ranging from program consultation to community outreach. The creator of workshops certified by the California Board of Behavioral Sciences for pre-licensure and continuing education credits, she has presented to nearly three hundred organizations on substance dependence and abuse, personality disorders, and adults molested as children.*

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TAKING ON ALCOHOL, PHARMACEUTICAL, AND TOBACCO ADVERTISING:

AN INTERVIEW WITH JEAN KILBOURNE,EdD

WILLIAM L. WHITE, MA

I first heard Dr. Jean Kilbourne speak at a National Council on Alcoholism and Drug Dependence (NCADD) meeting in Kansas City many years ago. I can still recall the power of this presentation and the images she used to illustrate the tactics and messages used to promote alcohol, tobacco, and psychoactive prescription drugs. It was one of those presentations you walk away from never looking at the world in the same way again. Following that, I have been an avid reader and admirer of Dr. Kilbourne's continued contributions. I recently had the opportunity to interview Dr. Kilbourne about her life and her work. Please join us in this engaging conversation.

Creating a New Profession

Bill White: For more than four decades you have pursued a professional career focus—a blended role of media analyst, lecturer, author, filmmaker, and public health advocate—that did not exist before you created it. How did the portrayal of women in media advertising first capture your attention?

Jean Kilbourne: Let me start at the very beginning. In 1968, I saw an ad that changed my life. At the time, I had a series of very mindless jobs. I graduated from Wellesley College in 1964 and had to go to secretarial school right afterwards in order to get a job. A few years later I had a job placing ads in the British medical journal the *Lancet*. One of the ads was for a birth control pill called "Ovulen 21." The ad said, "Ovulen 21 works the way a woman thinks—by weekdays, not by cycle days." Basically, the ad was saying that women were too stupid to remember our cycles, but we could remember the days of the week. To help us, there was a photograph of a smiling woman in the ad and there were seven boxes in her head, one for each day of the week. So, Monday was a laundry basket, Tuesday was an iron, that kind of thing. I looked at this and I thought, "There's something really wrong with this." I took it home and I put it on my refrigerator.

Then I began to look at other ads and to collect them. I put them up with magnets on my refrigerator and started to see a pattern in the images. In those days, nobody else was looking at advertising in this way. I think everyone felt that advertising was stupid and trivial and that we had many more important things to deal with. As far as I know, I was the first person to do this in any kind of systematic way. I continued collecting the ads and got a camera and a copy stand and made slides out of them. Then I put together a slideshow and began to show it to people. One thing led to another. I didn't intend to have this be my life's work, but that is what happened.

Bill White: Did you have a sense early on that this was part of your personal destiny?

Jean Kilbourne: Yes. I would say that happened very quickly. I was involved in the beginning of the second wave of the women's movement at that time. I'd also had some experience as a model. Job opportunities for women in those days were very limited. I could be a secretary or a waitress or maybe a teacher if I went back to school. Those were all very low-paying jobs, but I could also be a model and make a thousand dollars a day, which in those days was big money and still isn't at all bad! I experienced a lot of pressure to capitalize on the way that I looked at that time and to do some modeling. I did some photographic modeling. I did a little bit of runway modeling for the fashion designer Oleg Cassini in New York City. I did a little bit when I lived in London and Paris. It was very soul-destroying. There wasn't any language in those days to describe feeling objectified. A woman was supposed to simply be grateful for the attention, but it didn't feel good to me.

There was also a huge amount of sexual harassment that came with the territory. So I would sort of dabble in the modeling and then I'd step back and I'd get a job as a waitress. I knew I wasn't going to try to make a career out of modeling. Whether I could have or not, I don't know, but I decided not to do that. Though, it left me with a life-long interest in the whole idea of what beauty is, what it means, who wins, who loses, and why the image is so powerful.

Those were the kinds of questions that drew me in as I looked at the images in these ads I was collecting. With my own experience of being turned into an object and how that felt, I was very aware of the fact that this attention was going to be very short-lived—that to be a beautiful young woman was somewhat like being very rich, but with the absolute assurance that you would someday be bankrupt. I could see that happening all around me. As women aged out, which in those days was hitting thirty, they were often treated with contempt. Or, at the very least, they became invisible.

In 1969, I decided to become a teacher and I went back to school. I got a master's degree and I taught at a suburban high school for three years and then I taught at Emerson College in Boston for three years. It was during that time that I really started using the slides of the ads that I'd collected. I had put together a slide presentation that I called "The Naked Truth: Advertising's Image of Women." It was very powerful when I used it in my classes. The students loved it. They had never thought of any of this before and it forced them to look at things in a very different way.

So I knew that I was onto something, but it took me quite a while to really make it my career. There were a couple of reasons for that. One is that I had a real terror of public speaking. I was always a good public speaker, but I was just so terrified of it. However, I had something I really wanted to say. So I just did it and, as with anything, eventually it became much easier.

The other thing that really coincided with my deciding to make this a career was that I quit drinking in the spring of 1976. It was soon thereafter that I got an agent and started to give the slide presentations all around the country. Sobriety gave me energy and it gave me confidence and a sense of possibility. I hadn't had any of that before.

This is also one of the reasons why I've been so concerned for so many decades about alcohol and alcoholism, particularly as they affect women. I saw what happened to me—all this potential was being drowned. I was a very high-functioning alcoholic, but nonetheless I was running on one cylinder. My sobriety helped launch my career and my feeling that this was what I wanted to do.

Bill White: When did your work begin to focus on alcohol, tobacco, and pharmaceutical advertising?

Jean Kilbourne: In the 1970s, I started to look at alcohol and tobacco advertising and I developed slide presentations on these topics. So I had presentations on the image of women in advertising and on alcohol and tobacco advertising. Students generally responded very positively to the presentations because the information was all so new to them. I also use a lot of humor in my presentations and they weren't expecting that. I think they were grateful that they weren't being harangued

and that instead I was encouraging them to ridicule and to laugh at these ads.

I was using a very different angle than what was traditionally used for alcohol and tobacco education in those days. The emphasis had always been on how bad this stuff was for you and how it might kill you, none of which I felt was going to make very much difference to a teenager. I started smoking when I was thirteen and if someone had said to me, "You'll be dead by the time you're fifty," I would've said, "Good. Who wants to live to be that old?" If they showed me pictures of a diseased lung, I wouldn't have cared either because I wouldn't have thought of that as applying to me.

So I think my big insight during the 1970s was that the way to reach kids wasn't to talk about mortality or illness, but rather to show them that they were being manipulated and how this was being done. I used media literacy to suggest that the real authorities they should be rebelling against were Phillip Morris and Anheuser Busch, not their parents or their health educators or their teachers. I wanted them to be angry at the right targets. Gradually this became standard practice so that now media literacy is a part of virtually every kind of prevention program, but it really wasn't then.

Bill White: Media researcher George Gerbner described your presentations as a "form of mass vaccination" against manipulative media advertising and I think I actually experienced this after the first time I saw you present. I have never been able to look at advertisements the same.

Jean Kilbourne: You know, I loved that comment of George Gerbner's and I loved George Gerbner. He was a really important person to me. He was extraordinarily supportive when I was just starting out and was a wonderful mentor. That is a great quote from him.

Bill White: How consciously were you trying to "vaccinate" people?

Jean Kilbourne: Not very. I was trying to get people to take advertising seriously because very few people did and this is still the case. I always hear people say, "I don't pay attention to ads. I just tune them out. They have no effect on me." So I wanted people to take it seriously. More importantly, I wanted them to take these issues seriously—the sexism, the high-risk drinking, the dangers of tobacco—and to see these as serious issues fueled by advertising. I wanted them to see past the harm and look at the profits these industries were making and how they were making them.

Bill White: You once described the work you do as a "form of judo." Could you elaborate on what you mean by that?

Jean Kilbourne: What I meant when I described it as judo is that I was taking on these huge industries—the alcohol industry, the tobacco industry, the fashion industry, the beauty industry, the diet industry, the junk food industry. They had huge resources and huge amounts of power and control of the media through their advertising dollars. And here I am, this lone woman and her slideshow. There was no way I was going to have resources that even remotely approached those

wielded by these companies, but what I could do was use their own weight against them. I could use their material, their ads, and flip it so that people would look at them from a different point of view, a different perspective. That's what I meant when I said it was a kind of judo.

Bill White: What are your most vivid recollections of trying to convey your work to mass audiences through television shows and interviews?

Jean Kilbourne: I remember that at first it was terrifying. When I talked earlier about being afraid of public speaking, it was like every step I would overcome, there'd be another level. In the beginning, it was just being able to get up in front of a group of people and speak without shaking. Then I got comfortable doing that. Then it was larger groups and I eventually got comfortable doing that, and then it was television, which was really scary in the beginning, particularly national television. The first national show that I did was *The Today Show* in the late 1970s. I was just incredibly nervous and my oldest brother said, "Well, relax, Jean. The worst that can happen is you'll disgrace yourself in front of twenty million people." Which was very typical of my brother, but then of course it's also true.

It was easier in those days to be on television because people didn't have recorders—you were on and then you were off. Today people can analyze what you said, put it on YouTube, criticize your clothing, and do all kinds of stuff that they weren't able to do in those days. I was interviewed by Jane Pauley and it was great exposure, and then I did a lot more shows and finally was on *The Oprah Winfrey Show*. That was a whole other level of reaching people. I felt like all of the shows were a terrific way to get the message out to millions of people. I could be traipsing around the country for another five lifetimes and not be able to reach the numbers of people that I did just doing one of those shows.

I also did a lot of radio, which I actually prefer to television. With radio you can get into a lot more depth and it's a more thoughtful medium. You also don't have to care about how you look! Preparing for television takes up a huge amount of time, particularly for women, because we know we're going to be judged at least partly by how we look

Bill White: You know, I'd like to explore the whole issue of women, addiction, and advertising a bit more in depth and I'm wondering if we could start by having you give some examples of some of the themes you found within alcohol and tobacco ads targeting women.

Jean Kilbourne: When I first started looking at alcohol ads, I realized with absolute horror that the alcohol industry understood alcoholism better than any other group. They really got it. They understood addiction in general, but they certainly understood alcoholism. One of the things they understood was the core of loneliness that is at the heart of all addictions. Even if one doesn't start out lonely, to be an addict is to end up lonely. They were playing on that in the ads by offering the bottle as the friend and as the lover.

Alcohol ads encourage people to feel that they are in a relationship with alcohol, which is, of course, how alcoholics feel. I used to joke that Jack Daniels was my most constant lover, and that Jack Daniels wouldn't let me down. So they were on to this. Of course, they also use sex to sell alcohol to both women and men. Alcohol ads are often about how the bottle will help a man have sex or have better sex or that the bottle itself will be the lover and partner, metaphorically speaking. For women, the pitch is more about romance and intimacy. Alcohol ads often show a couple in a romantic setting with this wonderful amber light around them, as if by drinking you could get into this cozy situation. This was part of what was done and still is in alcohol ads targeting women.

But there were so many other things, too. Marian Sandmaier published her wonderful book *The Invisible Alcoholics*, which I believe was the first book about women and alcoholism, in 1980. It was a very powerful book that resonated with me. She wrote that in our culture high-risk drinking is seen as making men more masculine, but as making women less feminine. Women alcoholics are especially seen as less feminine. There is such a powerful stigma against female alcoholics. So the alcohol ads hyperfeminize women in order to offset this. The ads use beautiful, young women to convey to other women that this sophisticated drink will make them look like these women. The alcohol advertisers have really done their homework. They understand how addiction works and, in particular, how addiction works with women. The same thing is done with cigarette advertising—portraying the cigarette as a friend, a constant companion.

Bill White: Do you see a relationship between this targeting of women by the alcohol and tobacco industries and the dramatic growth of alcohol and tobacco addiction among women over the course of the twentieth century?

Jean Kilbourne: Absolutely. One of the things that happened was that the alcohol industry began targeting women more and more directly, in part because they had to constantly open up new markets. Of course, they continued to target men, but they wanted to get women to drink more because that was such a huge potential market. So they did and continue to do all kinds of advertising that makes drinking seem sophisticated, feminine, and romantic. It parallels what the tobacco industry did in promoting cigarettes to women in the twenties and thirties, when smoking was still not really acceptable for women. The tobacco industry promoted smoking as something that was not only acceptable, but was also daring and a symbol of liberation; they did this with tremendous success.

Bill White: I'm thinking of this long line of tobacco and alcohol products that were developed specifically for women.

Jean Kilbourne: Yes, like Virginia Slims. Now the alcohol industry has developed this whole line of very sweet drinks for kids that bridge the gap between soft drinks and alcohol. They target girls most often because most boys wouldn't be caught dead drinking these feminized drinks because of the hypermasculine code that is so often such a straitjacket for boys. Girls are offered things like chocolate beer, tequila lollipops, ice cream with alcohol, and Jello with alcohol. The alcohol industry calls these drinks "entry drinks" because they're designed to get girls used to drinking alcohol. One of the dangers of these products is that they're so sweet one can miss the fact that they contain a lot of alcohol. Girls tend to weigh less than boys and so there's been a lot of trouble with girls drinking way too much of this stuff and then getting alcohol poisoning.

Bill White: I'm wondering if through the course of your studies you've had an opportunity to reflect on how the media portrays addicted and recovering women.

Jean Kilbourne: Addicted women have been portrayed forever as sexually promiscuous and bad mothers, but I can't recall many images of women in addiction recovery.

Bill White: Maybe the absence of recovering women is the story.

Jean Kilbourne: Maybe that is the story, you're right. There aren't very many portrayals of women in recovery, although there are more than there used to be. On television there have been far more men who are in recovery than women in recovery. I believe that Christine Cagney in *Cagney and Lacey* was the first. Jane Tennison in *Prime Suspect* gets sober at the end of the series. There have been some movies, of course, such as *The Morning After* and *28 Days*.

Bill White: I'm wondering if you've got a particular slant on alcohol advertising as a woman in recovery. Do you think women in addiction treatment need to be inoculated against the effects of the advertising you have described?

Jean Kilbourne: Oh, I actually think men and women both need to be inoculated against it. The research being done today by alcohol and tobacco marketers is far more sophisticated than it was when I started looking at these ads. Now they're very aware of psychological cues and

what sort of things trigger relapses in addiction; things like the flare of a match as you're lighting a cigarette or the amber light in the alcohol ads. I remember from my own drinking days that it was like stepping into this cave of amber light, and so I think that's a psychological cue, as is the foam on the head of beer in a beer ad. These are the kinds of cues that can trigger relapses and they're meant to—that's the whole point. This is why both men and women need to have media literacy be a part of their treatment because they're going to be going out into a world in which they will be bombarded with these beckoning cues to have a drink or a cigarette.

Bill White: Are treatment programs using any of your films to do this kind of education?

Jean Kilbourne: A lot of them do. I've also talked about eating disorders for decades and a lot of the eating disorder treatment centers use my films *Killing Us Softly* and *Slim Hopes: Advertising & the Obsession with Thinness*.

Film Projects

Bill White: Could you talk about the films?

Jean Kilbourne: A huge step for me was making *Killing Us Softly in 1979*. That turned my lecture "The Naked Truth: Advertising's Image of Women" into a film. The first version was unbelievably simple. It was one camera aimed at me as I gave a lecture and cost something like six thousand dollars to make. It was really cheap and cheaply made, but in today's language, it went viral. It became a huge hit and was widely used on college campuses and lots of other places. I've remade it three times since then, most recently in 2010 as *Killing Us Softly 4*. I've often heard that it's one of the most popular educational films of all times. When Upworthy recently promoted the trailer to *Killing Us Softly 4* on YouTube, it had over four million hits.

In 1982, I made a film called *Calling the Shots: Advertising Alcohol*, which I remade in 1991. I made *Pack of Lies: The Advertising of Tobacco* in 1992. In 2004, I combined the two into a film called *Deadly Persuasion: The Advertising of Alcohol & Tobacco*.

In 1995, I made *Slim Hopes: Advertising & the Obsession with Thinness*. In 2004, I made a film with my friend and colleague Jackson Katz called *Spin the Bottle: Sex, Lies, & Alcohol*, which is about drinking on college campuses. I've also hosted films by Neil Postman and George Gerbner. So I've made a wide range of films to get this information to small groups and to groups that can't afford speakers.

Industry Response

Bill White: What has been the response of the alcohol and tobacco industries to your work?

Jean Kilbourne: Their response has been nothing! But what they can do, because they have so much control over the media, is to make sure their critics don't get very much publicity. So when *Can't Buy My Love*, my first book (which was called *Deadly Persuasion* in hardcover) came out in 1999, the editor of a really big women's magazine said to me, "I love your book. I'd love to do something with it, but I can't touch it

because Absolut is one of our biggest sponsors." So they don't need to kill their critics and they don't need to sue them, all they need to do is deny them publicity.

One of the things that the alcohol industry did do to me in the beginning, however, when I was out there alone speaking about alcohol advertising, was to label me a "neo-prohibitionist" and "Carrie Nation." They said that I was trying to bring back prohibition, which was completely untrue and incredibly stupid, but I had to waste time addressing that whole argument instead of talking about the real issues.

Career Reflections

Bill White: As you reflect back over your career to date, in which you have received so much international recognition and innumerable awards, is there an aspect of your work that you feel personally best about?

Jean Kilbourne: Well, there are a couple of things. One is I get e-mails constantly from people all around the world because of the films, particularly *Killing Us Softly*, telling me how my work has really opened their eyes or made a difference in their lives. I've had lots and lots of young women say that they never identified as feminists until they saw the film and now they do and I feel very good about that. I also occasionally hear from people who, after reading my books or seeing my films, got sober or quit smoking. What could be better than that?

Bill White: Are there big items still on your agenda that you're currently tackling or hope to tackle in the near future?

Jean Kilbourne: That's a really good question. I'm not sure. I'm sort of at a crossroads right now. I'm still doing my lectures, but I'm not going to remake *Killing Us Softly*. I think four is enough! I'd like to write another book, but I'd like it to be a different kind of book, not a research-oriented book. So I'm thinking I might write a memoir about what it's been like to be an activist all these years.

Bill White: That would be wonderful, particularly as a primer for other young activists coming behind you. I'm wondering in that regard if there are others that you see coming behind you who are going to carry this work far into the future.

Jean Kilbourne: There are a lot of young women out there and some young men too who are doing really good work. Jennifer Siebel Newsom made a film a couple of years ago called *Miss Representation*. Her film is about the ways in which media images limit women's political efficacy and make it more difficult for women to become active politically or to see themselves as politicians or even involved in politics. It's a wonderful film. There's a young woman named Jennifer Pozner, who wrote a terrific book about reality TV called *Reality Bites Back*. She's a very smart writer and speaker and she's been doing a lot too. Andrea Quijada, the executive director of the Media Literacy Project, is doing great work.

My friend Jackson Katz has been talking about images of men for over twenty years and works to get men involved in ending violence against women. Jaclyn Friedman, Jessica Valenti, and other young feminists are doing a lot of work on these issues these days. Amy Jussel has a terrific blog and website called Shaping Youth. I know I'm leaving out so many people!

There's also an organization called About Face which is all about images of women in advertising. There are many other organizations now too, such as the Brave Girls Alliance. There's an extensive resource list on my website. So there are a lot of things going on now that give me hope that my work will continue.

Bill White: What advice would you offer young people interested in pursuing this advocacy work as a career?

Jean Kilbourne: I'd encourage people to do it. It's work that feels meaningful and I've just loved it. I still feel amazed that people actually pay me to talk about what I think. So, even though it can be exhausting—particularly the first decade or so when I was doing 110 lectures a year and going out on Monday and coming back on Friday—it is exciting. One has to have a lot of grit, determination, and stamina, but the rewards are terrific. I've also found it very important to work for myself and to be independent in that way.

Bill White: You and I have both seen people take on causes they're passionate about and then burn themselves out quickly. How have you been able to sustain your health and vitality over this long marathon you've run?

Jean Kilbourne: That's a very good question! There are lots of things. I have a very strong support system of friends and I'm also a part of the recovering community, which is a huge support system. I try to take care of myself and exercise; I love to be outdoors and to walk. I would say that the main thing has been my close friendships, particularly with other women, that have been so nurturing, and my close relationship with my daughter, who is doing very exciting work herself.

Bill White: Dr. Kilbourne, thank you so much for taking this time to reflect on your life and the advocacy work that you've pursued.

Dr. Kilbourne's books and films are available through the following link: www.jeankilbourne.com

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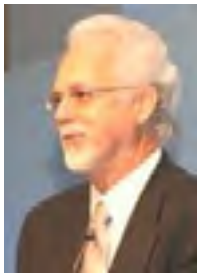

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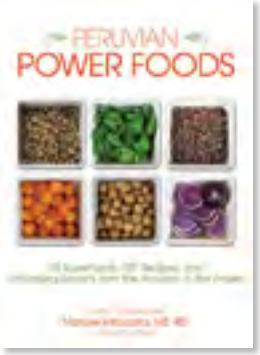

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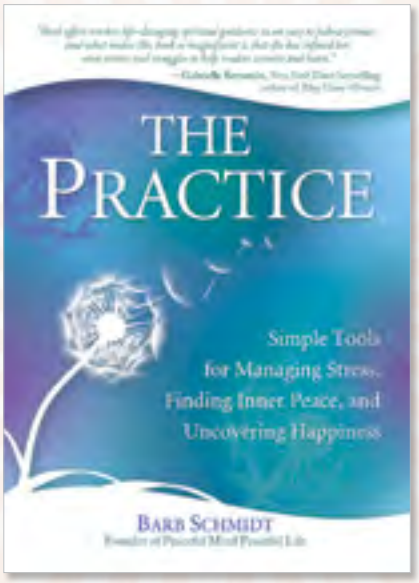

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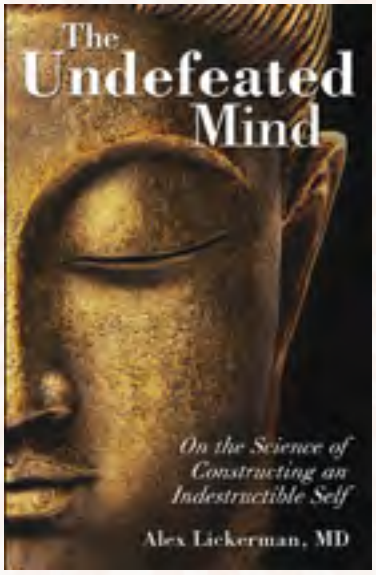

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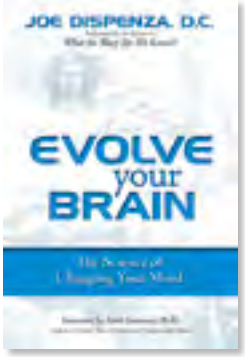

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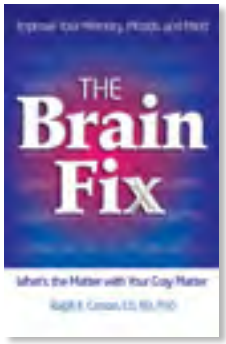

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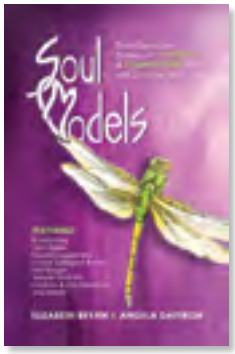

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From the *Journal of Substance Abuse Treatment*

LONG-TE
EFFECTS OF SPECIALIZED TRE
for Women with Substance Use Disorders

Elizabeth Evans, MA, Dana Levin, BS, Libo Li, PhD, & Yih-Ing Hser, PhD

WOMEN account for approximately one-third of the more than two million Americans who receive treatment for substance use disorders each year (SAMHSA, 2011). Of these women, two-thirds are of childbearing age and about 4 percent self-report being pregnant at treatment entry.

Substance abuse and dependence among mothers has many adverse health, social, and economic impacts. Foremost, the impacts of substance use during pregnancy and child-rearing are primary examples of how women's substance use disorders can have negative consequences that not only affect women themselves, but also the health and welfare of their family and the next generation.

Mothers with substance use disorders share many other problems common among substance abusers. For example, they demonstrate elevated risks for premature mortality, representing the loss of a significant number of years of potential life. Also salient among women with substance abuse and dependence is a variety of health problems including mental illness, injury and trauma, and HIV and other infectious diseases. Furthermore, having incurred health problems like these, women with substance use disorders are likely to use a hospital emergency room as their primary source for care. Consequently, not only does substance use place a woman and her acquaintances at risk for injury and disease, it also often leads to her utilization of particularly costly health care. Substance abuse and dependence is also a significant barrier to women's employability, employment, and economic self-sufficiency. Low-income women who abuse substances are at particular risk for persistent poverty, homelessness, criminal activity, and reliance on public assistance programs.

Treatment can function as a "recovery resource" that can help women to counteract or undo the disruptive effects of substance use disorders. A well-recognized potential problem, however, is that men outnumber women in publicly-funded substance abuse treatment programs by about two to one and, historically, this treatment system has been designed to treat mostly men (Ashley & Brady, 2005). Given this context, it has been suggested that many substance abuse treatment programs may not be able to provide adequate treatment therapies and settings to meet the special needs of women. Women who do not receive appropriate care may struggle to form a therapeutic alliance with treatment staff, drop out of treatment prematurely or fail to receive or consolidate the skills that are needed to sustain recovery from substance use disorders after treatment exit.

Specialized treatment programs for women with substance use disorders are a relatively recent innovation that developed to accommodate the unique, gender-specific needs and experiences of women (Greenfield & Grella, 2009). Nationwide, about one-third of all publicly funded substance abuse treatment facilities offer specialized treatment for adult women and a growing number report provision of special services for pregnant and postpartum women (SAMHSA, 2011). These programs tend to offer more services for women and may treat only women, creating a gender-specific, women-only (WO) environment that contrasts with mixed gender (MG) programs, which usually treat both men and women.

The effects of WO treatment on women's use of substances and related behaviors have been little examined. It may be that WO treatment can function as a turning point event that changes the course of women's drug use and addiction. Expectations about the effectiveness of WO treatment must be tempered, however, by the knowledge that besides substance abuse treatment, women with substance use disorders come into contact with many other service systems over time, including the criminal justice system, mental health settings, welfare programs, and primary health care. These social contexts may impose opportunities and constraints in ways that impact women's health-related behavior and decision making, above and beyond whatever effects may be precipitated by WO treatment.

Research Aim, Hypotheses, and Study Design

Few studies have examined the longer-term impact of WO versus MG treatment for women. Therefore, we conducted a study to examine ten-year outcomes among a cohort of mothers who received either WO or MG treatment for substance use disorders. We were also interested to know if the effects of WO treatment on outcomes were mediated by posttreatment exposure to criminal justice and health services systems. We anticipated that women treated in WO programs would have better outcomes than women treated in MG programs. In addition, we expected that WO treatment would be associated with differential exposure to criminal justice and health services environments

after treatment exit, and that these exposures would in turn function as an intervening mechanism through which WO treatment yielded better outcomes.

To explore these questions, we utilized data from the California Treatment Outcome Project (CalTOP), a study that recruited approximately 17,770 adults admitted to forty-three publicly-funded substance abuse treatment programs in thirteen California counties during 2000–2002 (Hser, Evans, Huang, & Anglin, 2004). CalTOP included 4,447 women who were pregnant or parenting children under age eighteen at treatment entry. Of the programs, three served men only, eight served women only (WO), and thirty-two served men and women (MG). We selected one thousand women to complete a ten-year follow-up interview, conducted from 2009–2011. Among the women targeted for follow-up, 713 completed the interview, 46 refused, 164 were not located, 54 were deceased, and 23 were found but unable to complete the interview. Thus, the overall relocation rate was 84 percent and, excluding women who were deceased or unable to complete the interview, the interview completion rate was 77 percent. Study procedures were approved by the Institutional Review Boards at UCLA and at the State of California Health and Human Services Agency.

At entry into substance abuse treatment, the cohort of women that we studied was about thirty-two years old on average. The sample was ethnically diverse. Most women had attained a high school degree, but few were employed and about 40 percent received public assistance. About one-fifth of women were currently married. Most had dependent children, with each woman caring for about two children. Most of the women primarily used methamphetamine, but use of heroin, alcohol, cocaine, and marijuana was also reported. More than half of the women had been using drugs for more than ten years. Women had needs in other areas besides substance use as indicated by rates of homelessness, involvement with the criminal justice system, chronic medical problems, and receipt of prescribed psychiatric medications. Women were treated in mostly outpatient or residential substance abuse treatment settings, although some women received methadone maintenance treatment.

Our first step was to explore whether women treated in WO settings were different from women treated in MG settings. Analysis indicated that women treated in WO programs were older than women treated in MG programs, more WO women were African American and fewer were Hispanic, and fewer WO women were pregnant. Also, WO women had used their primary drug for more years on average and had more prior treatments for substance use disorders.

In the ten years after treatment, women who received WO treatment had fewer arrests than women who received MG treatment. There were no differences by treatment setting in women's posttreatment exposure to incarceration, additional treatment for substance use disorders, and use of mental health services.

Factors Associated with Women's Long-Term Outcomes

Next, we examined women's status at the ten-year follow-up interview and the factors associated with women's outcomes. The relationships we sought to explore are shown graphically in Figure 1. The bolded lines indicate relationships that analysis indicated were statistically significant. First, we estimated statistical models to examine whether successful outcome was associated with treatment program type (WO vs. MG), while accounting for other reasons that might explain women's outcomes at follow-up. Successful outcome was defined by the following three criteria in the thirty days prior to the ten-year follow-up interview:

1. No use of any illicit drugs
2. Not involved with the criminal justice system, meaning no arrests, incarcerations or illegal activities
3. Must be alive

Analysis showed that about half of women overall had a successful outcome approximately ten years after having been treated for substance use disorders. In addition, WO treatment, compared to MG treatment, increased women's chances of achieving a successful outcome. Findings provide empirical support for the effectiveness of publicly-funded substance abuse treatment facilities that offer specialized treatment for adult women.

Besides receipt of WO treatment, successful outcome was also associated with certain characteristics of women as reported at entry into treatment. Specifically, being pregnant at treatment entry increased women's odds of success. For some women, pregnancy may mark a change in social roles and responsibilities that promotes drug

use cessation and sustained recovery. Findings suggest that treatment entry may be considered to be a teachable moment in time in which women who are pregnant may be particularly receptive to treatment and other intervention efforts. By offering services that enhance parenting skills or provide prenatal care, treatment may be able to help women remain engaged in treatment and experience child-rearing as a role that is more rewarding than drug use.

Other findings suggested that women who had more severe medical problems at treatment entry had worse long-term outcomes. A large body of research indicates that persistent drug addiction is complicated by the presence of severe problems in multiple health and social domains. Over time, the development of one problem may exacerbate or lead to the development of another. As the substance use disorder progresses, a woman may suffer more adverse consequences, collectively creating circumstances that can challenge her capacity to recover from addiction.

Finally, more women with a successful outcome were methamphetamine users and fewer used heroin and marijuana. Methamphetamine is recognized as a significant problem in California and evidence-based treatments are available to treat methamphetamine use. It may be that women in the successful outcome group benefitted from such specialized care.

Mechanisms That May Explain Why WO Treatment Enhances Women's Outcomes

Finally, we examined whether experiences that occurred after treatment explained the relationships between WO treatment and long-term outcomes. We measured these potential mediators using administrative records maintained by the State of California. These data provide an official record of women's arrests, prison incarcerations, treatment for substance use disorders, and use of mental health services during the ten years from treatment discharge to follow-up.

Results from our structural equation modeling indicated that the relationship between WO treatment and successful outcome was mediated by the number of arrests that occurred after treatment. Specifically, WO treatment, more so than MG treatment, was associated with fewer arrests in the ten years after treatment, and fewer arrests over this time period had a positive effect on women's outcomes. This finding suggests that reducing exposure to criminal justice settings is one mechanism through which specialized treatment for women with substance use disorders achieves long-term benefits.

As for the other potential mediating mechanisms that were examined, WO treatment reduced exposure to incarcerated settings, drug treatment, and mental health care; however, these experiences were not associated with women's long-term outcomes. The relationships between these factors and their effects on outcomes are complex and dynamic, and therefore merit additional research.

Limitations of Research

Our findings must be considered within the context of several study limitations. We did not randomly assign women to WO or MG treatment, potentially introducing confounds that affect the outcomes. The sample of women that we studied demonstrated greater problem severity than other women in drug treatment, limiting the extent to which findings can be generalized. We relied on self-reported and administrative data, two data sources that are vulnerable to measurement bias. Finally, we do not know whether the MG programs in the study actually treated men and women in the same groups or sessions, or whether patients were separated by gender and treated in gender-specific ways.

Implications

A considerable number of studies have reported similarities and differences in the ways that women and men experience substance abuse and dependence. Among the most robust findings is that there are factors unique to women that heighten the risks and burdens of drug addiction. To address women's unique needs, the last two decades have witnessed a proliferation of specialized programs to treat substance use disorders among women. These programs are thought to improve outcomes, but research on their effectiveness is limited and the factors that explain variations in outcomes are poorly understood.

This study is the first study to assess the long-term effects of this type of specialized treatment programming on women's substance use and other outcomes. Most importantly, this study provides empirical support for the long-term beneficial impact of specialized WO substance use disorder treatment on women. Furthermore, this study identifies associations between specialized treatment and exposures to criminal justice systems and health

systems that help to explain the causal mechanisms through which specialized treatment for women can advance women's recovery from substance use disorders.

Findings have implications for the provision of substance use disorder treatment for women. In particular, women with substance use disorders often exhibit a number of other addiction-related health and social problems that, if left unaddressed, can undermine a woman's recovery efforts. Therefore, treatment environments that are sensitive to women's issues or are designed specifically to treat women may constitute treatment ecologies that are particularly supportive of women's recovery. These environments may be most beneficial if they help women to resolve what was impaired by drug addiction, but are also equipped to detect and address other issues which may affect women's recovery.

For instance, beyond addressing a woman's drug addiction, treatment programs can prepare women for long-term recovery in a number of other ways. This might include helping women to achieve economic self-sufficiency, thereby reducing her reliance on acquisitive crime. Treatment can provide women with opportunities to interact with others who are caring and supportive of a woman's recovery. Facilitating women's access to treatment for physical problems and mental illness that can exacerbate drug addiction is perhaps one of the most critical roles that treatment can play. Finally, treatment can provide a means for women to reap several of the other rewards besides abstinence that can accompany recovery. Protocols developed by the Center for Substance Abuse Treatment (CSAT) are a key resource for learning about best-practice guidelines for the treatment of substance use disorders. The protocol, titled "Substance Abuse Treatment: Addressing the Specific Needs of Women," provides clinical and administrative information to assist treatment counselors, clinical supervisors, program administrators, and others working with women with substance use disorders on how to respond to the specific treatment needs of women (CSAT, 2009).

More studies are needed to further elucidate which subgroups of women with substance use disorders can benefit from specialized care and how those benefits are achieved. In the meantime, the findings from our work can be used to improve existing services, diffuse women-focused treatment, and develop other treatment innovations that are designed to prevent or ameliorate the adverse consequences of substance abuse and dependence among women. C

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HOARDING:

Is An Intervention RIGHT FOR YOU AND YOUR CLIENT?

Dorothy Breininger

You receive an urgent phone call from a potential client, or another mental health professional in your field, perhaps a television show or a prosecuting attorney about an individual who hoards. With a plea in their voice, they ask if you can assist with a "hoarding intervention" or at the very least assist in the counseling of this individual about his or her hoarding issues. Knowing the delicacy of this population and the severe possible consequences that individuals can face due to their hoarding situations, how do you best respond?

For some of your clients an intervention is ideal, and for others it may negatively impact their mental health. To make the best decision, you must consider the following: when or if a traditional clean-out or intervention clean-out is necessary, the difference between interventions sanctioned by government officials versus your client's personal decision to de-hoard, the pros and cons for yourself and your client, what is needed for an effective intervention or quick clean-out, who belongs on your team, how do you best put together a team for an intervention, and what to do when an intervention goes wrong.

It is estimated that there are between five million and fourteen million people in the US who are compulsive hoarders. Many researchers argue that these figures are underestimated and that a majority of hoarders remain undocumented and untreated. Not surprisingly, there is a shortage of therapists to go around. Because of the popularity of television shows about hoarding, it is understood by most family members that a therapist should be involved in this decluttering process and are being sought after more and more to lead interventions around this addiction. Because the media has popularized hoarding and interventions, we are now being called on to provide the "interventionist" service as well.

Let's start with the various possible definitions of hoarding as it relates to a hoarding intervention.

Popular Definition

According to the Mayo Clinic, hoarding is "the excessive collection of items, along with the inability to discard them" (2011). Now, couple that with what many Americans read or watch on television in a TV show called *Hoarders* or *Intervention*, and a public or popular definition is created.

Television Definition

A possible "television definition" of a hoarding intervention is making an effort to solve a very serious problem, while creating a sizzling visual for viewing audiences worldwide. Do we love this? Many would say no. Does it make a huge difference for the masses of people around the world? Probably.

Professional Definition

My colleague and costar on the show *Hoarders*, Dr. Michael A. Tompkins, defines hoarding by placing an emphasis on four central factors: excessive acquiring, difficulty discarding, living in cluttered spaces, and having significant distress or impairment. He advises using the harm reduction technique in his interventions, which basically means to do no harm and meet the hoarder at his or her level.

A Professional Organizer's Definition

Judith Kolberg, the founder of the Institute for Challenging Disorganization, introduced us to the definition of hoarding many years ago. Kolberg clarifies: "With chronically disorganized people, recurrence of disorganization is a central concern. With people who hoard, the issue is not so much recurrance, as it is perpetual disorganization into the future" (2009).

Public Health Definition

The government service sector, known as "public health," that represents the health of the community and our neighborhoods, might define hoarding as it impacts the community as a whole. Examples of public health concerns due to hoarding are rodents, fire and safety, building and safety, viruses, animal control or child endangerment:

- Two thousand rats in a home, impacting the neighborhood with viruses and epidemic rat breeding
- Twenty goats living in a home in a suburban neighborhood, causing damage to the home while surrounding home values plunge
- Child or animal endangerment cases being reported
- New York penthouse apartment experiencing bedbugs and fire trap conditions, and tenants moving out

A Landlord's Definition

He or she might say "I know I need to be politically correct here, but I don't want all my tenents freaking out, I don't want a lawsuit on my hands, and I don't want my property value to drop. How can we get rid of these people? What do I have to do? Can't we do some sort of intervention here?"

A Desperate Family Member's Definition

"I don't get it! My mom seems fine with her hoard, but I can't take it anymore. I'm in agony, I'm suffering, and I can't seem to make a difference. I am completely powerless around this. Please God, if I could only get this cleaned up for her. I don't know what to do. I don't even know what this 'hoarding' really is!"

Hoarder Definition

"I don't think I'm a hoarder. If I need to clean this up then I will, but I don't think I need to right now." Notice the family's definition as compared to the hoarder's definition of his or her own situation—they are super different.

After reviewing these various definitions you will come to understand that you probably relate to one group more than another. What feels right for you? It is my belief that in order for you to consider working with an individual who hoards, leading an intervention or advising others on trying an intervention, you will need to understand for yourself to which group you best relate.

In the twenty years I've been working with individuals who hoard, I find I relate best to the desperate family member's definition and the public health definition. I see the value in doing interventions because of these perspectives. I have chosen to work on behalf of the desperate families and for the

world of public health at large. In doing so, I believe I also help the individual who hoards.

Knowing the delicacy of this population and the severe possible consequences that individuals can face due to their hoarding situations, how do you best respond in terms of an intervention? What determines delicacy for this hoarding population? How delicate is their mental health—are they getting help? Is their physical health and well-being at stake? For example, do they or their spouse have cancer or need a kidney transplant? Is there a major financial impact on an already overburdened social service agency? Is the family in need of social services for drug or sexual abuse counseling? Are there other matters of delicacy such as the splitting of families, loss of work, or long-term trauma? Are they experiencing a lack of trust in people or the world, or a feeling of being unsafe?

There are so many delicate traits in working with someone who hoards and it is my hope to emphasize compassion in terms of implementing a hoarding intervention. As a comparison, we might ask ourselves why we should show compassion for a chronic relapsing alcoholic. Should we not act accordingly with our hoarding population as well? An intervention requires compassion and understanding. Whether we are talking about someone who hoards or drinks to excess, there is a delicacy to their emotional health. We must endeavor to understand the delicate aspects of our clients' lives.

Aside from the obvious consequences of job loss, home eviction, and displacement of children or animals due to hoarding, there are other consequences we should be aware of such as: major depressive disorder, bipolar disorder, anxiety disorder, obsessive compulsive disorder, ADHD, sexual disfunction, eating disorder, panic disorder, phobias, schizophrenia, delusional thinking, and suicidal thoughts or actions.

These consequences are serious not just for the person who hoards, but for the surrounding family and community. Answers to these consequences lean heavily on the overtaxed public health system and often go unanswered. Public agencies face decreasing funds and fewer people to lead the charge for folks who face these consequences. Thus, the interventions are more often being led or handled by family members, professional organizers, privately paid therapists, trained interventionists, and junk teams.

To Intervene or Not Intervene

If you were approached to lead an intervention, how would you best respond? Some suggestions are to determine your definition of hoarding and which population you are representing or serving and then be direct and clear to all those involved; especially to and for whom you are conducting the intervention. You will want to get a clear distinction of what the delicacies of your client are around this project and understand for yourself which of the disorders and consequences are not a fit for you. For example, are you prepared to work closely with someone who has suicidal tendancies due to hoarding? Finally, you will want to set up your own personal support system of professional organizers, volunteers, and understanding colleagues.

For most of our clients a hoarding intervention seems like a nightmare, yet for the surrounding family members it seems like a dream come true. It is often believed that an intervention has far less potential for success if there is nothing at stake. When working with others to determine whether an intervention is the right path to take, consider looking at the following to learn if any of these areas of life are at stake for your client. If they are experiencing a crisis in one or more areas listed below, they may be an ideal candidate for an intervention instead of a longer term behavioral approach.

- Do they have financial pains because their bills aren't being paid?
- Is a family member's health in jeopardy and he or she cannot return home from the hospital unless the hoard is cleaned up?
- Is a child's education suffering due to something as simple as not having a place to study at home, or is a child being ridiculed at school because of rumors about his or her family home?
- Are relationships suffering with a divorce looming or, of equal concern, that family members can't eat a meal together at the table?
- Is your client on the verge of getting fired due to hoarding on the job?
- Is there even a hint of self-loathing which has turned into suicidal thinking?

Other criteria for deciding if an intervention is necessary include:

- Timing—are there eviction deadlines or child protective services deadlines?
- A public health hazard—is your client facing fines or prosecution by city officials?
- Limited alternatives

Another criteria to consider is whether this is an intervention of critical choice, whereby we investigate the impact not just around the individual who hoards, but rather the impact on the critical masses, such as children, animals, family, neighbors, communities, and the public health system. Finally, are there any legal ramifications due to the hoard? Will jail time be served if this is not handled? Will conservators take over the decision making of our client?

Beginning an Intervention

So, who belongs on your team and how do you put together the best team for an intervention? It is imperative to have one leader in place and having others agree to allow that leader to oversee the intervention. Other participants may include social workers, clergy, animal control, veterinarians, child protective services, adult protective services, police, building and safety, housekeeping teams, junk removal teams, pest control, hazmat cleanup crews, and car towing services.

Once we are able to discern the criteria for whether an intervention is necessary, let's look at how to guide the people in need. Here are some steps you will want to consider:

Garner trust. Rather than appoaching our clients with the question of "What do you want to get rid of here?" let's gain their trust by sharing how we want to help them keep what's valuable to them while also getting them out of this big, overwhelming, financial, legal, and emotional mess. We will also need to gain the trust of the family members involved, as many will be skeptical too.

Be straight with clients, repeatedly, about the expected outcome. For example, "We must stay on this task of clearing out the back yard on November 16 or the city will come and clear it for you. They will not ask your opinion, they will not give you a choice in the matter, and you will be billed and fined for the work done to you against your will. You have a choice in this matter; what would you like to do?"

Be firm. A typical tactic by some of our hoarding clientele can be repeated negotiation or even manipulation. It is beneficial to validate your client's tactic and then immediately come back with a firm and focused response.

Remain detached from the outcome. Give up your vision and the desire to see your vision come to fruition. You may never get to have the vision delivered. However, by remaining detached from how the outcome looks, it gives your client and their family members the space they may need to experience the ups and downs of the situation while still landing at a feasible end-game.

Interposition yourself between the family and the individual who hoards. The term "interpositioning" is used when you physcially place yourself between the hoarding client and other family members, work crews, or even televison cameras and newspaper reporters. The client must be able to have one lifeline, one person to talk to. One person to whom he or she can confide, make requests, and give answers. You may wish to set up an intervention so that all others report to you; that reporting relationship can begin in advance of the intervention, resume during the intervention, and continue especially after the intervention. To minimize the anxiety our clients may experience, it is best to only have one person presenting questions to the client and making the ultimate decisions.

Have goals in place, either written or in photo form. If your client would like to go back to work or school, or begin RVing around the country, bring these goals into the intervention. Goals can automatically help "change the channel" from a negative intervention to an intervention fueled with positive life goals for the future.

Counselor Self-Care

While we have spent some time looking at how we can help our hoarding client feel secure with this intervention, let's look at how we can feel secure with our choices. The thought of an intervention can be daunting. To allow yourself to stay strong throughout the process, it is important to hold tightly to your mission. Having a goal or mission is how you can remain secure with choices when all others may be upset around you. Leading an intervention places you in the middle of a lot of unexpressed anger, pain, resentment, sadness, and loss.

This is the time to ask yourself what is best for the individual, the family, the immediate situation, and the public at large. Questions to ask yourself might include:

- Are children involved?
- Are animals involved?
- Is the spouse or are other family members suffering?
- Is there substance abuse?
- Has suicide been brought up?
- Is the city, county or state involved in the case?
- Is this a public health issue?
- Can I take a stand for the greater good even when the individual cannot see it?

If you have decided to move forward with a hoarding intervention, you must have the stamina to lead, the flexibility to let go of the outcome, and the support and self-care to endure the experience. Notice that you are included in this conversation. When looking to generate the pros and cons around self-care, I turn to self-help author and guru, Louise Hay (1984). I look to answer questions for my client and myself.

Deservability

Allow yourself to accept the good whether you think you deserve it or not. What do you want that you are not having? What do you deserve?

Think about your inner child

Many of our clients feel lost, lonely, and rejected. Guess what? We can feel that way too. Sometimes that is why many of us reach into the world of caregiving or public service. Be sure to nourish your young self. Allow your client and yourself to get in touch with the young inner self by asking: What frightens you? What do you need in order to feel safe during this intervention?

Plan for an optimum energy level

Every cell within our bodies responds to every single thought we think. Supplying our minds and bodies with positive affirmations prior to an intervention can be invaluable for you and your client. Examples of affirmations are: "I listen to my body's messages," "My health is radiant, vibrant, and dynamic right now," and "I deserve good health."

Fears

In any given situation, we have a choice between love and fear—fear of change, not changing, the future, intimacy, being alone, and letting go of the past. Our clients will

certainly experience fear around an intervention. We too may experience fear as we lead our clients and their families through unknown territory. Writing a mantra to guide you and your client through the rough waters can change the tide from nervous to nirvana. An example might look like: "Everyone sees my value. I trust my needs will be taken care of. I am relaxed and I flow with life easily and effortlessly. I will always attract all the help I need."

Effective Intervention Checklist

With self-care in place, let's look at what is needed for an effective intervention or quick clean-out. Is there family support? Can a professional organizer be involved? Are medications readily available for treatment? Is there a project timeline with dates and tasks in place, both leading up to intervention and after the intervention? Is a solution or goal in place prior to the intervention? Is there a clear understanding of the benefit of the intervention? What are the ramifications of the intervention? What supplies are needed? Finally, ask yourself if you have proper assistance. Remember, this cannot be done alone!

Even the most organized of us cannot control outcomes. What do you do when a hoarding intervention goes wrong? Of course we want to avoid an "intervention gone wrong" at all costs, thus, advance planning is crucial. Yet, all key intervention team members must understand that we are not in control of the situation—the intervention could fail. To avert a failed intervention, we need to put the following four keys in place.

1. It is strongly suggested that clients use a professional. This may be you or you may need to seek an interventionist, but the plain fact is that most family members are not accustomed to confronting and addressing problems with each other. They may carry guilt from the past or bring up unresolved and unrelated issues.
2. Do not waiver from the determined goal. Do not lose focus on this goal once the intervention starts. Make sure that all who are involved are willing to do what it takes to make this intervention happen. Sometimes the addict will shift blame to other family members and try to take on the role of a victim.
3. Do not allow the family to become divided. Involve all members of the family in the intervention planning. Make sure that everyone who will be attending agrees with the ultimate goal. If even one family member isn't on board, he or she may secretly tell the hoarder about the intervention in advance or take sides with the hoarder.
4. Have an immediate plan of action. Prior to the intervention, make sure you have a plan of action that will actually get your client help after the intervention.

Now it is critical to remember that your hoarding client may not be ready at all. He or she may be completely unwilling and will not move off the dime around their situation.

Your best use of time when an intervention fails to launch or fails mid-stream, is to begin your work with the family, if they are willing. This is where we teach families compassion, knowledge, and the avoidance of enabling behavior. Sometimes our best work happens with failed interventions because it teaches the family—as Al-Anon does for family members of alcoholics—that we must let the hoarder experience his or her own consequences. Those very consequences just might catapult them into taking the first step toward their own hoarding recovery. C

Dorothy Breininger *is one of America's most trusted professional organizers. And the author of* Stuff YOur Face Or Face Your Stuff. *She has served on the board of directors for the National Association of Professional Organizers (NAPO), is a member of the National Study Group on Chronic Disorganization (NSGCD), and an annual sponsor for the Los Angeles Hoarding Conference.*

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AD INDEX

Codependency Revisited: Examining the Neurobiology that Leads to Addiction

1. What are the only kinds of relationships that codependency can occur in?

Ⓐ Family and friends
Ⓑ Peer and community
Ⓒ Romantic and work
Ⓓ Codependency can occur in any kind of relationship

2. True or False. Schore devised the internal working model (IWM) of attachment, and it states that in infancy, children mentally represent their attachment figures.

Ⓐ True Ⓑ False

3. All of the following were listed as consequences of poor IWM in children, except:

Ⓐ Trusting only internal experiences
Ⓑ Lacking positive sense of self
Ⓒ Mistrusting others
Ⓓ Inhibiting growth of psychological regulatory systems

4. True or False. Children in the first year of life have twice as many neurons as adults.

Ⓐ True Ⓑ False

5. The representations of relating to people that infants internalize eventually become the underlying structure shaping which of the following areas?

Ⓐ Sensation and perception
Ⓑ Thought and behavior
Ⓒ Memory and feeling
Ⓓ All of the above

Medical Marijuana and Hospice: Where is the Evidence?

1. Which of the following were not listed as results of research on medical marijuana?

Ⓐ Suicide and increased anxiety
Ⓑ Testicular cancer and stroke
Ⓒ Addiction and psychotic disorders
Ⓓ None of the above, these are all valid results

2. As listed in the article, medical marijuana has been shown to have positive effects on all of the following illnesses or conditions, except:

Ⓐ Cluster headaches
Ⓑ Neuropathic pain
Ⓒ Anxiety
Ⓓ AIDs

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3. True or False. In 1995, California became the first state to pass legislation to legalize medical marijuana.

Ⓐ True Ⓑ False

4. Which of the following was not listed as an ethical quandary involving medical marijuana that might face hospice employees?

Ⓐ Federal law still views marijuana as illegal
Ⓑ Medical marijuana doesn't have a recommended dosage
Ⓒ Medical marijuana cannot be dispensed by a pharmacy
Ⓓ None of the above, these are all valid quandaries

5. True or False. It is estimated that there are approximately four hundred components in marijuana, but tetrahydrocannabinol (THC) is the only one that has been involved in research.

Ⓐ True Ⓑ False

Listening for Psychic Retreats in Early Recovery Treatment for SUDs

1. All of the following are true about psychic retreats, except:

Ⓐ Psychic retreats are systems of primitive defenses
Ⓑ Psychic retreats provide an escape from reality
Ⓒ Psychic retreats are organized networks of object relations
Ⓓ None of the above, all statements are true

2. True or False. According to John Steiner, psychic retreats begin during an addict's infancy and/or childhood and involve overwhelming trauma and neglect.

Ⓐ True Ⓑ False

3. Which of the following is not one of the four stages of the Integrative Treatment Model (ITM)?

Ⓐ Active drinking and drugging
Ⓑ Denial
Ⓒ Early recovery
Ⓓ Ongoing recovery

4. True or False. All psychic retreaters have some form of substance use disorder.

Ⓐ True Ⓑ False

5. Which of the following is/are not true about features of psychic retreat object relations?

Ⓐ The retreater is never afraid of the internal characters
Ⓑ Internal characters may protect retreaters with vengeance or shelter them
Ⓒ Internal characters may be an island or a light bulb
Ⓓ Both B and C

Counselor Magazine Evaluation Quiz

Scale: 1 (low) – 5 (high)

Presenter (USJT)
Knowledgeable in content area

1 2 3 4 5

Content consistent with objectives

1 2 3 4 5

Content
Infortmation was suitable and useful to course topic

1 2 3 4 5

Article was appropriate to my education and licensure level

1 2 3 4 5

Information in the article was current

1 2 3 4 5

Appropriate for intended audience (Intermediate to advanced levels)

1 2 3 4 5

Clarity of content

1 2 3 4 5

Support
Did you need to contact the Program Administrator?

1 2 3 4 5

LEARNING OBJECTIVES:

After reading the following articles, the participant should be able to:

Codependency Revisited: Examining the Neurobiology that Leads to Addiction

1. Explain that codependency is a psychological condition in which a person is controlled and/or manipulated by another who is affected with a pathological condition, such as drug abuse, alcoholism or narcissism.
2. Discuss how codependency can begin from the moment a person is born if he or she doesn't receive the necessary safety, regulation, food, and comfort from a caregiver.
3. Demonstrate how young people with codependency issues may turn to drugs, alcohol, eating disorders, workaholism, gambling, and other behaviors to soothe their insecurity and shame.
4. Describe how codependents are fueled to give of themselves because growing up with a lack of attunement, experiencing shame, and having to take care of one's caregivers contracts the dopamine in their systems.

Medical Marijuana and Hospice: Where is the Evidence?

1. Critique the movement to legalize medical marijuana from a palliative care perspective and a scientific perspective.
2. List the benefits of medical marijuana, which include helping those with cluster headaches, neuropathic pain, and posttraumatic stress disorder (PTSD).
3. Analyze potential issues that could arise with medical marijuana legalization, such as the fact that it is not something that can be placed on a patient's medication administration record, it cannot be dispensed by a pharmacy, and there is no recommended dose.
4. Discuss the main concerns of medical marijuana legalization, such as the lack of research, studies, and evidence to determine whether it has no detrimental long-term effects on patients.

Listening for Psychic Retreats in Early Recovery Treatment for SUDs

1. Describe how psychic retreats are a method of protection against early trauma and neglect in which people withdraw into their own minds and deal with internal objects that have a distinct character.
2. Analyze how psychic retreats are held at bay by drinking and drugging, and how addicts in early recovery one again find themselves in need of the retreats as a way of coping with past trauma.
3. Explain the inner-workings of psychic retreats, such as how the destructive and dependent aspect of the addict is projected onto objects or characters that can include anything from a mafia gang or group of leprechauns to an island or a glass room.
4. Demonstrate knowledge of how the addict who experiences psychic retreats finds his or herself lacking the experience to deal with conflicts, the ability to accept help from real people, and the capability of relying on people for company and comfort.

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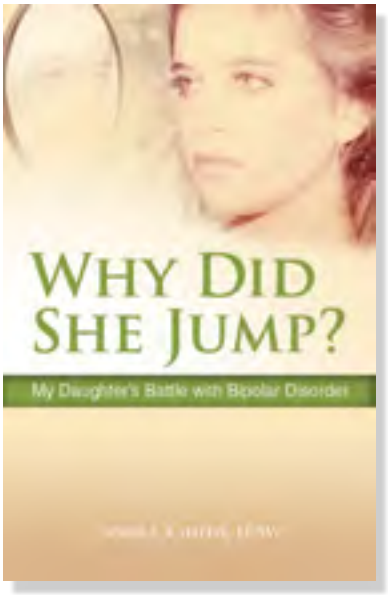
Why Did She Jump?

By Joan E. Childs

Reviewed by Leah Honarbakhsh



Why Did She Jump? conveys the heartbreaking tale of author Joan E. Childs's experience of losing a daughter to suicide—suicide that was a direct result of bipolar I disorder. Childs takes readers through her family's experiences of terror and chronic illness, loss and abyssal grief, and finally peace and acceptance.

Childs first realized that her daughter Pamela was seriously ill when Pam was twenty-four years old, in October 1989. At that time, Pam was a clinical therapist working in Los Angeles, California, for the John Bradshaw Center. Childs writes that "because of her youth and her inexperience, combined with her predisposition to bipolar disorder, Pam was vulnerable and susceptible to receiving the patients' negative energy" despite the success she had with her patients. Pam suddenly began to have hallucinations and exhibit signs of paranoia, eventually becoming so disoriented that Childs and Pam's father rushed her home to South Florida, not realizing that this would be the beginning of a very long, very arduous journey.

Through exceptional storytelling, both in the present and in flashbacks, Childs shares the turmoil that surrounded her family after the discovery of what would then become Pam's many years of struggles against bipolar I disorder. Shocking her friends, her siblings, and her parents, Pam's disorder was a daily battle against hallucinations, paranoia, and complete terror. She had explosive fits, became verbally abusive, and had to be constantly reminded to take care of her hygiene. Pam saw demons surrounding her mother and had grandiose fantasies about being chosen as a mediator between God and Lucifer. Throughout these desultory shifts in her nature, she would be depressed or prone to panic while her medications did nothing to alleviate her symptoms. Childs presents Pam's illness in a glaring spotlight, allowing readers to fully understand the distressing and unpredictable workings of bipolar I disorder.

After Pam's suicide, Childs's passage through grief came in stages every therapist and counselor knows—shock, anger, and guilt ruled her life for the months following her loss. Pam had been able to conceal the worst from her family up until the few months before her death, but still the questions remained: How was Childs, as a clinical therapist, unable to save her own daughter? How was Pam's father, a licensed physician, unable to recognize the signs that she was dangerously ill? After months of numbness, tears, and unsuccessful attempts to attend support groups, Childs finally learned to grieve, accept Pam's death, and let go.

Why Did She Jump? is a narrative of healing, the strength of family, and the power of love. In this book, Childs relives the most horrific part of her life to show readers that grief can be overcome and that no matter how bleak the world might seem after a tragedy, there is always hope and life after loss.

> *"This is what I have learned: to live each day as if it were my last, because one day it will be." – Joan E. Childs*

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